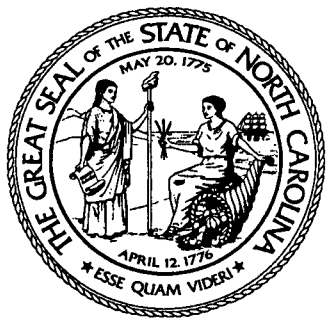
2005-2006

HOUSE INSURANCE

COMMITTEE MINUTES



House Insurance Committee

2005-2006

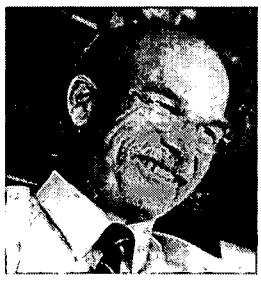
Representative L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE INSURANCE COMMITTEE
2005 – 2006 SESSION



Rep. Hugh Holliman
Chairman



Rep. Bill Faison
Vice-Chair



Rep. John Hall
Vice-Chair



Rep. Edd Nye
Vice-Chair



Rep. Mitchell Setzer
Vice-Chair



Rep. Lucy Allen



Rep. Cary Allred



Rep. David Almond



Rep. Jeff Barnhart



Rep. Harold Brubaker



Rep. William Current



Rep. Robert Grady



Rep. Julia Howard



Rep. Howard Hunter



Rep. Linda Johnson



Rep. Deborah Ross



Rep. Drew Saunders



Rep. Fred Steen



Rep. Ron Sutton



Rep. William Wainwright



Rep. Tom Wright

HOUSE COMMITTEE ON INSURANCE
MEMBERSHIP

MEMBER	ASSISTANT	PHONE	OFFICE	SEAT
Holliman, Hugh, Chairman	Carol Bowers	5-0873	1213	55
Faison Bill, Vice-Chair	Katie Jackelen	5-3019	417A	93
Hall John, Vice-Chair	Phyllis Cameron	3-5878	611	60
Nye Edd, Vice-Chair	Jo Bobbitt	3-5477	639	23
Setzer Mitchell, Chair	Joanna Mills	3-4948	1204	49
Allen, Lucy	Melissa Riddle	3-5860	1307	92
Allred, Cary	Jean Allred	3-5905	606	38
Almond, David	Alice Falcone	3-5741	1315	107
Barnhart, Jeff	Pamela Ahlin	5-2009	608	76
Brubaker, Harold	Cindy Coley	5-4946	1229	2
Current, William	Wendy Miller	3-5809	539	108
Grady, Robert	Neta Grady	5-9644	302A	4
Howard, Julia	Anne Soles	3-5904	1106	3
Hunter, Howard	Barbara Phillips	3-2962	613	68
Johnson, Linda	Rachel Faison	3-5861	1006	28
Ross, Deborah	Margie Penven	3-5773	2223	65
Saunders, Drew	Ruth Fish	3-5606	2217	48
Steen, Fred	Chris Floyd	3-5881	514	64
Sutton, Ron	Juanita Coley	5-0875	1321	71
Wainwright, William	Blinda Edwards	3-5995	532	8
Wright, Tom	Clarestene Stewart	3-5754	528	19

Ex-Officio Members:

Culpepper, Bill	Dot Crocker	5-3028	404	36
Cunningham, Pete	Valerie Rustin	3-5778	541	7
Eddins, Rick	Dorie Monroe	3-5828	1002	26
Hackney, Joe	Emily Reynolds	3-5752	2207	69

Legislative Staff: Research – 733-2578

Tim Hovis
Kory Goldsmith
Ben Popkin

2/28/05

ATTENDANCE

HOUSE INSURANCE COMMITTEE

DATES:	3/17/05	3/30/05	4-14-05	4-19-05	4-21-05	4-26-05	5-3-05	5/5/05	5-10-05	5-12-05	5/19/05	5/24/05	5-26-05	6-2-05	7-5-05	8-2-05
Rep. Hugh Holliman, Chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rep. Bill Faison, Vice-Chair	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rep. John Hall, Vice-Chair			✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rep. Edd Nye, Vice-Chair	✓	✓	✓				✓	✓			✓					
Rep. Mitchell Setzer, Vice-Chair	✓	✓		✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rep. Lucy Allen	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Rep. Cary Allred	✓	✓	✓			✓	✓		✓	✓		✓				
Rep. David Almond	✓	✓	✓			✓	✓		✓	✓	✓	✓				✓
Rep. Jeff Barnhart	✓	✓		✓		✓			✓				✓	✓		✓
Rep. Harold Brubaker	✓	✓		✓		✓	✓		✓		✓	✓				
Rep. William Current	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rep. Robert Grady	✓		✓				✓			✓	✓	✓				✓
Rep. Julia Howard	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓		
Rep. Howard Hunter																
Rep. Linda Johnson	✓		✓	✓		✓						✓				
Rep. Deborah Ross	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Rep. Drew Saunders	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Rep. Fred Steen	✓		✓			✓	✓	✓		✓	✓	✓				✓
Rep. Ron Sutton	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓
Rep. William Wainwright		✓	✓		✓	✓				✓	✓	✓				✓
Rep. Tom Wright	✓			✓	✓	✓				✓					✓	
																✓
Rep. Harold Brubaker, Ex-officio	✓	✓														
Rep. Bill Culpepper, Ex-officio																
Rep. Pete Cunningham, Ex-officio																
Rep. Rick Eddins, Ex-officio																
Tim Hovis. Staff Attorney	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓
Kory Goldsmith, Staff Attorney	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	
Ben Popkin, Staff Attorney	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓		✓		✓	✓

ATTENDANCE

HOUSE INSURANCE COMMITTEE

2005 SESSION

DATES:	5-4-05	4.27.05													
Rep. Hugh Holliman, Chairman		✓													
Rep. Bill Faison, Vice-Chair		✓													
Rep. Edward Jones, Vice-Chair		✓													
Rep. Edd Nye, Vice-Chair		✓													
Rep. Mitchell Setzer, Vice-Chair															
Rep. Lucy Allen		✓													
Rep. Cary Allred															
Rep. David Almond		✓													
Rep. Jeff Barnhart		✓													
Rep. Harold Brubaker		✓													
Rep. William Current		✓													
Rep. Robert Grady		✓													
Rep. Julia Howard		✓													
Rep. Howard Hunter															
Rep. Linda Johnson		✓													
Rep. Deborah Ross		✓													
Rep. Drew Saunders		✓													
Rep. Fred Steen		✓													
Rep. Ron Sutton		✓													
Rep. William Wainwright		✓													
Rep. Tom Wright		✓													
Rep. Rick Eddins, Ex-officio															
Rep. Bill Culpepper, Ex-officio															
Rep. Pete Cunningham, Ex-officio															
Rep. Joe Hackney, Ex-officio															
Tim Hovis. Staff Attorney		✓													
Kory Goldsmith, Staff Attorney															
Ben Popkin, Staff Attorney		✓													

2005-2006 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H0020	Holliman	HEALTH INSURANCE CREDIT/MINIMUM WAGE.	*H	Ref To Com On Finance	03-10-05	03-17-05
H0644	Holliman	AGENT/BAIL BONDS APPLICANT PETITION DEADLINE.-AB	H	Ref To Com On Insurance	03-16-05	
$ H0645=	**Holliman**	**AMEND WARRANTY/ SERVICE AGMT LAWS/ STUDY**	***H**	**Re-ref Com On Appropriations**	**03-16-05**	**05-12-05**
H0646	Holliman	INSURANCE COMPANY FEE CONSOLIDATION.-AB	*H	Pres. To Gov. 8/ 24/2005	03-16-05	04-18-05
H0647	Holliman	DOI HEARING/UNAUTH. INS. SUMMARY C&D ORDER.-AB	H	Ref To Com On Insurance	03-16-05	
H0653=	Holliman	CREDIT INSURANCE CHANGES.-AB	*HR	Ch. SL 2005-181	03-16-05	06-02-05
H0654	Holliman	CONFIDENTIAL INSURANCE MKT./ FINANCIAL DOC.-AB	*HR	Ch. SL 2005-206	03-16-05	04-21-05
H0655	Holliman	BETTER INSURANCE/ ANNUITY DISCLOSURE.-AB	*HR	Ch. SL 2005-234	03-16-05	04-25-05
H0656=	Holliman	WORKERS' COMP/SELF-INSURED GUARANTY ASSOC.-AB	H	Ref To Com On Insurance	03-16-05	
H0657	Holliman	PRODUCER COMP. TRANSPARENCY AND BROKER DUTY.-AB	*H	Ref To Com On Commerce	03-16-05	05-25-05
$ H0658	**Holliman**	**CODE OFFICIALS PROFESSIONALISM.-AB**	***HR**	**Ch. SL 2005-102**	**03-16-05**	**05-04-05**
H0659=	Holliman	UNAUTHORIZED INSURER MISCONDUCT.-AB	H	Ref To Com On Insurance	03-16-05	
H0660	Holliman	INSURANCE FINANCIAL CHANGES.-AB	*HR	Ch. SL 2005-215	03-16-05	04-18-05
H0672	Holliman	REDUCE HOLDING PERIOD FOR UNCLAIMED PROPERTY.-AB	*HR	Ch. SL 2005-132	03-17-05	05-04-05
H0673	Holliman	INTERSTATE INSURANCE PRODUCT REG. COMPACT.-AB	*HR	Ch. SL 2005-183	03-17-05	05-12-05
H0674	Holliman	INSURANCE PEO EXAMINATION AUTHORITY.-AB	H	Ref To Com On Insurance	03-17-05	
H0675=	Holliman	INSURANCE TECHNICAL CORRECTIONS.-AB	H	Ref To Com On Insurance	03-17-05	
H0727	Holliman	HIPAA COMPLIANCE AND FAIRNESS.-AB	H	Ref To Com On Insurance	03-17-05	
H0733	Holliman	LICENSE INSURANCE STATISTICAL ORGANIZATIONS.-AB	*HR	Ch. SL 2005-210	03-17-05	04-25-05
H0734	Holliman	NAVASSA ZONING JURISDICTION.	*H	Ref To Com On Rules, Calendar, and Operations of the House	03-17-05	05-02-05
H0735	Holliman	ACCIDENT & HEALTH INSUR./RATE STABILIZATION.-AB	*H	Pres. To Gov. 8/ 23/2005	03-17-05	04-27-05
H0737	Holliman	HEALTH INSURANCE	*HR	Ch. SL 2005-223	03-17-05	04-20-05

'$' indicates the bill is an appropriation bill.
A bold line indicates the bill is an appropriation bill.
'*' indicates that the text of the original bill was changed by some action.
'=' indicates that the original bill is identical to another bill.

2005-2006 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		CHANGES.				
H0817=	Pate	AMEND FIREMEN'S RELIEF FUND REQUIREMENT.	H	Ref To Com On Insurance	03-21-05	
H1185	Moore	FIRE DEPARTMENT GRANTS.	H	Ref To Com On Insurance	04-12-05	
H1225	Holliman	INFORM INSURANCE CONSUMERS ABOUT SURCHARGE.	H	Ref To Com On Insurance	04-14-05	
H1236	Holliman	INSURANCE BD. OF GOVERNORS MEMBERSHIP.	*HR	Ch. SL 2005-242	04-18-05	05-25-05
H1244=	Hill	MOTOR VEHICLE REPAIR CONSUMER PROTECTION.	H	Re-ref Com On Judiciary III	04-18-05	05-03-05
H1312=	Wright	INSURANCE PREMIUM DISCOUNT/PREVENTION COURSE.	H	Ref To Com On Insurance	04-20-05	
H1524	Wilson	COMPETITIVE SELECTION/ SUPPLEMENTAL INSURANCE.	*H	Re-ref Com On Rules, Calendar, and Operations of the House	04-21-05	05-23-05
H1526=	Frye	AVERY COUNTY/HERITAGE PARK AUTHORITY.	*H	Re-ref Com On Finance	04-21-05	05-31-05
$ H1535	**Insko**	**ESTABLISH NC HEALTH INSURANCE RISK POOL.**	**H**	**Ref To Com On Insurance**	**04-21-05**	
$ H1768	**Gibson**	**AMEND WORKERS' COMPENSATION ACT/ FUNDS.**	**H**	**Ref to the Com on Insurance and, if favorable, to the Com on Rules, Calendar, and Operations of the House**	**05-12-05**	
S0140=	Fred Smith	AMEND FIREMEN'S RELIEF FUND REQUIREMENT.	*H	Re-ref Com On Insurance	07-14-05	
S0277	Walter H. Dalton	MOTOR VEHICLE SELF-INSURERS.	*H	Ref To Com On Insurance	06-02-05	
S0319	Daniel G. Clodfe	WORKERS' COMP. SELF-INSURANCE SECURITY.	*H	Pres. To Gov. 8/ 24/2005	07-06-05	08-23-05
S0552=	Walter H. Dalton	DOI HEARING/UNAUTH. INS. SUMMARY C&D ORDER.-AB	*HR	Ch. SL 2005-217	04-25-05	07-05-05
S0577=	Walter H. Dalton	UNAUTHORIZED INSURER MISCONDUCT.-AB	HR	Ch. SL 2005-209	04-11-05	07-05-05
S0615=	Scott Thomas	INSURANCE TECHNICAL CORRECTIONS.	H	Ref To Com On Insurance	05-16-05	
S0626=	Scott Thomas	HIPAA COMPLIANCE AND FAIRNESS.-AB	*HR	Ch. SL 2005-224	04-12-05	07-07-05
S0685	Stan Bingham	REVISE PROFESSIONAL EMPLOYER ORGANIZATION ACT.	*HR	Ch. SL 2005-124	03-29-05	03-30-05
S0687	John H. Kerr III	VOLUNTEER RESCUE/EMS FUNDING.	*HR	Ch. SL 2005-283	05-31-05	07-27-05
S0707=	Philip E. Berger	AGENT/BAIL BONDS APPLICANT PETITION DEADLINE.	*HR	Ch. SL 2005-240	04-12-05	07-07-05
S0881	Linda Garrou	LAPSE IN LIABILITY	*H	Ref To Com On	08-15-05	

'$' indicates the bill is an appropriation bill.
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'*' indicates that the text of the original bill was changed by some action.
'=' indicates that the original bill is identical to another bill.

2005-2006 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		INSURANCE.		Insurance		

'$' indicates the bill is an appropriation bill.
A bold line indicates the bill is an appropriation bill.
'*' indicates that the text of the original bill was changed by some action.
'=' indicates that the original bill is identical to another bill.

MINUTES
HOUSE COMMITTEE ON INSURANCE
March 17, 2005

The House Committee on Insurance met at 11:00 AM on Thursday, March 17, 2005 in Room 1228. The following Representatives attended, Chairman Hugh Holliman, Vice Chairs: Bill Faison, Edd Nye, Mitchell Setzer, Members: Lucy Allen, Cary Allred David Almond, Jeff Barnhart, Harold Brubaker, William Current, Robert Grady, Julia Howard, Linda Johnson, Deborah Ross, Drew Saunders, Fred Steen, Ron Sutton, and Tom Wright.

Chairman Holliman called the meeting to order. He introduced the Pages, the Sgt.-At-Arms, and welcomed staff and visitors. See Attachments I and II. He requested a moment of silence for Vice-Chair Rep. John Hall who had passed away the day before.

Rep. Holliman asks Vice-Chair Setzer to conduct the meeting as HB 20 - Small Business Health Insurance Credit was introduced by him. Rep. Setzer then ask Rep. Holliman to speak on HB 20. Rep. Holliman explained that the legislation is needed for small businesses with 25 employees or less and would help with the rising cost of health insurance. See Attachment III.

Bill Sponsors Rep. Bordsen reminded the committee members about the economical development possibilities and Rep. Goforth spoke to the cost and incentives for small businesses and asks for the members support.

Greg Thompson with NFIB spoke in support of this legislation. After some discussion and questions from members, Cindy Averette, Finance Committee Counsel, spoke about the fiscal note and the bill summary. See Attachments IV and V.

Rep. Ross made a motion for a favorable report and re-referred HB 20 to Finance. The Committee concurred.

The meeting was adjourned at 11:23 AM.

Representative. L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2003-2004 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **Thursday, March 17, 2005**

TIME: **11:00 AM**

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 20 -SMALL BUSINESS HEALTH INSURANCE CREDIT – Rep. Holliman

Respectfully,
Representative Holliman
Chairman

I hereby certify this notice was filed by the committee assistant at the following offices at 1:30 PM on March 10, 2005.

___Principal Clerk
___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

HOUSE INSURANCE COMMITTEE

March 17, 2005
11:00 AM
Room 1228/1327 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. John Hall
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

HB 20 – Small Business Health Insurance Credit – Rep. Holliman

Attachment 1

HOUSE COMMITTEE ON INSURANCE

March 17, 2005
11:00 AM
Room 1228 Legislative Building

Pages:

Name (please print)	County	Representative
Daniel Stevens	Wake	R. Capps
Andy Allen	Cleveland County	D. Clary

Sergeant-At-Arms (please print)

Toussaint L. Avent
FRANK PROVO
Charles Williams

Attachment II

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — March 17, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Shore	NC Pediatric Society
Rep Jerry Dockham	N.C. House
David Barnes	Poyner Spruill LLP
David Crawford	AIA North Carolina
Abby Emanuelson	Nat'l MS Society
Guy Ralph	DOR
Liz Hodge	KCLH
Steve Warsaw	NC Farm Bureau
Roz Sawicki	NC Child Care Coalition
Anne Dunn	AARP
Lynn Tenga	NMRS

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — March 17, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Frank W. Folger	NCDOI
BILL HALE	ACLI
Robert Parham	Young, Moore
	JD, AL, PA
DON HUBERT	NCDOC
	NCAHP
BILL SCOGGIN	KCLH
LEE HOOKS	KCLH
Ken Wright	BCBSNC
	ALCASTOR

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — March 17, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Paul Pulley	NCATL
John Medlin	Gov affairs
Stephanie Dorko	Charlotte Chamber
Debra Simpson	Carolinas AGC
Kelly Redmond	DeSR
Jon Hunt	NCRA
Angie White	Speaker's Staff

attachment III

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 1

HOUSE BILL 20

Short Title:	Small Business Health Insurance Credit.	(Public)
Sponsors:	Representatives Holliman, Bordsen, Goforth, Ross (Primary Sponsors); Alexander, L. Allen, Allred, Bell, Brown, Carney, Coates, Daughtridge, Dickson, England, Faison, Frye, Gibson, Glazier, Goodwin, Hackney, Haire, Harrell, Harrison, Insko, Johnson, Jones, LaRoque, Luebke, Martin, McGee, McLawhorn, Pate, Rapp, Saunders, Sherrill, Stiller, Underhill, Warren, Weiss, Wilkins, Williams, Womble, and Wray.	
Referred to:	Finance.	

January 31, 2005

A BILL TO BE ENTITLED

AN ACT TO PROVIDE A TAX CREDIT FOR SMALL BUSINESSES THAT PROVIDE EMPLOYEE HEALTH INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 3B of Chapter 105 of the General Statutes is amended by adding a new section to read:

"**§ 105-129.16D. Credit for small business employee health benefits.**

(a) Credit. – A small business that provides health benefits for all of its eligible employees during the taxable year is allowed a credit to offset its costs in providing health benefits for its eligible employees. For the purposes of this subsection, a taxpayer provides health benefits if it pays at least fifty percent (50%) of the premiums for health care coverage that equals or exceeds the minimum provisions of the basic health care plan of coverage recommended by the Small Employer Carrier Committee pursuant to G.S. 58-50-125.

The credit is equal to a dollar amount per eligible employee, not to exceed the taxpayer's costs of providing health benefits for its eligible employees during the taxable year. For each eligible employee for whom the taxpayer provides health benefits, the amount is four hundred dollars ($400.00).

(b) Allocation. – If the taxpayer is an individual who is a nonresident or a part-year resident, the taxpayer must reduce the amount of the credit by multiplying it by the fraction calculated under G.S. 105-134.5(b) or (c), as appropriate. If the taxpayer is not an individual and is required to apportion its multistate business income to this State, the taxpayer must reduce the amount of the credit by multiplying it by the apportionment fraction used to apportion its business income to this State.

(c) Definitions. – The following definitions apply in this section:

(1) Eligible employee. – Defined in G.S. 58-50-110.

(2) Small business. – A taxpayer that employs no more than 25 employees throughout the taxable year."

SECTION 2. This act becomes effective for taxable years beginning on or after January 1, 2006.

Attachment IV

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2005

Legislative Fiscal Note

BILL NUMBER: House Bill 20 (First Edition)

SHORT TITLE: Small Business Health Insurance Credit.

SPONSOR(S): Representatives Holliman, Ross, Goforth, and Bordsen

FISCAL IMPACT
($MIL.)

Yes (X) **No ( )** **No Estimate Available ( )**

	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
REVENUES:					
State General Fund	**-21.5**	**-48.1**	**-48.6**	**-49.3**	**-50.2**
EXPENDITURES:					
POSITIONS (cumulative):					

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Income taxes are administered by the Department of Revenue. The enactment of the bill is not expected to affect the budget requirements of the Department.

EFFECTIVE DATE: Tax years beginning on or after January 1, 2006.

BILL SUMMARY: Allows an employer who provides health benefits for all employees to take a state tax credit for the employer's costs in providing the benefits. The credit can be taken against the income or franchise tax. To be eligible, the employer must pay at least 50% of the premiums for health coverage that meets or exceeds the minimum provisions of a basic health care plan of coverage recommended by the Small Employer Carrier Committee. In addition, the employer must have no more than 25 employees.

The credit is equal to 100% of the employer's cost of providing the benefits, up to a maximum of $400 for each employee covered. The credit is limited to 50% of tax liability, with a five-year carryforward.

ASSUMPTIONS AND METHODOLOGY: The first step in the analysis was to review the detailed employer health insurance data from the 2001 Medical Expenditure Panel Survey from the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. The data included a tabulation of the number of firms in North Carolina who offered health coverage for employees, by size of firm. One of the breakpoints in the distribution data was for firms of 25 or less employees. The data indicated that 31% of employees are presently covered by employer-sponsored plans in this category.

The survey data included a tabulation of the cost of various types of coverage. For 2001 the average employer's costs ranged from $3,024-$4,971 per year, depending on the number of family members covered. Data for 1998-2002 from the Department of Insurance indicates that the average annual cost is rising at double-digit rates. Since the credit limit will be far less than 100% of a typical employer's cost, the actual amount of the average costs do not affect the calculation.

There is no way to make a reliable prediction of the proportion of uncovered employees who would receive coverage as a result of the $400 tax credit. For the purpose of this analysis, it was assumed that 10% of the uncovered employees would begin to be covered.

The credit is limited to 50% of the taxpayer's income tax liability for the tax year. In this analysis, we are assuming that the limitation leads to a credit utilization rate of 80% in the year of credit eligibility.

The credit cost was calculated using the 2001 survey data. The number was used also for 2005 under the assumption that the sharp rise in the employer's cost for health insurance coverage has reduced the proportion of employers who choose to provide coverage. Thus, the number of covered workers would not rise even though the number of small business establishments would go up.

For years following 2005, annual growth based on projected nonagricultural employment in North Carolina was used. This estimate was made by the nationally recognized forecasting firm, Economy.com (January 2005).

The tax year costs were then split into fiscal years using the assumption that 45% of the cost of a credit would occur during the January-June period and the remainder during the second half of the tax year. The 45% assumption reflects April and June estimated tax payments and the fact that taxpayers can avoid an underpayment penalty for estimated taxes by sending in at least 90% of the annual liability during the tax year.

SOURCES OF DATA: A review of similar incentives in a handful of other states did not provide any useful information due to the differences in types of incentives.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: David Crotts

APPROVED BY: James D. Johnson, Director
Fiscal Research Division



DATE: March 4, 2005

Signed Copy Located in the NCGA Principal Clerk's Offices

Attachment V

HOUSE BILL 20:
Small Business Health Insurance Credit

BILL ANALYSIS

Committee:	Insurance	**Introduced by:**	Rep. Holliman
Date:	March 17, 2005	**Summary by:**	Cindy Avrette
Version:	1st Edition		Finance Committee Counsel

SUMMARY: ***House Bill 20 would provide a tax credit to a small business that provides health insurance to all of its full-time employees. The amount of the credit would be $400 per each eligible employee for whom the taxpayer provides health insurance benefits. A small business is defined to be a taxpayer that employs no more than 25 employees throughout the taxable year. The credit would be in addition to any expense deduction the taxpayer claimed on its income tax return for the health insurance costs. The bill would become effective for taxable years beginning on or after January 1, 2006.***

CURRENT LAW: The General Assembly has enacted legislation over the past several years to encourage small businesses to provide health insurance benefits to their employees. In 1991, the General Assembly enacted the 'Small Employer Group Health Insurance Reform Act' to promote the availability of accident and health insurance coverage, to prevent abusive rating practices, and to develop standard and basic health care plan coverage. The General Assembly also made the provision of health insurance a requirement of eligibility for both the Bill Lee Act credits and grants awarded under the Job Development Grant Program. In 2003, the General Assembly established the North Carolina Health Insurance Innovations Commission to address the availability and affordability of adequate health insurance coverage for small business owners and employees.

Under the Internal Revenue Code, an employer may deduct premiums paid for health insurance cost of its employees as a business expense. According to data from the 2001 Medical Expenditure Panel Survey from the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, 31% of employees employed by firms with 25 or fewer employees are covered by employer-sponsored plans. For 2001, the average employer's costs of providing this coverage ranged from $3,024 to $4,971 per year, depending on the number of family members covered. Data for 1998-2002 from the Department of Insurance indicates that the average annual cost is rising at double-digit rates.

BILL ANALYSIS: House Bill 20 creates a new tax credit for a taxpayer that employs no more than 25 full-time employees and pays at least 50% of the premiums for health insurance coverage for those employees. The health insurance benefits offered to those employees must equal or exceed the minimum provisions of the basic health care plan of coverage recommended by the Small Employer Carrier Committee. The credit amount is equal to $400 per eligible employee, not to exceed the taxpayer's cost of providing the health insurance benefits. The taxpayer may use the credit against either its income tax or its franchise tax liability. The credit may not exceed 50% of the taxpayer's tax liability. Any unused portions of the credit may be carried forward for five years. The bill becomes effective for taxable years beginning on or after January 1, 2006.

TECHNICAL CONSIDERATIONS: The statutory reference needs to be changed because the one referenced is already being used. The definition of 'small business' needs to stipulate that the employees are ***full time*** employees so that the term is consistent with the definition of 'eligible employee': Lastly, the Article into which this statute is being added expires January 1, 2006, the same date that the statute itself becomes effective.

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative **HOLLIMAN** (Chair) for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 20 A BILL TO BE ENTITLED AN ACT TO PROVIDE A TAX CREDIT FOR SMALL BUSINESSES THAT PROVIDE EMPLOYEE HEALTH INSURANCE.

☐ With a favorable report.

☒ With a favorable report and recommendation that the bill be re-referred to the Committee on ~~Appropriations~~ ☐ Finance ☒ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to the committee substitute bill (#), ☐ which changes the title, unfavorable as to (the original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

03/19/03

MINUTES

HOUSE COMMITTEE ON INSURANCE
March 30, 2005

The House Committee on Insurance met at 10:00 AM on Wednesday, March 30, 2005 in Room 1228. The following Representatives attended, Chairman Hugh Holliman, Vice Chairs: Bill Faison, Edd Nye, Mitchell Setzer, Members: Lucy Allen, Cary Allred David Almond, Jeff Barnhart, Harold Brubaker, William Current, Julia Howard, Deborah Ross, Ron Sutton, William Wainwright.

Chairman Holliman called the meeting to order. He introduced the pages, the Sgt.-At-Arms, and welcomed staff and visitors. See Attachment I.

Senator Bingham sponsor of a Proposed Committee Substitute - SB 685 - Revise Professional Employer Organization Act was unable to attend.

Frank Folger, Legislative Counsel for the Department of Insurance, explained the importance of SB 685 and spoke about how a committee substitute would give funding to the department to enforce the regulation of professional employer organizations (PEOs). Mr. Folger explained each section of the bill and answered committee questions. See Attachment II and III.

Ed Turlington representing the National Association of Professional Employers (NAPE) reported that Senators Bingham and Rand had started work on this issue in 2002 and explained PEO's.

Senator Rand speaking on behalf of Sen. Bingham explained how this bill extends the deadline for PEO licensing to avoid confusion over possible criminal penalties if a PEO were not licensed by the existing deadline and provides funding for the Insurance Department to enforce the act.

An amendment was adopted to remove a provision providing for a decrease in fees for de minimis registration. See Attachment IV. Rep. Brubaker made a motion to approve the amendment and the committee concurred.

Rep. Sutton made a motion for a favorable PCS and to refer the bill to House Appropriations. Motion carried unanimously.

The Meeting was adjourned at 10:35 AM

Representative. L. Hugh Holliman, Chairman

Carol Bowers, Committee Assistant

Carol Bowers (Rep. Holliman)

Subject: FW: House Committee on Insurance

Note: Date and Time Change

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE:	**Wednesday, March 30, 2005**
TIME:	**10:00 AM**
LOCATION:	**1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

SB 685-Revise Professional Employer Organization Act. -Senator Bingham

Respectfully,
Representatives Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 12:30 PM on March 29, 2005

___Principal Clerk
___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

HOUSE INSURANCE COMMITTEE

March 30, 2005
10:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

SB 685 - Revise Professional Employer Organization Act – Senator Bingham

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative **HOLLIMAN** (Chair) for the Committee on **INSURANCE**.

☒ Committee Substitute for
S.B. 685 A BILL TO BE ENTITLED AN ACT TO REVISE THE PROFESSIONAL EMPLOYER ORGANIZATION ACT BY PROVIDING FOR THE CANCELLATION OF SURETY BONDS UNDER CERTAIN CIRCUMSTANCES, DECREASING THE FEE FOR LIMITED LICENSES, ESTABLISHING THE REQUIREMENTS FOR LIMITED LICENSES, REQUIRING THE COMMISSIONER OF INSURANCE TO PROVIDE FOR ALTERNATIVE LICENSES, PROVIDING THAT APPLICANTS FOR LICENSURE ARE NOT REQUIRED TO PROVIDE EVIDENCE TO THE COMMISSIONER THAT THE WORKERS' COMPENSATION PREMIUM PAID BY THE APPLICANT IS COMMENSURATE WITH EXPOSURE AND ANTICIPATED CLAIM EXPERIENCE FOR ALL EMPLOYEES COVERED UNDER POLICIES IN THE NAME OF THE LICENSEE, REVISING THE LAW GOVERNING EVIDENCE OF FINANCIAL RESPONSIBILITY FOR ORGANIZATIONS APPLYING FOR LICENSURE ON OR BEFORE JUNE 30, 2005, CHANGING THE EFFECTIVE DATE FOR LICENSURE OF PROFESSIONAL EMPLOYER ORGANIZATIONS TO JULY 1, 2005, PROVIDING A TRANSITION PERIOD FOR ORGANIZATIONS REGISTERING UNDER ARTICLE 89 OF CHAPTER 58 OF THE GENERAL STATUTES, AND AUTHORIZING THE USE OF FUNDS FROM THE INSURANCE REGULATORY FUND FOR REGULATION OF PROFESSIONAL EMPLOYER ORGANIZATIONS.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☒ With a favorable report as to the committee substitute bill ~~(# _____)~~ House ☒ which changes the title, unfavorable as to (the original bill) ~~(Committee Substitute Bill # _____)~~, (and recommendation that the committee substitute bill ~~# _____~~ House be re-referred to the Committee on Appropriations.)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

ATTACHMENT 1

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — March 30, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Marlene Foster	NCAHIP
[signature]	IFNC
[signature]	[illegible]
Steve Woodson	NC Farm Bureau
[signature]	Nationwide
CURTIS WOODS	INTERN (REP. SUTTON)
Lee Hoag	NCCLH
[signature]	Young, Moore
John McKay	Governor
[signature]	BPOLH
[signature]	PWKOL

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — March 30, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	NCAHP
Courtney Crowder	NC DOI
	NMRS

ATTACHMENT II

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 685

Commerce Committee Substitute Adopted 3/24/05

PROPOSED HOUSE COMMITTEE SUBSTITUTE S685-CSRG-4 [v.2]

3/30/2005 9:11:41 AM

Short Title: Revise Professional Employer Organization Act. (Public)

Sponsors:

Referred to:

March 21, 2005

A BILL TO BE ENTITLED

AN ACT TO REVISE THE PROFESSIONAL EMPLOYER ORGANIZATION ACT BY PROVIDING FOR THE CANCELLATION OF SURETY BONDS UNDER CERTAIN CIRCUMSTANCES, DECREASING THE FEE FOR DE MINIMIS REGISTRATION, ESTABLISHING THE REQUIREMENTS FOR DE MINIMIS REGISTRATION, PROVIDING THAT APPLICANTS FOR LICENSURE ARE NOT REQUIRED TO PROVIDE EVIDENCE TO THE COMMISSIONER THAT THE WORKERS' COMPENSATION PREMIUM PAID BY THE APPLICANT IS COMMENSURATE WITH EXPOSURE AND ANTICIPATED CLAIM EXPERIENCE FOR ALL EMPLOYEES COVERED UNDER POLICIES IN THE NAME OF THE LICENSEE, REVISING THE LAW GOVERNING EVIDENCE OF FINANCIAL RESPONSIBILITY FOR ORGANIZATIONS APPLYING FOR LICENSURE ON OR BEFORE JUNE 30, 2005, PROVIDING FOR CONDITIONAL AUTHORITY FOR A PROFESSIONAL EMPLOYER ORGANIZATION TO OPERATE PENDING CONSIDERATION OF ITS LICENSE APPLICATION UPON A SHOWING OF FINANCIAL STABILITY AND NEED, AUTHORIZING THE USE OF FUNDS FROM THE INSURANCE REGULATORY FUND FOR REGULATION OF PROFESSIONAL EMPLOYER ORGANIZATIONS, AND APPROPRIATING FUNDS TO THE DEPARTMENT FOR REGULATION OF PROFESSIONAL EMPLOYER ORGANIZATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-89A-50 reads as rewritten:

"**§ 58-89A-50. Surety bond; letter of credit.**

(a) An applicant for licensure shall file with the Commissioner a surety bond in the amount of one hundred thousand dollars ($100,000) in favor of the State of North Carolina.

(b) The surety bond required by this section shall be in a form acceptable to the Commissioner, issued by an insurer authorized by the Commissioner to write surety business in this State, and maintained in force while the license remains in effect or any obligations or liabilities of the applicant, licensee or PEO previously licensed by this State remain outstanding.

(c) The surety bond required by this section may be exchanged or replaced with another surety bond if (i) the surety bond applies to obligations and liabilities that arose during the period of the original surety bond, (ii) the surety bond ~~that~~ meets the requirements of this ~~section if~~ section, and (iii) 90 days' advance written notice is provided to the Commissioner.

(d) A licensee shall not require a client company to contribute in any manner to the payment of the surety bond required by this section.

(e) Notice of cancellation or nonrenewal of the surety bond required by this section shall be provided to the Commissioner in writing at least 45 days before cancellation or nonrenewal.

(e1) A surety bond may be cancelled by the issuer of the bond with respect to future obligations or liabilities upon proper notice pursuant to this section and without regard to approval or acceptance of the Commissioner.

(f) In lieu of the surety bond required by this section, an applicant may submit to the Commissioner an irrevocable letter of credit in a form acceptable to the Commissioner issued by a financial institution, the deposits of which are insured by the Federal Deposit Insurance Corporation, or may maintain on deposit with the Commissioner an amount equal to the amount required under subsection (a) of this section in cash or in value of securities of the kind specified in ~~G.S. 58-5-20 and subject to the same conditions as the surety bond.~~ G.S. 58-5-20.

(g) This section does not apply to persons who are licensed pursuant to the alternative licensing procedures set forth in ~~G.S. 58-89A-76.~~ G.S. 58-89A-76 or to persons who are de minimis registrants pursuant to G.S. 58-89A-75.

(h) The license of any licensee that fails to provide and maintain a surety bond, letter of credit, cash, or securities pursuant to this section shall be automatically and immediately suspended, and the licensee shall tender its license to the Commissioner within three days of failure to satisfy this requirement."

SECTION 2. G.S. 58-89A-65 reads as rewritten:

"**§ 58-89A-65. Fees.**

(a) Each applicant for a professional employer organization license ~~or limited professional employer organization license~~ shall pay to the Commissioner, before the issuance of the license, a nonrefundable application fee of one thousand dollars ($1,000).

(b) Each licensee shall pay to the Commissioner when filing the information required under G.S. 58-89A-70(d) an annual filing fee of one thousand dollars ($1,000).

(c) Each applicant for (i) alternative licensing under ~~G.S. 58-89A-76 and each applicant for~~ G.S. 58-89A-76, ~~renewal of a license provided under G.S. 58-89A-76~~ and each de minimis registrant under G.S. 58-89A-75, shall pay to the Commissioner, before issuance or renewal of the license, a fee of five hundred dollars ($500.00).

(d) When the Commissioner finds that a licensee has committed an act that is a ground for disciplinary violation under G.S. 58-89A-155 or that a licensee has committed a prohibited act in violation of G.S. 58-89A-170, and such decision becomes final following the conclusion of all administrative or judicial proceedings, the Commissioner may charge an applicant or licensee reasonable fees to recover the Department's costs associated with investigations, inspections, examinations, and any other administrative or enforcement responsibilities created under this Article.

(e) Fees collected by the Commissioner under this Article shall be deposited in the Insurance Regulatory Fund under G.S. 58-6-25 and shall be used to implement this Article."

SECTION 3. G.S. 58-89A-75 reads as rewritten:

"**§ 58-89A-75. ~~Limited license.~~ De minimis registration.**

~~The Commissioner, by rule, shall provide for the issuance of a limited license to a person who seeks to offer limited professional employer services in this State.~~ A person who seeks to offer limited professional employer services in this State shall be eligible for de minimis registration status upon compliance with this section and may operate as a de minimis registrant in this State upon notification pursuant to this section. A person shall satisfy the requirements for a de minimis registration only if the professional employer organization:

(1) Does not maintain a physical professional employer organization office located in this State;

(2) Does not employ salespersons who reside or direct their sales activities in this State;

(3) Does not employ directly or in common control with another person, as defined in G.S. 58-89A-5(12), more than 50 assigned employees in this State;

(4) Does not advertise through any media outlet physically located in this State; and

(5) Is a licensed or registered professional employer organization in at least one other state of the United States; and

(6) Is operated by and under the control of persons of good moral character.

A professional employer organization operating under a de minimis registration shall be subject to all of the responsibilities and authority of a licensee under this Article except for G.S. 58-89A-50, G.S. 58-89A-60 and G.S. 58-89A-70(c), (d), and (e).

A person seeking de minimis registration status shall notify the Commissioner, on a form prescribed by the Commissioner, attesting that the professional employer organization meets all of the eligibility requirements for de minimis registration status under this section and, additionally provide, at a minimum, the following information:

(1) The name of the professional employer organization, the address of its principal office, the name of the contact person, and the taxpayer or employer identification number.

(2) A list by jurisdiction of each name under which the registrant has operated in the preceding five years, including any alternative names, names of predecessors, and, if known, successor business entities;

(3) A list of all officers, directors, and controlling person(s) of the registrant and their biographical information in a form to be determined by the Commissioner; and

(4) The location of the business records of the person.

If the Commissioner finds that the person seeking de minimis registration has not fully met the requirements for de minimis registration, the person shall not be eligible for de minimis registration status and the Commissioner shall notify the person in writing. Within 30 days after service of the notification, the person may make a written demand upon the Commissioner for a review to determine the reasonableness of the Commissioner's action. The review shall be completed without undue delay, and the person 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 person may make a written demand upon the Commissioner for a hearing under Article 3A of Chapter 150B of the General Statutes if the person disagrees with the outcome.

If the Commissioner determines that the notification of eligibility for de minimis registration is incomplete, the Commissioner shall notify the person of the deficiency, and the registrant shall be allowed time, not to exceed 15 days from the date notice of the deficiency is provided to the person, to correct the deficiency. Failure of the person to correct the deficiency within the 15 day time period shall result in the de minimis being deemed denied. Except as otherwise provided in this section, a person notified of a deficiency under this section may continue to operate while the deficiency is being corrected unless the Commissioner determines that the person is ineligible for de minimis registration status or is otherwise not authorized to operate in this State.

After a de minimis registrant's initial notification, a de minimis registrant shall annually notify the Commissioner of its continuing eligibility for de minimis registration status no earlier than January 1 and no later than January 15 of each year. The annual notification shall include the attestation of eligibility for de minimis registration and any change in the information previously provided to the Commissioner under this section."

SECTION 4. G.S. 58-89A-110(d) reads as rewritten:

"(d) A license shall not be issued to any professional employer organization unless (i) the organization first files with the Commissioner evidence of workers' compensation coverage for all assigned employees in this State, including those leased from or coemployed with another ~~person, and that the premium paid by the licensee is~~ person, and (ii) the organization certifies to the Commissioner that it has provided its workers' compensation carrier with proper and necessary documentation to allow the carrier to determine and charge a premium that is commensurate with exposure and anticipated claim experience for all employees covered under policies issued by the carrier in the name of the licensee."

SECTION 5. Section 2 of S.L. 2004-162 reads as rewritten:

"**SECTION 2.** The Department of Insurance shall report to the ~~2005~~ 2007 General Assembly on the implementation, administration, and enforcement of Article 89 of Chapter 58 of the General Statutes, as enacted in Section 1 of this act. In its report, the Department shall recommend any statutory changes required to regulate professional employer organizations and enforce Article 89 of Chapter 58 of the General Statutes."

SECTION 6. Section 3 of S.L. 2004-162 reads as rewritten:

"**SECTION 3.** A person registered to engage in and offer professional employer services in this State, pursuant to G.S. 58-89-15, on ~~the last day prior to the effective date of this act~~ December 31, 2004 may continue to operate pending approval of the person's application for a license as long as the application is filed with the Commissioner no later than ~~April 1, 2005.~~ July 1, 2005. If the application for licensure is denied, the person shall cease offering professional employer services in this State. ~~A~~ Except as otherwise provided herein, a person not registered to engage in and offer professional employer services in this State, pursuant to G.S. 58-89-15, on ~~the last day prior to the effective date of this act~~ December 31, 2004 shall not engage in or offer professional employer services in this State until the person has been issued a license under this act.

A person that was not registered to engage in and offer professional employer services in this State, pursuant to G.S. 58-89-15 on December 31, 2004, may engage in and offer professional employer services prior to approval of licensure upon satisfying each of the following conditions:

1) The person submits with its application an audited GAAP financial statement that has been issued no more than 90 days from the date the application is received by the Commissioner, and the statement is accompanied by an unqualified opinion;
2) The person is a licensed or registered professional employer organization in good standing in at least one other state of the United States;
3) The person has a client pre-existing December 31, 2004 and that client acquires or adds employees in this State on or before July 1, 2005.
4) The person has submitted its application for licensure in compliance with the provisions of Article 89A of Chapter 58 of the General Statutes on or before July 1, 2005.

The conditional authority to engage in and offer professional employer services pursuant to this provision shall cease upon the earliest of the following: the granting of a license under Article 89A of Chapter 58 of the General Statutes, the denial of a license under Article 89A of Chapter 58 of the General Statutes, or the failure to satisfy any of the conditions upon which the conditional authority exists.

Notwithstanding any other provision of this act, an audited GAAP financial statement filed with the Commissioner by an applicant for licensure that otherwise meets the requirements of this act shall be accepted by the Commissioner if it has been filed with the Commissioner on or before June 30, 2005, has been issued within the previous 180 days, and covers a fiscal year that ended December 31, 2004, or is otherwise acceptable to the Commissioner."

SECTION 7. G.S. 58-6-25(d) is amended by adding a new subdivision to read:

"(9) Money appropriated to the Department of Insurance for the regulation of the professional employer organization industry pursuant to Article 89A of Chapter 58 of the General Statutes."

SECTION 8. Effective July 1, 2005, there is appropriated from the Insurance Regulatory Fund established in G.S. 58-6-25 to the Department of Insurance the sum of one hundred fifty thousand dollars ($150,000) for the 2005-2006 fiscal year for the regulation of the professional employer organization industry pursuant to Article 89A of Chapter 58 of the General Statutes.

SECTION 9. Except as otherwise expressly provided in this act, this act is effective when it becomes law.

ATT. III

SENATE BILL 685:
Revise Professional Employer Organization Act

BILL ANALYSIS

Committee:	House Insurance Committee	**Introduced by:**	Senators Bingham and Rand
Date:	March 29, 2005	**Summary by:**	Tim Hovis*
Version:	S685-CSRG-4[v.2]		Committee Counsel

BACKGROUND: Article 89A of Chapter 58 of the General Statutes, *the North Carolina Professional Employer Organization Act*, was passed by the General Assembly in 2002 to require registration of professional employer organizations (PEOs) in the State. The Act was amended in 2004 to require PEOs to be licensed by the Department of Insurance, in addition to the Act's registration requirements.

A "professional employer organization" is defined in Article 89A as "a person that offers professional employer services." Typically, PEOs contract with businesses to provide human resource, employee benefit, payroll and workers compensation functions for the business. Under existing law, PEOs doing business in the State are required to file completed license applications by April 1, 2005. A violation of the Act is punishable by civil penalties and conviction of a Class H felony.

SUMMARY: Current law requires an applicant for licensure to file with the Commissioner of Insurance a surety bond in the amount of $100,000. **Section 1** of the bill amends this law to allow the issuer of the bond to cancel the bond, but only with respect to future obligations or liabilities under the bond. Likewise, a bond may be exchanged or replaced, but only if the new surety bond applies to obligations arising during the period of the original bond. However, a licensee must maintain a bond at all times and failure to do so will result in an automatic and immediate suspension of his or her PEO license.

Section 2 of the bill reduces the fee for a limited professional employer organization license from $1,000 to $500. The bill also changes the name of a limited license to a "de minimis registration." Current law authorizes the Commissioner of Insurance to provide for a limited PEO license by rule.

Section 3 of the bill establishes standards for de minimis registration status. To qualify for de minimis registration, the PEO must:

- Not maintain a physical professional employer organization office in the State.
- Not employ salespersons who reside or direct sales activities in the State.
- Not employ directly or in common control with another person more than 50 assigned employees in the State.
- Not advertise through any media outlet physically located in the State.
- Be a licensed or registered PEO in at least one other state.
- Be operated by and under control of persons of good moral character.

A person seeking de minimis registration status must notify the Commissioner on a prescribed form attesting that the PEO meets all eligibility requirements and provide additional information including the name and address of its principal office, a list by jurisdiction of each name under which the registrant has operated during the preceding five years, a list of all officers directors and controlling persons of the registrant, and the location of the business records of the person.

Section 3 also provides a process by which the Commissioner notifies a person of his or her ineligibility for de minimis registration and a review of the Commissioner's decision. The Commissioner must also notify a registrant of an incomplete registration and must allow a registrant 15 days from notification to correct the deficiency. After approval of a de minimis registration, the registrant must annually notify the Commissioner of its continuing eligibility for de minimis registration status.

Section 4 clarifies G.S. 58-89A-110(d) to require a PEO to certify to the Commissioner that it has provided its workers compensation carrier with all proper and necessary documentation for the carrier to determine and charge a premium commensurate with anticipated claim experience. The PEO does not need to provide evidence of this documentation.

Section 5 changes existing reporting requirements on the implementation, administration and enforcement of the Act to require the Department to report to the 2007 General Assembly instead of the 2005 Session.

Section 6 changes the deadline for filing a license application. Under current law, a person who registered prior to the Act's effective date of January 1, 2005 may continue to operate pending approval of the person's application for licensure if the license application is filed no later than April 1, 2005.

Section 6 moves the deadline to file an application for licensing from April 1, 2005 to July 1, 2005. This section also provides conditions under which a PEO that failed to register on or before December 31, 2004 may offer PEO services pending approval of license application. For this provision to apply, the license application must be submitted on or before July 1, 2005.

In addition, Section 6 provides that for initial license applications received prior to June 30, 2005, the Commissioner must accept a GAAP financial statement prepared within the previous 180 days. The statement must cover a fiscal year ending December 31, 2004 or later.

Section 7 provides that money from the Insurance Regulatory Fund may be used to reimburse the General Fund for money appropriated to the Department for regulation of PEOs.

Section 8 of the bill appropriates for the regulation of PEOs $150,000 to the Department from the Insurance Regulatory Fund for the 2005-2006 fiscal year.

EFFECTIVE DATE: Senate Bill 685 would become effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

Attachment IV

Page 1 of 2

EDITION No. _____

H. B. No. _____ DATE _____

S. B. No. 685 proposed comm. sub. Amendment No. _____

COMMITTEE SUBSTITUTE _____ (to be filled in by Principal Clerk)

Rep.)
) _____
Sen.)

1 moves to amend the bill on page 2, line 36

2 ( ) WHICH CHANGES THE TITLE

3 by rewriting the line to read:

4 "~~professional employer organization license~~

5 de minimis registration" shall pay to the

6 Commissioner, before the";

7

8 and on page 2 line 35,

9 by deleting "~~or~~" and substituting "or";

10

11 and on page 2, lines 41-43

12 by rewriting the lines to read:

13 (c) Each applicant for alternative licensing

14 under G.S. 58-89A-76 and each applicant for renewal

15 of a license provided under 58-89A-76

16 shall pay to the Commissioner,";

17

18 and on page 1, lines 5-6

19 by rewriting the lines to read:

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE _____

S. B. No. 685 proposed committee sub. Amendment No. _____

COMMITTEE SUBSTITUTE _____ (to be filled in by Principal Clerk)

Rep.)
) _____
Sen.)

1 moves to amend the bill on page _____, line _____
2 ( ) WHICH CHANGES THE TITLE
3 by _____
4 "CERTAIN CIRCUMSTANCES,
5 ESTABLISHING THE REQUIREMENTS
6 FOR DE MINIMIS"
7
8
9
10
11
12
13
14
15
16
17
18
19

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 14, 2005

The House Committee on Insurance met at 11:00 AM on Thursday, April 14 , 2005 in Room 1228. The following Representatives attended, Chairman Hugh Holliman, Vice Chairs: Edward Jones, Bill Faison, Edd Nye. Members: Representatives Lucy Allen, Cary Allred David Almond, William Current, Robert Grady, Julia Howard, Linda Johnson, Deborah Ross, Drew Saunders, Fred Steen, Ron Sutton and William Wainwright.

Chairman Holliman called the meeting to order. He introduced the pages, the Sgt.-At-Arms, and welcomed staff and visitors. He paid a special welcome to Rep. Jones on his appointment to the committee. See Attachment I.

Rep. Holliman called on Frank Folger, Legislative Counsel for the Department of Insurance to explain the four agency bills on the agenda.

Mr. Folger spoke to the following bills:

HB 646 - Insurance company Fee Consolidation.-AB
Mr. Folger explained how the bill would change fees paid by insurers. Rep. Sutton ask for a favorable report and referred to Finance. Motions carried.
See Attachments II and III.

HB 654 - Confidential Insurance Mkt./Financial Doc.-AB
After some committee discussion about confidentially protection and an amendment to delete line 18-22 the bill was temporally displaced and would continue discussion at the next Insurance meeting. Attachment IV.

HB 660 - Insurance Financial Changes.-AB
Rep. Holliman ask for a motion to accept the PCS. Rep. Sutton made the motion and the motion carried. Mr. Folger explained each section of the bill and why the changes are necessary for the agency. After some discussion, Rep. Sutton made a motion for a favorable report as amended and to roll the bill with the amendment into a new committee substitute . Motion carried. See Attachment V.

HB 737 - Improve Health Insurance Underwriting.-AB
After brief discussion and due to time this bill was held over for next Insurance meeting.

The Meeting was adjourned at 11:58 AM

Representative. L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **Thursday, April 14, 2005**

TIME: **11:00 AM**

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 646 - Insurance Company Fee Consolidation. -AB –
Rep. Holliman

HB 737 - Improve Health Insurance Underwriting. -AB –
Rep. Holliman and Rep. Wright

HB 654 - Confidential Insurance Mkt./Financial Doc.-AB –
Rep. Holliman

HB 660 - Insurance Financial Changes. -AB –
Rep. Holliman

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **3:25 PM on April 12, 2005**.

___Principal Clerk
___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

HOUSE INSURANCE COMMITTEE

April 14, 2005
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

HB 646 - Insurance Company Fee Consolidation. -AB –
Rep. Holliman

HB 654 - Confidential Insurance Mkt./Financial Doc.-AB –
Rep. Holliman

HB 660 - Insurance Financial Changes. -AB –
Rep. Holliman

HB 737 - Improve Health Insurance Underwriting. -AB –
Rep. Holliman and Rep. Wright

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative **HOLLIMAN** (Chair) for the Committee on **INSURANCE.**

☐ Committee Substitute for
H.B. 646 A BILL TO BE ENTITLED AN ACT TO CONSOLIDATE VARIOUS FEES INTO THE ANNUAL LICENSE CONTINUATION FEE PAID BY LICENSED INSURANCE COMPANIES TO ENHANCE EFFICIENT ADMINISTRATION OF FEE COLLECTION AND PROCESSING.

☐ With a favorable report.

☒ With a favorable report and recommendation that the bill be re-referred to the Committee on ~~Appropriations~~ ☐ Finance ☒ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to the committee substitute bill (#), ☐ which changes the title, unfavorable as to (the original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

03/19/03

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative **HOLLIMAN** (Chair) for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 660 A BILL TO BE ENTITLED AN ACT TO MAKE VARIOUS CHANGES TO THE INSURANCE FINANCIAL LAWS UNDER CHAPTER 58 OF THE GENERAL STATUTES.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☒ With a favorable report as to the committee substitute bill ~~(#), ☐ which changes the title,~~ unfavorable as to (the original bill), ~~(Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on).~~

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

03/19/03

ATTACHMENT 1

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — April 14, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cam Cole	BPMHC
David Stoller	State Farm
Patricia Ramey	NCACC
[illegible]	NCAEC
Don Johnson	Friend of Bill Faison
David Barness	Poyner + Spruill
Kari Barsness	OSBM
Rick Zechini	NC Assoc. of REALTORS
Andy Romanet	NCLM
[illegible]	NCAHP
[illegible]	BCBSNC
[illegible]	NMRS

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — April 14, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	KCLH
	IFNC
	MMAC Insurance
	GAHA
	NCAHP
Barbara Carsley	BSCGR
Bill Rush	AZP
Courtney Crowder	NCDOI

Attachment II

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 1

HOUSE BILL 646

Short Title:	Insurance Company Fee Consolidation.-AB	(Public)
Sponsors:	Representative Holliman.	
Referred to:	Insurance, if favorable, Finance.	

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO CONSOLIDATE VARIOUS FEES INTO THE ANNUAL LICENSE CONTINUATION FEE PAID BY LICENSED INSURANCE COMPANIES TO ENHANCE EFFICIENT ADMINISTRATION OF FEE COLLECTION AND PROCESSING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-6-5 reads as rewritten:

"**§ 58-6-5. Schedule of fees and charges.**

The Commissioner shall collect and pay into the State treasury fees and charges as follows:

(1) For filing and examining an insurance company application for admission, a nonrefundable fee of two hundred fifty dollars ($250.00), to be submitted with ~~such filing; for filing and auditing annual statement, one hundred dollars ($100.00); for filing any other papers required by law, twenty-five dollars ($25.00); for each certificate of examination, condition, or qualification of company or association, fifteen dollars ($15.00); for each seal when required, ten dollars ($10.00); for a list of licensed insurance companies, ten dollars ($10.00).~~ the filing; for each certification or confirmation of an insurance company deposit held by the Commissioner pursuant to this Chapter, twenty-five dollars ($25.00).

(2) Repealed by Session Laws 1977, c. 376, s. 2.

(3) The Commissioner shall receive for copy of any record or paper in his office fifty cents (50¢) per copy ~~sheet and ten dollars ($10.00) for certifying same, or any fact or data from the records of his office and for the examination and approval of charters of companies, twenty-five dollars ($25.00).~~ sheet.

(4) He shall collect all other fees and charges due and payable into the State treasury by any company, association, order, or individual under his Department.

(5) Repealed by Session Laws 1999-435, s. 1."

SECTION 2. G.S. 58-6-7 reads as rewritten:

"**§ 58-6-7. Licenses; perpetual licensing; annual license continuation fees for insurance companies.**

(a) In order to do business in this State, an insurance company shall apply for and obtain a license from the Commissioner. The license shall be perpetual and shall continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with this Chapter and subject to any other applicable provision of the insurance laws of this State. Except as provided in subsection (b) of this section, the insurance company shall pay a fee for each year the license is in effect, as follows:

For each domestic farmer's mutual assessment fire insurance company ..... $ 25.00

For each fraternal order ..... ~~100.00~~ 500.00

For each of all other insurance companies, except mutual burial associations taxed under G.S.105-121.1 ..... ~~1,000.00~~ 1,500.00

The fees levied in this subsection are in addition to those specified in G.S. 58-6-5.

~~(b) When the paid-in capital stock or surplus, or both, of an insurance company, other than a farmer's mutual assessment company or a fraternal order, does not exceed one hundred thousand dollars ($100,000), the fee levied in this section shall be one-half the amount specified.~~

(c) Upon payment of the fee specified above and the fees and taxes elsewhere specified each insurance company, exchange, bureau, or agency, shall be entitled to do the types of business specified in Chapter 58, of the General Statutes of North Carolina as amended, to the extent authorized ~~therein, except that: Insurance companies authorized to do either the types of business specified for (i) life insurance companies, or (ii) for fire and marine companies, or (iii) for casualty and fidelity and surety companies, in G.S. 58-7-75, which shall also do the types of business authorized in one or both of the other of the above classifications shall in addition to the fees above specified pay one hundred dollars ($100.00) for each such additional classification of business done.~~ therein. All fees and charges collected by the Commissioner under this Chapter are nonrefundable.

(d) Any rating bureau established by action of the General Assembly of North Carolina shall be exempt from the fees in this section."

SECTION 3. G.S. 58-7-150 and G.S. 58-7-155 are repealed.

SECTION 4. G.S. 58-8-60(b) reads as rewritten:

"(b) The articles of incorporation shall provide for the name of the corporation, to be approved by the Commissioner; the kinds of insurance it proposes to transact and on what business plan or principle; and the place of its location in the State. The certificate of incorporation must be subscribed and sworn to by a majority of the board of directors before an officer authorized to take acknowledgement of deeds, who shall certify the

certificate to the Commissioner. The Commissioner shall review the certificate and articles of incorporation and file them with the Secretary of State in accordance with ~~G.S. 58-7-35 upon payment of the required fees.~~ G.S. 58-7-35."

SECTION 5. G.S. 58-65-55 reads as rewritten:

"**§ 58-65-55. Issuance and continuation of license.**

(a) Every corporation subject to this Article shall pay to the Commissioner a fee of two hundred fifty dollars ($250.00) for filing an application for a license. Fee payment shall be contemporaneous with the filing. Before issuing or continuing any such license or certificate the Commissioner may make such an examination or investigation as the Commissioner deems expedient. The Commissioner shall issue a license upon the payment of a fee of ~~one thousand dollars ($1,000)~~ one thousand five hundred dollars ($1,500) and upon being satisfied on the following points:

(1) The applicant is established as a bona fide nonprofit hospital service corporation as defined by this Article and Article 66 of this Chapter.

(2) The rates charged and benefits to be provided are fair and reasonable.

(3) The amounts provided as working capital of the corporation are repayable only out of earned income in excess of amounts paid and payable for operating expenses and hospital and medical and/or dental expenses and such reserve as the Department deems adequate, as provided hereinafter.

(4) That the amount of money actually available for working capital be sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of the issuance of the certificate.

(b) The license shall continue in full force and effect, subject to payment of an annual license continuation fee of ~~one thousand dollars ($1,000),~~ one thousand five hundred dollars ($1,500), subject to all other provisions of subsection (a) of this section and subject to any other applicable provisions of the insurance laws of this State."

SECTION 6. G.S. 58-67-160 reads as rewritten:

"**§ 58-67-160. Fees.**

Every health maintenance organization subject to this Article shall pay to the Commissioner a fee of two hundred fifty dollars ($250.00) for filing an application for a license and an annual license continuation fee of ~~one thousand dollars ($1,000)~~ one thousand five hundred dollars ($1,500) for each license. The license shall continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provisions of the insurance laws of this State."

SECTION 7. This act becomes effective July 1, 2005, and applies to applications filed, licenses issued, and licenses continued on or after that date.

HOUSE BILL 646:
Insurance Company Fee Consolidation-AB

Attachment III

BILL ANALYSIS

Committee:	House Insurance Committee	**Introduced by:**	Representative Holliman
Date:	April 13, 2005	**Summary by:**	Tim Hovis
Version:	First Edition		Committee Counsel

SUMMARY: House Bill 646 makes changes to fees paid by insurers to the Department of Insurance to consolidate various fees into the licensing and license continuation fees.

The bill eliminates fees for filing and auditing annual statements, filing papers required by law, issuance of certificates of examination, condition, or qualification of a company or association, for required seals, lists of insurance companies, certifying records or data from the Commissioner's office, the examination or approval of charters, and fees for additional classifications of business beyond an insurer's primary classification.

To offset the loss of revenue from the elimination of the above fees, licensing and license continuation fees for most insurers are increased from $1000 to $1500. The fee for fraternal order licensing and license continuation are also increased from $100 to $500.

The bill also eliminates exceptions and reductions in fees for HMOs and other insurers, including medical service corporations such as Blue Cross & Blue Shield and Delta Dental, and HMOs.

Frank Folger with the Department of Insurance has provided a detailed summary which is set out below.

H646 INSURANCE COMPANY FEE CONSOLIDATION

This bill is intended to enhance the efficiency of the Department of Insurance by consolidating various fees charged to insurance companies on an "a la carte" basis into the annual license continuation fee already paid by licensed insurance companies. Both the Department and the companies will benefit from being relieved of the administrative time associated with the collecting and processing of these fees.

Specifically, the bill eliminates fees charged companies for:

- the filing and auditing of annual statements
- the filing of any other papers required by law
- each certificate of examination, condition or qualification of company or association
- each seal, when required
- a list of licensed insurance companies
- certifying any record or paper in the Commissioner's office or any fact or data from the records of his office
- the examination and approval of charters of companies
- additional classifications of business which a company does beyond its primary business

The bill would recover the estimated loss of revenue by the elimination of those fees by increasing:

- The initial license and annual license continuation fee for fraternal orders to $500 (from $100)
- The initial license and annual license continuation fee all other insurance companies except domestic farmer's mutual assessment fire insurance companies and mutual burial associations taxed under G.S. 105-121.1 to $1500 (from $1000)
- Eliminating the exception to full fee charges to insurance companies with less than $100,000 in paid in capital and stock (one-half of the fee to be charged)
- Equalizing the fees charged to Article 65 companies (currently BCBS and Delta Dental) and HMOs with other insurance companies such that each would pay a $250 application fee if newly applying for licensure and has to pay $1500 as an initial license fee and annual license continuation fee.

The bill would become effective July 1, 2005 and apply to applications filed, licenses issued and licenses continued on or after that date.

The Department knows of no opposition to this bill.

The statutes set out below are repealed in Section 3 of House Bill 646.

§ 58-7-150. Consolidation.

(a) A domestic insurer may consolidate with another insurer, subject to the following conditions:

(1) The plan of consolidation must be submitted to and be approved by the Commissioner before the consolidation.

(2) The Commissioner shall not approve the plan unless the Commissioner finds that it is fair, equitable to policyholders, consistent with law, and will not conflict with the public interest. If the Commissioner disapproves the plan, the Commissioner shall state the reasons for the disapproval and call for a hearing.

(3) No director, officer, member or subscriber of any such insurer, except as is expressly provided by the plan of consolidation, shall receive any fee, commission, other compensation or valuable consideration whatever, for in any manner aiding, promoting or assisting in the consolidation.

(4) Any consolidation as to an incorporated domestic insurer shall in other respects be governed by the general laws of this State relating to business corporations. The consolidation of a domestic mutual insurer may be effected by vote of two thirds of the members voting thereon pursuant to such notice and procedure as the Commissioner may prescribe.

(b) Reinsurance of all or substantially all of the insurance obligations or risks of existing or in-force policies of a domestic insurer by another insurer under an assumption reinsurance agreement, as defined in G.S. 58-10-25(a)(2), shall be deemed a consolidation for the purposes of this section. This section does not apply to consolidations to the extent regulated by Article 19 or other Articles of this Chapter.

(c) An application for consolidation under this section shall be accompanied by a nonrefundable fee of two hundred fifty dollars

§ 58-7-155. Application fee.

Every application for redomestication under G.S. 58-7-60 and G.S. 58-7-65 shall be accompanied by a nonrefundable fee of two hundred dollars

Attachment IV

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H **1**

HOUSE BILL 654

Short Title:	Confidential Insurance Mkt./Financial Doc.-AB	(Public)
Sponsors:	Representative Holliman.	
Referred to:	Insurance.	

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO ENHANCE THE CONFIDENTIAL TREATMENT OF INSURANCE MARKET CONDUCT ANALYSIS AND FINANCIAL ANALYSIS FILES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 2 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-2-240. Market conduct analysis, financial analysis, and related information not public record.**

Notwithstanding any other provision of law, all market conduct analysis and financial analysis documents, ratios, programs, findings, or other information, and copies thereof produced by, obtained by, or disclosed to the Commissioner or any other person in connection with a market conduct analysis or financial analysis shall be confidential, are not subject to subpoena, and shall not be made public by the Commissioner or any other person, except as provided in this section, G.S. 58-2-128, and G.S. 58-2-132(g) through (j). The Commissioner may use these documents, materials, findings, or other information in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties.

If the Commissioner determines that the interest of an insurer's policyholders or the public will be served by the publication of these documents, materials, findings, or other information, the Commissioner may, after giving the insurer notice and opportunity to be heard, publish all or any part thereof in such a manner as the Commissioner deems appropriate."

SECTION 2. G.S. 58-2-132(f) reads as rewritten:

"(f) All working papers, information, documents, and copies thereof produced by, obtained by, or disclosed to the Commissioner or any other person in connection with an ~~examination~~ examination, market conduct analysis, or financial analysis shall be given confidential treatment, are not subject to subpoena, and shall not be made public by the Commissioner or any other person. The Commissioner may use the documents,

materials, or other information in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties."

SECTION 3. This act becomes effective October 1, 2005.

ATTACHMENT V

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H D

HOUSE BILL 660*
PROPOSED COMMITTEE SUBSTITUTE H660-CSRC-16 [v.1]

4/13/2005 7:07:21 PM

Short Title: Insurance Financial Changes.-AB (Public)

Sponsors:

Referred to:

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS CHANGES TO THE INSURANCE FINANCIAL LAWS UNDER CHAPTER 58 OF THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-2-150 reads as rewritten:

"**§ 58-2-150. ~~Oath~~ required for compliance with law.**

Before issuing license to any insurance company to transact the business of insurance in this State, the Commissioner shall require, in every case, in addition to the other requirements provided for by law, that the company file with ~~him~~ the Commissioner the affidavit of its president or other chief officer that it accepts the terms and obligations of Articles 1 through ~~64~~ 67 of this Chapter as a part of the consideration of the license."

SECTION 2. G.S. 58-3-100(a)(2) reads as rewritten:

"(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.~~ After considering the standards under G.S. 58-30-60(b), the Commissioner determines that the continued operation of the insurer is hazardous to its policyholders, to its creditors, or to the general public."

SECTION 3. G.S. 58-5-50 reads as rewritten:

"**§ 58-5-50. Deposits of foreign life insurance companies.**

In addition to other requirements of Articles 1 through 64 of this Chapter, all foreign life insurance companies shall deposit securities, as specified in G.S. 58-5-20, having a market value of four hundred thousand dollars ($400,000) as a prerequisite of doing business in this State. All foreign life insurance companies shall deposit an additional two hundred thousand dollars ($200,000) where such companies cannot show three years of net operational gains prior to admission. ~~Foreign life insurance companies that~~

~~are licensed on or before the effective date of this section shall have one year from that date to comply with this section.~~"

SECTION 4. G.S. 58-5-90 reads as rewritten:

"**§ 58-5-90. Deposits held in trust by Commissioner or Treasurer.**

(a) Deposits by Domestic Company. – The Commissioner or the Treasurer, in ~~his~~ that officer's official capacity, shall take and hold in trust deposits made by any domestic insurance company for the benefit of all of the insurer's policyholders and for the purpose of complying with the laws of any other state to enable the company to do business in that state. The company making the deposits is entitled to the income thereof, and may, from time to time, with the consent of the Commissioner or Treasurer, and when not forbidden by the law under which the deposit was made, change in whole or in part the securities which compose the deposit for other solvent securities of equal par value. Upon request of any domestic insurance company ~~such officer~~ the Commissioner of the Treasurer may return to the company the whole or any portion of the securities of the company held by ~~him~~ the officer on deposit, when ~~he~~ the officer is satisfied that ~~they~~ the deposits are subject to no liability and are ~~not~~ no longer required to be ~~longer~~ held by any provision of law or purpose of the original deposit.

(b) Deposits by Foreign or Alien Company. – The Commissioner or Treasurer, in that respective officer's official capacity, shall take and hold in trust deposits made by any foreign or alien insurance company for the benefit of the holders of all insurance contracts of the company who are citizens or residents of this State or who hold policies issued upon property in this State in accordance with G.S. 58-5-70. The Commissioner or Treasurer may return to the trustees or other representatives authorized for that purpose any deposit made by a foreign or alien insurance company, when it appears that the company has ceased to do business in the State and is under no obligation to policyholders or other persons in the State for whose benefit the deposit was made.

(c) Action to Enforce or Terminate the Trust. – An insurance company which has made a deposit in this State pursuant to Articles 1 through 64 of this Chapter, or its trustees or resident managers in the United States, or the Commissioner, or any creditor of the company, may at any time bring an action in the Superior Court of Wake County against the State and other parties properly joined therein, to enforce, administer, or terminate the trust created by the deposit. The process in this action shall be served on the officer of the State having the deposit, who shall appear and answer in behalf of the State and perform such orders and judgments as the court may make in such action."

SECTION 5. G.S. 58-6-15 reads as rewritten:

"**§ 58-6-15. Annual license continuation fee definition; requirements.**

For purposes of this Chapter only, "annual license continuation ~~fee means~~" fee" means the fee specified in G.S. 58-6-7 ~~submitted to the Commissioner~~ for each year the license is in effect after the company's year of initial licensing. The annual license continuation fee must be submitted annually on or before the first day of March ~~on a form to be supplied by the Commissioner each year~~ for as long as the license is to remain in effect. If the Commissioner is satisfied that the company has met all requirements of law and appears to be financially solvent, the Commissioner shall not revoke or suspend the license of the company, and the company shall be authorized to

do business in this State, subject to all other applicable provisions of the insurance laws of this State. Nothing contained in this section shall be interpreted as applying to licenses issued to individual representatives of insurance companies."

SECTION 6. Article 7 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-7-46. Notification to Commissioner for president or chief executive officer changes.**

All domestic insurers organized under the laws of this Chapter shall provide the Commissioner written notice of any change that occurs in the position of president or chief executive officer of the insurer no later than 30 days after the change. Notice shall include the name of the insurer, the name of the person previously holding the position of president or chief executive officer, the name of the person currently holding the position, and the date the position change took place."

SECTION 7. G.S. 58-7-170 reads as rewritten:

"**§ 58-7-170. Diversification.**

(a) Every insurer must maintain an amount equal to its entire policyholder-related liabilities and the minimum capital and surplus required to be maintained by the insurer under this Chapter invested in coin or currency of the United States and in investments authorized under this Chapter, other than the investments authorized under G.S. 58-7-183 or G.S. 58-7-187, except G.S. 58-7-187(b)(1).

(b) Investments eligible under subsection (a), except investments acquired under G.S. 58-7-183, are subject to the following limitations, other limitations of this section, and any other limitations that are expressly provided for in any provision under which the investment is authorized:

(1) The cost of investments made by insurers in stock authorized by G.S. 58-7-173 shall not exceed twenty-five percent (25%) of the insurer's admitted assets, provided that no more than twenty percent (20%) of the insurer's admitted assets shall be invested in common stock; and the cost of an investment in stock of any one corporation shall not exceed three percent (3%) of the insurer's admitted assets. Notwithstanding any other provision in this Chapter, the financial statement carrying value of all stock investments shall be used for the purpose of determining the asset value against which the percentage limitations are to be applied. Investments in the voting securities of a depository institution, or any company that controls a depository institution, shall not exceed five percent (5%) of the insurer's admitted assets. As used in this subdivision, "depository institution" has the same meaning as in section 3 of the Federal Deposit Insurance Act, 12 U.S.C. § 1813; and includes any foreign bank that maintains a branch, an agency, or a commercial lending company in the United States.

(2) The cost of Canadian investments authorized by G.S. 58-7-173 shall not exceed forty percent (40%) of the insurer's admitted assets in the aggregate, provided that no more than twenty-five percent (25%) of

the insurer's admitted assets shall be invested in Canadian investments authorized by G.S. 58-7-173(11).

(c) 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~~ mortgage-backed securities authorized by G.S. 58-7-173(1), (2), (8), or (17), and backed by a single collateral ~~package,~~ pool, 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~~ mortgage-backed securities without the Commissioner's consent if the admitted value of all those 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~~ mortgage-backed securities permitted by G.S. 58-7-173(17) shall not exceed thirty-five percent (35%) 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~~ Mortgage-backed securities authorized by G.S. 58-7-173(1), (2), or (8) shall only be subject to the single collateral ~~package~~ pool limitation and the sixty percent (60%) aggregate limitation. No later than January 31, 1999, an insurer that has mortgage investments that exceed the limitations specified in this subsection shall submit to the Commissioner a plan to bring the amount of mortgage investments into compliance with the specified limitations by January 1, 2004.

(d) Without the Commissioner's prior written approval, the cost of investments permitted under G.S. 58-7-173 and G.S. 58-7-178, and that are classified as medium to lower quality obligations, other than obligations of subsidiaries or affiliated corporations as that term is defined in G.S. 58-19-5, shall be limited to:

(1) No more than twenty percent (20%) of an insurer's admitted assets;

(2) No more than ten percent (10%) of an insurer's admitted assets in obligations ~~that have been given a rating of~~ designated a 4, 5, or 6 ~~by the Securities Valuation Office of the NAIC;~~ in accordance with the Purposes and Procedures Manual of the NAIC Securities Valuation Office;

(3) No more than three percent (3%) of an insurer's admitted assets in obligations ~~that have been given a rating of~~ designated a 5 or 6 ~~by the Securities Valuation Office of the NAIC;~~ in accordance with the Purposes and Procedures Manual of the NAIC Securities Valuation Office; and

(4) No more than one percent (1%) of an insurer's admitted assets in obligations ~~that have been given a rating of~~ designated a 6 ~~by the Securities Valuation Office of the NAIC.~~ in accordance with the Purposes and Procedures Manual of the NAIC Securities Valuation Office.

(5), (6). Repealed by Session Laws 1993, c. 452, s. 11.

(e) As used in subsections (d), (f), (g), and (h) of this section, "medium to lower quality obligations" means obligations ~~that have been given a rating of~~ designated a 3, 4, 5, or 6 ~~by the Securities Valuation Office of the NAIC.~~ in accordance with the Purposes and Procedures Manual of the NAIC Securities Valuation Office.

(f) Each insurer shall possess and maintain adequate documentation to establish that its investments in medium to lower quality obligations do not exceed the limitations under subsection ~~(d).~~ (d) of this section.

~~(g) The provisions of subsections (d), (e), and (f) of this section apply to any investment made after December 31, 1991. If an insurer's investments in medium to lower quality obligations equal or exceed the maximum amounts permitted by subsection (d) as of December 31, 1991, the insurer shall not acquire any additional medium to lower quality obligations without the Commissioner's prior written approval. An insurer that is not in compliance with subsection (d) of this section as of December 31, 1991, may hold until maturity or until December 31, 1995, whichever is sooner, only those medium to lower quality obligations it owns on that date, if the obligations were obtained in compliance with the law in effect when the investments were made. If the insurer sells, transfers, or otherwise disposes of the securities before maturity, the insurer may not acquire any medium to lower quality obligations as substitutions or replacements without the Commissioner's prior approval.~~

~~(h) An insurer that is not in compliance with subsection (d) of this section on December 31, 1991, shall file with its annual statement a separate schedule of the medium to lower quality obligations it owns on December 31, 1991. Until it is in compliance with subsection (d) of this section, the insurer shall file with each succeeding annual and quarterly statement a separate schedule of the medium to lower quality obligations it owns as of the reporting date of the filed statement.~~

(i) Failure to obtain the Commissioner's prior written approval shall result in any investments in excess of those permitted by subsection (d) of this section not being allowed as an asset of the insurer.

(j) The Commissioner may limit the extent of an insurer's deposits with any financial institution if the Commissioner determines that the financial solvency of the insurer is threatened by a deposit in excess of insured limits.

(k) The provisions of this section supersede any inconsistent provision of section 106 of the Secondary Mortgage Market Enhancement Act of 1984, 15 U.S.C. § 77r-1, to the extent permitted by that Act."

SECTION 8. G.S. 58-7-173(11) reads as rewritten:

"(11) Bonds, notes, or other interest-bearing or interest-accruing obligations of any solvent institution organized under the laws of the United States, of any state, Canada or any Canadian province; provided ~~such~~ the instruments are ~~rated and valued by the Securities Valuation Office of the NAIC.~~ designated and valued in accordance with the Purposes and Procedures Manual of the NAIC Securities Valuation Office. The cost of investments made under this subdivision in any one issuer shall not exceed three percent (3%) of an insurer's admitted assets."

SECTION 9. G.S. 58-7-173(17) reads as rewritten:

"(17) ~~Mortgage pass-through securities and derivatives thereof, that have been rated as investment grade by the Securities Valuation Office of the NAIC~~ Mortgage-backed securities that are designated a 1 or 2 in accordance with the Purposes and Procedures Manual of the NAIC Securities Valuation Office including, without limitation, collateral mortgage obligations backed by a pool of mortgages of the kind, class, and investment quality as those eligible for investment under G.S. 58-7-179."

SECTION 10. G.S. 58-7-178(b) reads as rewritten:

"(b) An insurer, whether or not it is authorized to do business or has outstanding insurance contracts on lives or risks in any foreign country, may invest in bonds, notes, or stocks of any foreign country or alien corporation that are substantially of the same kinds, classes, and investment grades as those otherwise eligible for investment under this Chapter. The aggregate cost of investments under this subsection shall not exceed ten percent (10%) of the insurer's admitted assets, provided that the cost of investments in any one foreign country under this subsection shall not exceed three percent (3%) of the insurer's admitted assets."

SECTION 11. G.S. 58-10-120(1) reads as rewritten:

"(1) "Mortgage guaranty insurers report of policyholders position" means the ~~annual~~ supplementary report required by the Commissioner."

SECTION 12. Article 10 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-10-140. Report of policyholder's position.**

Each mortgage guaranty insurance company doing business in this State must file on a form prescribed by the Commissioner a Mortgage Guaranty Insurers Report of Policyholders Position. The supplemental reports shall be filed with the annual and quarterly statements pursuant to G.S. 58-2-165."

SECTION 13. G.S. 58-15-30(a) reads as rewritten:

"(a) No reciprocal shall engage in any insurance transaction in this State until it has obtained a license to do so in accordance with the applicable provisions of Articles 1 through 64 of this Chapter. ~~Such~~ The license shall ~~expire on the last day of June of each year.~~ continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provisions of the insurance laws in this State."

SECTION 14. 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(5); maintain the amounts of capital and surplus specified in ~~G.S. 58-16-5(2),~~ G.S. 58-16-5(2); and remain in ~~substantial~~ compliance with ~~the statutes listed in~~ G.S. 58-16-5(6), (7), and ~~(8).~~ (8) and with G.S. 58-7-46."

SECTION 15. G.S. 58-19-30(b)(1) reads as rewritten:

"(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."

SECTION 16. G.S. 58-47-140 reads as rewritten:

"**§ 58-47-140. Other provisions of this Chapter.**

The following provisions of this Chapter apply to workers' compensation self-insurance groups that are subject to this Article:

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, 58-7-73, and Articles 13, 19, 30, 33, 34, and 63 of this Chapter apply to groups."

SECTION 17. G.S. 58-56-2(5)*l.* reads as rewritten:

"*l.* ~~A person licensed as a managing general agent in this State, whose activities are limited exclusively to the scope of activities conveyed under the license.~~A managing general agent as defined in G.S. 58-34-2(a)(3), whose activities are limited exclusively to the scope of the activities set forth in the managing general agency contract filed by an insurer with the Commissioner in accordance with G.S. 58-34-2(i)."

SECTION 18. G.S. 58-65-2 reads as rewritten:

"**§ 58-65-2. Other laws applicable to service corporations.**

The following provisions of this Chapter are applicable to service corporations that are subject to this Article:

G.S. 58-2-125.	Authority over all insurance companies; no exemptions from license.
G.S. 58-2-150.	Oath required for compliance with law.
G.S. 58-2-155.	Investigation of charges.
G.S. 58-2-160.	Reporting and investigation of insurance and reinsurance fraud and the financial condition of licensees; immunity from liability.
G.S. 58-2-162.	Embezzlement by insurance agents, brokers, or administrators.
G.S. 58-2-185.	Record of business kept by companies and agents; Commissioner may inspect.
G.S. 58-2-190.	Commissioner may require special reports.
G.S. 58-2-195.	Commissioner may require records, reports, etc., for agencies, agents, and others.
G.S. 58-2-200.	Books and papers required to be exhibited.
G.S. 58-3-50.	Companies must do business in own name; emblems, insignias, etc.
G.S. 58-3-100(c),(e).	Insurance company licensing provisions.
G.S. 58-3-115.	Twisting with respect to insurance policies; penalties.

G.S. 58-7-46.	Notification to Commissioner for president or chief executive officer changes.
G.S. 58-50-35.	Notice of nonpayment of premium required before forfeiture.
G.S. 58-51-25.	Policy coverage to continue as to mentally retarded or physically handicapped children."

SECTION 19. G.S. 58-67-25 reads as rewritten:

"**§ 58-67-25. Deposits.**

(a) The Commissioner shall require a minimum deposit of five hundred thousand dollars ($500,000) for all full service medical health maintenance organizations or such higher amount as he deems necessary for the protection of enrollees. ~~The minimum deposit for a full service medical health maintenance organization authorized to operate on July 17, 1987, and having a deposit of less than five hundred thousand dollars ($500,000) shall be as follows:~~

~~(1) $250,000 by December 31, 1987~~

~~(2) $500,000 by December 31, 1988.~~

~~Any health maintenance organization not authorized to do business on July 17, 1987, must comply with the minimum initial deposit of five hundred thousand dollars ($500,000).~~

(b) The Commissioner shall require a minimum deposit of twenty-five thousand dollars ($25,000) for all single service health maintenance organizations or such higher amount as he deems necessary for the protection of enrollees.

(c) All deposits required by this section shall be administered in accordance with the provisions of ~~G.S. 58-5-1.~~ Article 5 of this Chapter."

SECTION 20. G.S. 58-67-115(b)(2) reads as rewritten:

"(2) Whenever the reimbursements described in this subsection exceed ten percent (10%) of the HMO's total costs for health care services over the immediately preceding six months, the HMO shall file a written report with the Commissioner containing the information necessary to determine compliance with sub-subdivision (b)(1)a. of this section ~~no later than 30 business days from the first day of the month.~~ with its financial statements filed pursuant to G.S. 58-2-165. Upon an adequate showing by the HMO that the requirements of this section should be waived or reduced, the Commissioner may waive or reduce these requirements to such an amount as he deems sufficient to protect enrollees of the HMO consistent with the intent and purpose of this Article."

SECTION 21. G.S. 58-67-171 reads as rewritten:

"**§ 58-67-171. Other laws applicable to HMOs.**

The following provisions of this Chapter are applicable to HMOs that are subject to this Article:

G.S. 58-2-125.	Authority over all insurance companies; no exemptions from license.
G.S. 58-2-150.	Oath required for compliance with law.
G.S. 58-2-155.	Investigation of charges.

G.S. 58-2-160.	Reporting and investigation of insurance and reinsurance fraud and the financial condition of licensees; immunity from liability.
G.S. 58-2-162.	Embezzlement by insurance agents, brokers, or administrators.
G.S. 58-2-185.	Record of business kept by companies and agents; Commissioner may inspect.
G.S. 58-2-190.	Commissioner may require special reports.
G.S. 58-2-195.	Commissioner may require records, reports, etc., for agencies, agents, and others.
G.S. 58-2-200.	Books and papers required to be exhibited.
G.S. 58-3-50.	Companies must do business in own name; emblems, insignias, etc.
G.S. 58-3-100(c),(e).	Insurance company licensing provisions.
G.S. 58-3-115.	Twisting with respect to insurance policies; penalties.
G.S. 58-7-46.	Notification to Commissioner for president or chief executive officer changes.
G.S. 58-7-73.	Dissolution of insurers.
G.S. 58-50-35.	Notice of nonpayment of premium required before forfeiture.
G.S. 58-51-25.	Policy coverage to continue as to mentally retarded or physically handicapped children.
G.S. 58-51-35.	Insurers and others to afford coverage to mentally retarded and physically handicapped children.
G.S. 58-51-45.	Policies to be issued to any person possessing the sickle-cell trait or hemoglobin C trait."

SECTION 22. G.S. 58-2-215(b)(1) reads as rewritten:

"(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,~~ filings and any other insurance regulatory matters, in conducting all hearings, and through any final adjudication."

SECTION 23. G.S. 58-12-40 reads as rewritten:

"**§ 58-12-40. Supplemental provisions; rules; exemptions.**

(a) The provisions of this Article are supplemental to any other provisions of the laws of this State, and do not preclude or limit any other powers or duties of the Commissioner under those laws, including Article 30 of this Chapter.

(b) Risk-based capital instructions, risk-based capital reports, adjusted risk-based capital reports, risk-based capital plans, and revised risk-based capital plans are solely for use by the Commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers. The Commissioner shall not use any of these reports or plans for rate making nor consider or introduce them as evidence in any rate proceeding. The Commissioner shall not use these reports or plans to calculate or derive any elements of an appropriate premium level or rate of return for any kind of insurance that an insurer or any affiliate is authorized to write.

Insurance Comm. authority

(c) The Commissioner may exempt from the application of this Article any domestic property or casualty insurer ~~that does all of the following:~~ that:

(1) Writes direct business only in this State.

(2) Writes direct annual premiums of ~~one thousand dollars ($1,000)~~ two million dollars ($2,000,000) or less.

(3) Assumes no reinsurance in excess of five percent (5%) of direct written premiums.

(d) The Commissioner may, in the Commissioner's discretion, exempt from the application of this Article:

(1) Any domestic town or county mutual insurance company organized under G.S. 58-7-75(5)d.

(2) Any domestic life or health insurer that:

a. Has no direct or assumed annual premiums; and

b. Has no direct or assumed policyholder obligations.

(3) Any domestic health maintenance organization that:

a. Writes only direct business in this State;

b. Assumes no reinsurance in excess of five percent (5%) of direct written premiums; and

c. Writes direct annual premiums for a comprehensive medical business of two million dollars ($2,000,000) or less, or is a single service health maintenance organization that covers less than 2,000 lives."

SECTION 24. G.S. 58-67-10 reads as rewritten:

"**§ 58-67-10. Establishment of health maintenance organizations.**

(a) Notwithstanding any law of this State to the contrary, any person may apply to the Commissioner for a ~~certificate of authority~~ license to establish and operate a health maintenance organization in compliance with this Article. No person shall establish or operate a health maintenance organization in this State, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization without obtaining a ~~certificate of authority~~ license under this Article. A foreign corporation may qualify under this Article, subject to its full compliance with Article 16 of this Chapter.

(b) (1) It is specifically the intention of this section to permit such persons as were providing health services on a prepaid basis on July 1, 1977, or receiving federal funds under Section 254(c) of Title 42, U.S. Code, as a community health center, to continue to operate in the manner which they have heretofore operated.

(2) Notwithstanding anything contained in this Article to the contrary, any person can provide health services on a fee for service basis to individuals who are not enrollees of the organization, and to enrollees for services not covered by the contract, provided that the volume of services in this manner shall not be such as to affect the ability of the health maintenance organization to provide on an adequate and timely

basis those services to its enrolled members which it has contracted to furnish under the enrollment contract.

(3) This Article shall not apply to any employee benefit plan to the extent that the Federal Employee Retirement Income Security Act of 1974 preempts State regulation thereof.

(3a) This Article does not apply to any prepaid health service or capitation arrangement implemented or administered by the Department of Health and Human Services or its representatives, pursuant to 42 U.S.C. § 1396n or Chapter 108A of the General Statutes, a provider sponsored organization or other organization certified, qualified, or otherwise approved by the Division of Medical Assistance of the Department of Health and Human Services pursuant to Article 17 of Chapter 131E of the General Statutes, or to any provider of health care services participating in such a prepaid health service or capitation arrangement. Article; provided, however, that to the extent this Article applies to any such person acting as a subcontractor to a Health Maintenance Organization licensed in this State, that person shall be considered a single service Health Maintenance Organization for the purpose of G.S. 58-67-20(4), G.S. 58-67-25, and G.S. 58-67-110.

(4) Except as provided in paragraphs (1), (2), (3), and (3a) of this subsection, the persons to whom these paragraphs are applicable shall be required to comply with all provisions contained in this Article.

(c) Each application for a ~~certificate of authority~~ license shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commissioner, and shall be set forth or be accompanied by the following:

(1) A copy of the basic organizational document, if any, of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments ~~thereto;~~ thereto. Any proposed articles of incorporation for the formation of a domestic health maintenance organization shall be filed with the Commissioner. The Commissioner shall examine the proposed articles. If the Commissioner finds that the proposed articles meet the requirements of the insurance laws of this State and otherwise determines that the articles should be approved, the Commissioner shall place a certificate of approval on the articles and submit the approved articles to the Secretary of State;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, and official positions of persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(4) A copy of any contract form made or to be made between any class of providers and the HMO and a copy of any contract form made or to be made between third party administrators, marketing consultants, or persons listed in subdivision (3) of this subsection and the HMO;

(5) A statement generally describing the health maintenance organization, its health care plan or plans, facilities, and personnel;

(6) A copy of the form of evidence of coverage to be issued to the enrollees;

(7) A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;

(8) Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement unless the Commissioner directs that additional or more recent financial information is required for the proper administration of this Article;

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

(10) A power of attorney duly executed by such applicant, if not domiciled in this State, appointing the Commissioner and his successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this State may be served;

(11) A statement reasonably describing the geographic area or areas to be served;

(12) A description of the procedures to be implemented to meet the protection against insolvency requirements of G.S. 58-67-110;

(13) A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances; and

(14) Such other information as the Commissioner may require to make the determinations required in G.S. 58-67-20.

(d) (1) A health maintenance organization shall file a notice describing any significant modification of the operation set out in the information required by subsection (c) of this section. Such notice shall be filed

with the Commissioner prior to the modification. If the Commissioner does not disapprove within 90 days after the filing, such modification shall be deemed to be approved. Changes subject to the terms of this section include expansion of service area, changes in provider contract forms and group contract forms where the distribution of risk is significantly changed, and any other changes that the Commissioner describes in properly promulgated rules. Every HMO shall report to the Commissioner for his information material changes in the provider network, the addition or deletion of Medicare risk or Medicaid risk arrangements and the addition or deletion of employer groups that exceed ten percent (10%) of the health maintenance organization's book of business or such other information as the Commissioner may require. Such information shall be filed with the Commissioner within 15 days after implementation of the reported changes. Every HMO shall file with the Commissioner all subsequent changes in the information or forms that are required by this Article to be filed with the Commissioner.

(1a) Any proposed change to the articles of incorporation shall be filed with the Commissioner. The Commissioner shall examine the proposed change to the articles. If the Commissioner determines that the proposed change should be approved, the Commissioner shall place a certificate of approval on the change and submit the approved change to the Secretary of State.

(2) The Commissioner may promulgate rules and regulations exempting from the filing requirements of subdivision (1) those items he deems unnecessary."

SECTION 25. G.S. 58-15-30 reads as rewritten:

"**§ 58-15-30. License, surplus, and deposit requirements.**

(a) No reciprocal shall engage in any insurance transaction in this State until it has obtained a license to do so in accordance with the applicable provisions of Articles 1 through 64 of this Chapter. ~~Such~~ The license shall ~~expire on the last day of June of each year.~~ continue in full force and effect, subject to timely payment of an annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provision of the insurance laws of this State.

(b) No domestic or foreign reciprocal shall be licensed in this State unless it has a surplus to policyholders of at least eight hundred thousand dollars ($800,000); and no alien reciprocal shall be licensed unless it has a trusteed surplus of at least eight hundred thousand dollars ($800,000).

(c) Each domestic, foreign, or alien reciprocal licensed in this State ~~must maintain a minimum deposit~~ shall deposit and maintain deposits with the Commissioner of at least ~~one hundred thousand dollars ($100,000)~~ four hundred thousand dollars ($400,000) in cash or in value of securities of the kind specified in G.S. 58-5-15, which shall be subject to ~~the same conditions as contained in~~ Article 5 of this Chapter."

SECTION 26. G.S. 58-13-20 reads as rewritten:

"**§ 58-13-20. Exception.**

(a) This Article does not apply to those reserve assets of an insurer that are held, deposited, pledged, hypothecated, or otherwise encumbered as provided in this section to secure, offset, protect, or meet those policyholder-related liabilities of the insurer that are established, incurred, or required under the provisions of a reinsurance agreement whereby the insurer has reinsured the insurance policy liabilities of a ceding insurer, provided:

(1) The ceding insurer and the reinsurer are both licensed to transact business in this State;

(2) Pursuant to a written agreement between the ceding insurer and the reinsurer, reserve assets substantially equal to the policyholder-related liabilities required to be established by the reinsurer on the reinsured business are either (i) deposited by or are withheld from the reinsurer and are in the custody of the ceding insurer as security for the payment of the reinsurer's obligations under the reinsurance agreement, and such assets are held subject to withdrawal by and under the separate or joint control of the ceding insurer, or (ii) deposited and held in trust account for that purpose and under those conditions with a ~~State or national bank domiciled in this State.~~ qualified United States financial institution.

(b) The Commissioner has the right to examine any of such assets, reinsurance agreements, or deposit arrangements at any time in accordance with his authority to make examinations of insurers as conferred by other provisions of this Chapter.

(c) For purposes of subdivision (a)(2) of this section, "qualified United States financial institution" means an institution that:

(1) Is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any of its states;

(2) Is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(3) Has been determined by either the Commissioner or the Securities Valuation Office of the NAIC to meet the standards of financial condition and standing considered necessary and appropriate to regulate the quality of financial institutions who serve as trustees."

SECTION 27. G.S. 58-8-20(e) reads as rewritten:

"(e) Guaranty capital may be reduced or retired by vote of the policyholders of the company and the assent of the Commissioner, if the net assets of the company above its reserve and all other claims and obligations, exclusive of guaranty capital, for two years immediately preceding and including the date of its last annual statement, is not less than twenty-five percent (25%) of the guaranty capital. ~~Due~~ Written notice of ~~such~~ the proposed action on the part of the company must be mailed to each policyholder of the company not less than 30 days before the meeting when the action may be taken, and

must also be advertised in two papers of general circulation, approved by the Commissioner, not less than three times a week for a period of not less than four weeks before ~~such~~ the meeting. The written notification to policyholders shall include a proxy statement to allow policyholders to vote on the proposed action without personal attendance at the meeting, and the Commissioner shall approve both the written notification and the proxy statement. An affirmative vote of at least two-thirds of the policy holders voting in person or by proxy is required to adopt the proposed action."

SECTION 28. This act becomes effective October 1, 2005.

House Bill 660:
Insurance Financial Changes.-AB

BILL ANALYSIS

Committee:	House Insurance	**Date:**	April 13, 2005
Introduced by:	Rep. Holliman	**Summary by:**	Kory Goldsmith
Version:	First Edition		Committee Counsel
	H660-CSRC-16[v.1]		

SUMMARY: ***The Proposed Committee Substitute makes technical corrections to the 1st Edition of the bill.***

See the attached summary prepared by Frank Folger, Legislative Counsel, Department of Insurance

HOUSE BILL 660
INSURANCE FINANCIAL CHANGES - AB

Summary: Makes various changes to financial laws under Chapter 58 of the General Statutes.

Section by section, this act would:

SECTION 1. Statutorily apply the oath of statutory compliance required of chief executive officers (CEOs) of all insurers doing business in this State to CEO/president of health maintenance organizations (HMOs), Blue Cross Blue Shield, and other medical service organizations consistent with current practice of these entities;

SECTION 2. Redefine "insurer's financial condition is unsound..." as basis for revocation, suspension, or restriction of the license of an insurer to ameliorate a technical problem caused by the change of the definition of "hazardous condition" in a rule that cross-references G.S. 58-30-60;

SECTION 3. Eliminate statutory deposit obsolete phase-in language

SECTION 4. Clarify for whose benefit statutory deposits of domestic companies and foreign companies are held to conform with existing guaranty association statutes;

SECTION 5. Make a technical correction in the annual license continuation fee definition language in G.S. 58-6-15 and clarify that the fee is submitted annually while the license is in continuation;

SECTION 6. Reinstate a notice requirement for domestic insurers having any change in the CEO or president that was inadvertently eliminated when the Department changed its insurer licensing from annual to perpetual;

SECTIONS 7. through 9. Implement use of current technical terminology regarding insurer investments as recommended by the NAIC Securities Valuation Office;

SECTION 10. Clarify that the percentage restriction on investment in foreign countries applies to investment in a single foreign country rather than foreign countries in the aggregate;

SECTIONS 11. and 12. Conform statutes to industry practice by providing that the "mortgage guaranty insurers report of policyholders position" be filed with annual and quarterly statements;

SECTION 13. Correct inadvertent failure of House Bill 276 to change language to implement perpetual licenses for reciprocals like other insurers;

SECTION 14. Remove the modifier "substantial" from the requirement of statutory compliance with certain statutory criteria for continued licensure for foreign and alien insurers and conform the statute to cross-reference the notice of change in CEO or president requirement proposal in this act;

SECTION 15. Eliminate intrastatute inconsistency regarding approval of insurer's guarantees to persons in its holding company system;

SECTION 16. Require statutorily, by reference to G.S. 58-7-73, that workers' compensation self-insurance groups submit for approval a plan of dissolution prior to proceeding with dissolution;

SECTION 17. Remove an incorrect reference in Article 56 of Chapter 58 (Third Party Administrators) referring to "licensing" of managing general agents in this State when they are not, in fact, licensed in this State, and clarifying the definition and cross-reference;

SECTION 18. Make changes to the applicability statute in Article 65 governing hospital, medical, and dental service corporations to conform to other amendments in this act;

SECTION 19. Remove obsolete HMO statutory deposit phase-in language and conform statute to current practice by subjecting the deposits to provisions of Article 5 regarding governance of those deposits;

SECTION 20. Replace excessive and unnecessary monthly reporting requirement with a quarterly reporting requirement for certain HMOs whose reimbursements for uncovered health care expenses exceed a stated threshold;

SECTION 21. Make changes to the applicability statute in Article 67 of Chapter 58, governing HMOs, to conform to other amendments in this act and to require HMOs to file a plan of dissolution for approval prior to proceeding with dissolution;

SECTION 22. Broaden the scope of services provided for under the Department's Consumer Protection Fund;

SECTION 23. Expand the Commissioner's authority to exempt insurers with limited premiums from risk-based capital provisions;

SECTION 24. Remove technical misnomer from the statute governing the establishment of HMOs, changing "certificate of authority" to "license" and require domestic HMOs to file for approval by the Commissioner its proposed articles of incorporation and, subsequently, any proposed changes to its articles of incorporation;

SECTION 25. Conform the statutory deposit amount requirements for reciprocals consistent with the changes made in House Bill 276 in 2003;

SECTION 26. Remove the requirement that encumbered assets used to pay policyholder liabilities under a reinsurance agreement between a ceding insurer and a reinsurer both licensed in this State be placed in a bank domiciled in this State and adopt instead requirements consistent with those for assets held in trust of unauthorized insurers pursuant to G.S. 58-7-26;

SECTION 27. Require a two-thirds majority vote of policyholder of a mutual insurance company to retire its guaranty capital and require Commissioner approval of the notification and proxy statement, consistent with the existing requirements for the issuance of guaranty capital by a mutual insurance company;

SECTION 28. Makes the act effective October 1, 2005.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 660 DATE _____

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE ~~SUBSTITUTE~~ X

(Rep.) Saunders
(Sen.)

1 moves to amend the bill on page 6, line 5

2 ( ) WHICH CHANGES THE TITLE

3 by deleting lines 28 - 34 and

4 renumbering the remaining

5 Sections accordingly.

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SIGNED _____

ADOPTED X FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

Attachment VI

Read me

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H D

HOUSE BILL 737*
PROPOSED COMMITTEE SUBSTITUTE H737-CSRG-10 [v.1]

4/13/2005 4:11:53 PM

Short Title: Improve Health Insurance Underwriting.-AB (Public)

Sponsors:

Referred to:

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT ASSOCIATION PREMIUM RATES FOR ACCIDENT AND HEALTH INSURANCE BE ACTUARIALLY SOUND AND THAT ASSOCIATIONS BE RATED AS A SINGLE GROUP WHEN THE COVERAGE PROVIDED IS NOT EMPLOYER-BASED, LIMIT AN INDIVIDUAL ACCIDENT AND HEALTH INSURER'S USE OF AN INDIVIDUAL'S OWN CLAIMS EXPERIENCE TO DEVELOP THE INDIVIDUAL'S RENEWAL RATE; EXEMPT A SOLE PROPRIETOR FROM THE FULL-TIME BASIS FOR THIRTY-HOUR WORKWEEK REQUIREMENTS TO BE ELIGIBLE FOR LARGE GROUP HEALTH COVERAGE LIKE THE PROPRIETOR'S FULL-TIME EMPLOYEES; CORRECT AN INADVERTENT CROSS-REFERENCE IN ORDER TO REAPPLY NEWBORN COVERAGE TO A MORE COMPREHENSIVE GROUP OF INSURERS; TECHNICALLY CORRECT AN OMISSION REGARDING PROVISIONS GOVERNING PREEXISTING CONDITIONS FOR LIMITED HEALTH, SUPPLEMENTAL HEALTH, AND SPECIFIED DISEASE POLICIES; DECREASE THE TOTAL NUMBER OF MEMBERS THAT SERVE ON THE SMALL EMPLOYER REINSURANCE POOL BOARD FROM NINE TO SIX; ALLOW PERSONS RETROACTIVELY ENROLLED IN MEDICARE PART B THE SAME SIX-MONTH OPEN ENROLLMENT PERIOD FOR MEDICARE SUPPLEMENT PLANS AS PERSONS WHO ENROLLED IN MEDICARE PART B WITHOUT A RETROACTIVE EFFECTIVE DATE OF COVERAGE; TECHNICALLY CORRECT THE REVOCATION AND SUSPENSION LAW TO INCLUDE A BENEFICIARY OF A LIFE OR ANNUITY CONTRACT AS A CLAIMANT; AND AMEND THE UTILIZATION REVIEW LAWS TO CLARIFY THAT SUCH LAWS PLAINLY APPLY TO INDIVIDUAL INSURANCE COVERAGE AS WELL AS GROUP COVERAGE.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 58-51-80(1a) reads as rewritten:

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

a. The policy may insure members of the association or associations, employees of the association or associations, or employees of members, or one or more of the preceding or all of any class or classes for the benefit of persons other than the employee's employer.

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

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

SECTION 1.(b) G.S. 58-51-95 is amended by adding the following new subsection to read:

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

...

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

(1) Health status.

(2) Medical condition (including physical and mental illnesses).

(3) Claims experience.

(4) Duration from issue.

(5) Receipt of health care.

(6) Medical history.

(7) Genetic information."

SECTION 2.(a) G.S. 58-65-60 is amended by adding the following new subsection to read:

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

...

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

SECTION 2.(b) G.S. 58-67-85 is amended by adding the following new subsection to read:

"§ 58-67-85. Master group contracts, filing requirement; required and prohibited provisions.

...

"(d1) When determining employee eligibility for a large employer, as defined in G.S. 58-68-25(10), an individual proprietor, owner, or operator shall be defined as an "employee" for the purpose of obtaining coverage under the employee group health plan and shall not be held to a minimum workweek requirement as imposed on other eligible employees."

SECTION 2.(c) G.S. 58-51-80(c) reads as rewritten:

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

...

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

SECTION 3. G.S. 58-51-30(b) reads as rewritten:

"§ 58-51-30. Policies to cover newborn infants, foster children, and adopted children.

...

"(b) Every health benefit plan, as defined in ~~G.S. 58-3-167~~,G.S. 58-51-115(a)(1), that provides benefits for any sickness, illness, or disability of any minor child or that provides benefits for any medical treatment or service furnished by a health care provider or institution to any minor child shall provide the benefits for those occurrences beginning with the moment of the child's birth if the birth occurs while the plan is in force. Every health benefit plan shall extend coverage to a newborn child without requirements for prior notification unless an additional premium charge to add the dependent is due. If an additional premium charge is due to cover the dependent, the health benefit plan shall cover the newborn child from the moment of birth if the newborn is enrolled within 30 days after the date of birth. Foster children and adopted children shall be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home or placement for adoption. Every health benefit plan shall extend coverage to a foster child or adopted child without requirements for prior notification unless an additional premium charge to add the foster child or adopted child is due. If an additional premium charge is due to cover the foster child or adopted child, the health benefit plan shall cover the foster child or adopted child upon placement in the foster home or placement for adoption if the foster child or adopted child is enrolled within 30 days after the placement in the foster home or placement for adoption."

SECTION 4.(a) G.S. 58-51-15(a)(2) reads as rewritten:

"**§ 58-51-15. Accident and health policy provisions.**

(a) Required Provisions. – Except as provided in subsection (c) of this section each such policy delivered or issued for delivery to any person in this State shall contain the provisions specified in this subsection in the substance of the words that appear in this section. Such provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve.

...

(2) A provision in the substance of the following language:

TIME LIMIT ON CERTAIN DEFENSES:

a. After two years from the date of issue or reinstatement of this policy no misstatements except fraudulent misstatements made by the applicant in the application for such policy shall be used to void the policy or deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period.

The foregoing policy provision may be used in its entirety only in major or catastrophe hospitalization policies and major medical policies each affording benefits of five thousand dollars ($5,000) or more for any one sickness or injury; disability income policies affording benefits of one hundred dollars

($100.00) or more per month for not less than 12 months; and franchise policies. Other policies to which this section applies must delete the words "except fraudulent misstatements."

(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of G.S. 58-51-15(b), (1), (2), (3), (4) and (5) in the event of misstatement with respect to age or occupation or other insurance.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium:

1. Until at least age 50 or,
2. In the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE."

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.)

b. This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions are covered under this policy _____ (insert number of months or days, not to exceed one year) after the effective date of coverage. Preexisting conditions mean "those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of the person's coverage." ~~Credit~~ Except for the excepted benefits described in G.S. 58-68-25(b), 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 4.(b) G.S. 58-51-15(h) reads as rewritten:

"**§ 58-51-15. Accident and health policy provisions.**

...

"(h) Preexisting Condition Exclusion Clarification. – Sub-subdivision (a)(2) b. of this section does not apply ~~to:~~to policies issued to eligible individuals under G.S. 58-68-60.

~~(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 5. G.S. 58-50-150(b) reads as rewritten:

"**§ 58-50-150. North Carolina Small Employer Health Reinsurance Pool.**

...

Reduce to 6 months

"(b) ~~Within 30 days after January 1, 1992, the Commissioner shall give notice to all carriers of the time and place for the initial organizational meeting, which shall take place within 90 days after the notice from the Commissioner.~~ The members shall select the initial Board, subject to the Commissioner's approval. The Board shall consist of ~~nine~~ six members. There shall be no more than two members of the Board representing any one carrier. In determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. ~~The voting rights to determine initial Board membership shall be weighted based upon net group health benefit plan premium derived from this State in the previous calendar year. Thereafter, voting~~ Voting rights shall be based on net group health benefit plan premium derived from small employer business. The Board shall at all times, to the extent possible, include at least one domestic insurance company licensed to transact accident and health insurance, one HMO, one nonprofit hospital or medical service plan. ~~Six~~ Five of the members of the Board shall be small employer carriers. In approving selection of the Board, the Commissioner shall assure that all members are fairly represented."

SECTION 6. G.S. 58-54-45(a) reads as rewritten:

"**§ 58-54-45. By reason of disability.**

(a) 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 Plans A, C, and J 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. For those persons that are retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration, the application must be submitted within a six-month period beginning with the month in which the person receives notification of the retroactive eligibility decision.

..."

SECTION 7. G.S. 58-3-100(c) reads as rewritten:

"**§ 58-3-100. Insurance company licensing provisions.**

...

(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after receiving written or electronic 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 one of the following:

(1) A statement made to the claimant or to the claimant's legal representative advising that the claim is being investigated.

(2) Payment of the claim.

(3) A bona fide written offer of settlement.

(4) A written denial of the claim.

A claimant includes an insured, a beneficiary of a life or annuity contract, a health care provider, or a health care facility that is responsible for directly making the claim with an insurer, HMO, service corporation, or MEWA. With respect to a claim under an

accident, health, or disability policy, if the acknowledgement sent to the claimant indicates that the claim remains under investigation, within 45 days after receipt by the insurer of the initial claim, the insurer shall send a claim status report to the insured and every 45 days thereafter until the claim is paid or denied. The report shall give details sufficient for the insured to understand why processing of the claim has not been completed and whether the insurer needs additional information to process the claim. If the claim acknowledgement includes information about why processing of the claim has not been completed and indicates whether additional information is needed, it may satisfy the requirement for the initial claim status report. This subsection does not apply to HMOs, service corporations, MEWAs or insurers subject to G.S. 58-3-225.

..."

SECTION 8. G.S. 58-50-61(a) is amended by adding the following new subdivision to read:

"**§ 58-50-61. Utilization review.**

(a) Definitions. – As used in this section, in G.S. 58-50-62, and in Part 4 of this Article, the term:

...

(2a) 'Certificate of coverage' includes a policy of insurance issued to an individual person or a franchise policy issued pursuant to G.S. 58-51-90.

..."

SECTION 9. Sections 1 through 4 of this act become effective January 1, 2006, and apply to policies or certificates issued or renewed on or after that date. The remainder of this act is effective when it becomes law and applies to policies or certificates issued or renewed on or after that date.

HOUSE BILL 737:
Improve Health Insurance Underwriting-AB

BILL ANALYSIS

Committee:	House Insurance Committee	**Introduced by:**	Representatives Holliman and Wright
Date:	April 13, 2005		
Version:	Proposed Committee Substitute	**Summary by:**	Tim Hovis Committee Counsel

SUMMARY: *House Bill 737 makes numerous substantive and technical changes to laws governing the regulation of insurance including:*

- *Amends G.S. 58-51-80, which defines group accident and health insurance, to require that association premium rates for accident and health insurance be actuarially sound and that associations be rated as a single group when the coverage provided is not employer-based.*
- *Amends G.S. 58-51-95 to limit an insurer's ability to use an individual's or a dependent of the individual's claims experience when developing the individual's renewal rates on individual health insurance policies.*
- *Amends G.S. 58-65-60, 58-67-8, and 58-51-80 to exempt a sole proprietor from the full-time basis or the 30 hour workweek requirements to be eligible for large group health coverage like the proprietor's full-time employees.*
- *Amends G.S. 58-51-30 governing policies covering newborn infants, foster children and adopted children to replace the reference to a definition of a health benefit plan with a different, broader statutory reference.*
- *Clarifies that statutory limitations on the definition of pre-existing conditions and the period of exclusion do apply to limited health, supplemental health, and specified disease policies, but that portability or credit for prior creditable coverage does not.*
- *Amend G.S. 58-50-150(b) to reduce the size of the Small Employer Health Reinsurance Pool Board from 9 to 6 members.*
- *Amends 58-54-45 governing the issuance of Medicare Supplement Plans by reason of disability to require an insurer to allow persons retroactively enrolled in Medicare Part due to a retroactive eligibility decision by the Social Security Administration the same six-month open enrollment period for Medicare Supplemental Plans as a person enrolled in Medicare Part B without a retroactive effective date of coverage.*
- *Amends G.S. 58-3-100 to include a beneficiary in the definition of a claimant.*
- *Amends G.S. 58-50-61 governing grievance and appeals to include a "policy of insurance" to clarify that these statutes apply to individual coverage and not just group coverage.*

Frank Folger with the Department of Insurance has provided the following section-by-section analysis of the bill.

SECTION 1(a).

Amend the statute that defines an association as a valid group for purposes of accident and health

insurance to require association premium rates to be actuarially sound and associations to be rated as a single group when the coverage provided is not employer based.

The Department's recent investigation into reunderwriting practices has indicated that some insurers may be rating individual (non-employer based) associations members as single one man groups each, using each individual's experience to rerate the individual upon renewal, rather than using the entire association's experience to determine renewal rates. Currently, the Department has little statutory authority addressing the rates for these types of groups. This amendment will give us the necessary authority to review questionable rating practices (not actuarially sound) and prevent the "reunderwriting" issue we have encountered.

SECTION 1(b).

Establish a new statute setting limitations upon an individual accident and health insurer's ability to use an individual's own claims' experience as a basis for developing the individual's renewal rate.

SECTION 2(a) –(c).

Amend the definition of "employee", with respect to large group employers (50 or more employees) to exempt a sole proprietor of a large group employer from having to establish evidence of full time basis or 30 hour workweek to meet eligibility for coverage under the policy provided for the employer's other employees.

The Department takes the position that an owner and/or operator of a large group employer should be eligible for the same health plan issued to his company and not be held to number of hours worked requirement. The Department has received complaints where a sole proprietor or partner of a partnership has been declared in-eligible for coverage under the company's policy because the proprietor doesn't meet the definition of an employee working 30 hours a week. In the interest of fairness, the Department supports exempting such individuals from minimum workweek requirements since they own the business providing the insurance in the group.

SECTION 3.

Remove the reference to health benefit plan as defined in 58-3-167 and replace with reference to health benefit plan as defined in 58-51-115(a)(1), which includes more kinds of insurance.

Prior to the 2001 Session, this statute requiring coverage of newborns applied to generally all types of health insurance coverage that provided coverage to children. Due to changes from 2001 session, the statute now applies only to major medical health coverages via the reference to 58-3-167. This means that for other types of coverage under which children are provided coverage, insurers are not required to provide coverage to newborn, foster and adopted children from the moment of birth or placement in the home and would not have to provide coverage for congenital defects or anomalies of such children either. Chief among lost coverage is dental insurance. The use of the limited definition of health benefit plan was an oversight which the Department would hope to correct through this measure.

SECTION 4.

Clarify that statutory limitations on the definition of pre-existing conditions and the period of exclusion do apply to limited health, supplemental health, and specified disease policies, but that portability (credit for prior creditable coverage) does not.

Specifically, the section would amend NCGS 58-51-15(a)(2)b. and repeal 58-51-15(h)(2) in order to clarify what limitations apply to limited health, supplemental health and specified disease coverages. A change in HB760 from the 2002 G.A. session exempted this coverage not only from portability but also from the requirements regarding how to define a pre-existing condition and how long such a condition could be excluded. This meant that insurers have had no limitations on how to define a pre-existing condition or how long one could be excluded on these coverages. This will place limitations upon an

insurer's ability to limit coverage for a pre-existing condition and afford coverage to insureds for pre-existing conditions at some point in time.

SECTION 5.

Amend NCGS 58-50-150(b) to reduce the size of the Small Employer Health Reinsurance Pool Board from 9 to 6 members. This change is sought to make the Board more efficient and to hopefully facilitate the Department's ability to obtain participation on the Board by member insurers, which has been a difficult task in recent years.

SECTION 6.

Provide an opportunity for an enrollment period for Medicare supplement insurance for those whose enrollment in Medicare Part B is a retroactive enrollment due to a retroactive eligibility decision based upon disability. This section would start the MedSupp enrollment period upon notification of the enrollment in Medicare Part B in those circumstances rather than the actual date in the retroactive enrollment.

SECTION 7.

Modify G.S.58-3-100 to include the words "a beneficiary" to the definition of claimant. This would require the insurer to acknowledge receipt of a claim to the beneficiary of a life or annuity contract if the claim was not paid within 30 days.

SECTON 8.

Amend the grievance and appeals statutes in Article 50 of Chapter 58 to include references to policy" along with "certificate" and "evidence of coverage" in order to clearly indicate that such statutes apply to individual coverage with utilization review (UR) not just group coverages. The Department has had individual health insurers argue that the UR rules, the appeals, and the grievance standards did not apply to the plan they had filed for approval because such a plan was an individual health insurance policy and not a "certificate of coverage".

SECTION 9.

Makes Sections 1 through 4 of the act effective January 1, 2006 and the rest is effective when it becomes law.

MINUTES

HOUSE COMMITTEE ON INSURANCE
April 19, 2005

The House Committee on Insurance met at 11:00 AM on Tuesday, April 19, 2005 in Room 1228. The following Representatives attended, Chairman Hugh Holliman, Vice Chairs: Bill Faison, Mitchell Setzer, Members: Lucy Allen, Jeff Barnhart, Harold Brubaker, William Current, Julia Howard, Linda Johnson, Deborah Ross, Drew Saunders, Ron Sutton, and Tom Wright.

Chairman Holliman called the meeting to order and welcomed Jim Long, Commissioner of Insurance to the meeting. Chairman Holliman ask for a motion to accept the PCS on HB 737 – Improve Health Insurance Underwriting.-AB. See Attachment I. Motion passed. Frank Folger, Legislative Counsel for the Department of Insurance was called on to explain an amendment changing the number of members that serve on the small employer reinsurance pool board. Attachment II. After some discussion, Rep. Sutton motioned to accept the amendment and that the PCS be rolled into a new PCS as amended for a favorable report. Motion was unanimously carried.

The House Pages, Sgt-At-Arms and visitors were recognized. Attachment III.

Mr. Folger was called on to speak on HB 654 – Confidential Insurance Mkt./Financial Doc.-AB. Mr. Folger explained the changes in Section 1 lines 9-15. See Attachment IV. Rep. Saunders made a motion to accept the PCS and motion carried. Kory Goldsmith, Staff Attorney explained a second amendment changing language in the bill. Rep. Ross made a motion to accept the amendment and motion carried. Attachment V. Mr. Folger spoke about the changes in the new PCS. George Teague, United Health Care spoke in support of this bill. Rep. Wright motioned for a favorable report on the PCS as amended and to be rolled into a new committee substitute. Motioned carried unanimously.

Chairman Holliman announced the Insurance Committee would meet on Thursday, April 21.

The Meeting was adjourned at 11:38 AM.

Representative L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: ~~Thursday~~ Tuesday CB, **April 19, 2005**

TIME: **11:00 AM**

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 737 - Improve Health Insurance Underwriting. -AB –
Rep. Holliman and Rep. Wright

HB 654 - Confidential Insurance Mkt./Financial Doc.-AB –
Rep. Holliman

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **4:00 PM on April 12, 2005**.

___Principal Clerk
___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

HOUSE INSURANCE COMMITTEE

April 19, 2005
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

HB 737 - Improve Health Insurance Underwriting. -AB –
Rep. Holliman and Rep. Wright

HB 654 - Confidential Insurance Mkt./Financial Doc.-AB –
Rep. Holliman

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative **HOLLIMAN** (Chair) for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 654 A BILL TO BE ENTITLED AN ACT TO ENHANCE THE CONFIDENTIAL TREATMENT OF INSURANCE MARKET CONDUCT ANALYSIS AND FINANCIAL ANALYSIS FILES.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☒ With a favorable report as to the committee substitute bill ~~(#), ☐ which changes the title~~, unfavorable as to (the original bill) ~~(Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on)~~

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

03/19/03

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative **HOLLIMAN** (Chair) for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 737 A BILL TO BE ENTITLED AN ACT TO REQUIRE THAT ASSOCIATION PREMIUM RATES FOR ACCIDENT AND HEALTH INSURANCE BE ACTUARIALLY SOUND AND THAT ASSOCIATIONS BE RATED AS A SINGLE GROUP WHEN THE COVERAGE PROVIDED IS NOT EMPLOYER-BASED, LIMIT AN INDIVIDUAL ACCIDENT AND HEALTH INSURER'S USE OF AN INDIVIDUAL'S OWN CLAIMS EXPERIENCE TO DEVELOP THE INDIVIDUAL'S RENEWAL RATE; EXEMPT A SOLE PROPRIETOR FROM THE FULL-TIME BASIS FOR THIRTY-HOUR WORKWEEK REQUIREMENTS TO BE ELIGIBLE FOR LARGE GROUP HEALTH COVERAGE LIKE THE PROPRIETOR'S FULL-TIME EMPLOYEES; CORRECT AN INADVERTENT CROSS-REFERENCE IN ORDER TO REAPPLY NEWBORN COVERAGE TO A MORE COMPREHENSIVE GROUP OF INSURERS; TECHNICALLY CORRECT AN OMISSION REGARDING PROVISIONS GOVERNING PREEXISTING CONDITIONS FOR LIMITED HEALTH, SUPPLEMENTAL HEALTH, AND SPECIFIED DISEASE POLICIES; DECREASE THE TOTAL NUMBER OF MEMBERS THAT SERVE ON THE SMALL EMPLOYER REINSURANCE POOL BOARD FROM NINE TO SIX; ALLOW PERSONS RETROACTIVELY ENROLLED IN MEDICARE PART B THE SAME SIX-MONTH OPEN ENROLLMENT PERIOD FOR MEDICARE SUPPLEMENT PLANS AS PERSONS WHO ENROLLED IN MEDICARE PART B WITHOUT A RETROACTIVE EFFECTIVE DATE OF COVERAGE; TECHNICALLY CORRECT THE REVOCATION AND SUSPENSION LAW TO INCLUDE A BENEFICIARY OF A LIFE OR ANNUITY CONTRACT AS A CLAIMANT; AND AMEND THE UTILIZATION REVIEW LAWS TO CLARIFY THAT SUCH LAWS PLAINLY APPLY TO INDIVIDUAL INSURANCE COVERAGE AS WELL AS GROUP COVERAGE.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☒ With a favorable report as to the committee substitute bill (#_____), ☒ which changes the title, unfavorable as to (the original bill), ~~(Committee Substitute Bill #_____), (and recommendation that the committee substitute bill #_____) be re-referred to the Committee on _____).~~

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

Attachment I

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 737*
PROPOSED COMMITTEE SUBSTITUTE H737-CSRG-11 [v.1]

4/18/2005 4:05:58 PM

Short Title: Improve Health Insurance Underwriting.-AB (Public)

Sponsors:

Referred to:

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT ASSOCIATION PREMIUM RATES FOR ACCIDENT AND HEALTH INSURANCE BE ACTUARIALLY SOUND AND THAT ASSOCIATIONS BE RATED AS A SINGLE GROUP WHEN THE COVERAGE PROVIDED IS NOT EMPLOYER-BASED, LIMIT AN INDIVIDUAL ACCIDENT AND HEALTH INSURER'S USE OF AN INDIVIDUAL'S OWN CLAIMS EXPERIENCE TO DEVELOP THE INDIVIDUAL'S RENEWAL RATE; EXEMPT A SOLE PROPRIETOR FROM THE FULL-TIME BASIS FOR THIRTY-HOUR WORKWEEK REQUIREMENTS TO BE ELIGIBLE FOR LARGE GROUP HEALTH COVERAGE LIKE THE PROPRIETOR'S FULL-TIME EMPLOYEES; CORRECT AN INADVERTENT CROSS-REFERENCE IN ORDER TO REAPPLY NEWBORN COVERAGE TO A MORE COMPREHENSIVE GROUP OF INSURERS; TECHNICALLY CORRECT AN OMISSION REGARDING PROVISIONS GOVERNING PREEXISTING CONDITIONS FOR LIMITED HEALTH, SUPPLEMENTAL HEALTH, AND SPECIFIED DISEASE POLICIES; DECREASE THE TOTAL NUMBER OF MEMBERS THAT SERVE ON THE SMALL EMPLOYER REINSURANCE POOL BOARD FROM ~~NINE~~ Five TO SIX; ALLOW PERSONS RETROACTIVELY ENROLLED IN MEDICARE PART B THE SAME SIX-MONTH OPEN ENROLLMENT PERIOD FOR MEDICARE SUPPLEMENT PLANS AS PERSONS WHO ENROLLED IN MEDICARE PART B WITHOUT A RETROACTIVE EFFECTIVE DATE OF COVERAGE; TECHNICALLY CORRECT THE REVOCATION AND SUSPENSION LAW TO INCLUDE A BENEFICIARY OF A LIFE OR ANNUITY CONTRACT AS A CLAIMANT; AND AMEND THE UTILIZATION REVIEW LAWS TO CLARIFY THAT SUCH LAWS PLAINLY APPLY TO INDIVIDUAL INSURANCE COVERAGE AS WELL AS GROUP COVERAGE.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 58-51-80(1a) reads as rewritten:

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

a. The policy may insure members of the association or associations, employees of the association or associations, or employees of members, or one or more of the preceding or all of any class or classes for the benefit of persons other than the employee's employer.

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

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

SECTION 1.(b) G.S. 58-51-95 is amended by adding the following new subsection to read:

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

...

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

(1) Health status.

(2) Medical condition (including physical and mental illnesses).

(3) Claims experience.

(4) Duration from issue.

(5) Receipt of health care.

(6) Medical history.

(7) Genetic information."

SECTION 2.(a) G.S. 58-65-60 is amended by adding the following new subsection to read:

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

...

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

SECTION 2.(b) G.S. 58-67-85 is amended by adding the following new subsection to read:

"**§ 58-67-85. Master group contracts, filing requirement; required and prohibited provisions.**

...

"(d1) When determining employee eligibility for a large employer, as defined in G.S. 58-68-25(10), an individual proprietor, owner, or operator shall be defined as an "employee" for the purpose of obtaining coverage under the employee group health plan and shall not be held to a minimum workweek requirement as imposed on other eligible employees."

SECTION 2.(c) G.S. 58-51-80(c) reads as rewritten:

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

...

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

SECTION 3. G.S. 58-51-30(b) reads as rewritten:

"§ 58-51-30. Policies to cover newborn infants, foster children, and adopted children.

...

"(b) Every health benefit plan, as defined in ~~G.S. 58-3-167~~,G.S. 58-51-115(a)(1), that provides benefits for any sickness, illness, or disability of any minor child or that provides benefits for any medical treatment or service furnished by a health care provider or institution to any minor child shall provide the benefits for those occurrences beginning with the moment of the child's birth if the birth occurs while the plan is in force. Every health benefit plan shall extend coverage to a newborn child without requirements for prior notification unless an additional premium charge to add the dependent is due. If an additional premium charge is due to cover the dependent, the health benefit plan shall cover the newborn child from the moment of birth if the newborn is enrolled within 30 days after the date of birth. Foster children and adopted children shall be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home or placement for adoption. Every health benefit plan shall extend coverage to a foster child or adopted child without requirements for prior notification unless an additional premium charge to add the foster child or adopted child is due. If an additional premium charge is due to cover the foster child or adopted child, the health benefit plan shall cover the foster child or adopted child upon placement in the foster home or placement for adoption if the foster child or adopted child is enrolled within 30 days after the placement in the foster home or placement for adoption."

SECTION 4.(a) G.S. 58-51-15(a)(2) reads as rewritten:

"§ 58-51-15. Accident and health policy provisions.

(a) Required Provisions. – Except as provided in subsection (c) of this section each such policy delivered or issued for delivery to any person in this State shall contain the provisions specified in this subsection in the substance of the words that appear in this section. Such provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve.

...

(2) A provision in the substance of the following language:

TIME LIMIT ON CERTAIN DEFENSES:

a. After two years from the date of issue or reinstatement of this policy no misstatements except fraudulent misstatements made by the applicant in the application for such policy shall be used to void the policy or deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period.

The foregoing policy provision may be used in its entirety only in major or catastrophe hospitalization policies and major medical policies each affording benefits of five thousand dollars ($5,000) or more for any one sickness or injury; disability income policies affording benefits of one hundred dollars

($100.00) or more per month for not less than 12 months; and franchise policies. Other policies to which this section applies must delete the words "except fraudulent misstatements."

(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of G.S. 58-51-15(b), (1), (2), (3), (4) and (5) in the event of misstatement with respect to age or occupation or other insurance.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium:

1. Until at least age 50 or,
2. In the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE."

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.)

b. This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions are covered under this policy _____ (insert number of months or days, not to exceed one year) after the effective date of coverage. Preexisting conditions mean "those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of the person's coverage." ~~Credit~~ Except for the excepted benefits described in G.S. 58-68-25(b), 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 4.(b) G.S. 58-51-15(h) reads as rewritten:

"**§ 58-51-15. Accident and health policy provisions.**

...

"(h) Preexisting Condition Exclusion Clarification. – Sub-subdivision (a)(2) b. of this section does not apply ~~to:~~to policies issued to eligible individuals under G.S. 58-68-60.

~~(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 5. G.S. 58-50-150(b) reads as rewritten:

"**§ 58-50-150. North Carolina Small Employer Health Reinsurance Pool.**

...

"(b) ~~Within 30 days after January 1, 1992, the Commissioner shall give notice to all carriers of the time and place for the initial organizational meeting, which shall take place within 90 days after the notice from the Commissioner.~~ The members shall select the initial Board, subject to the Commissioner's approval. The Board shall consist of ~~nine~~ five members. There shall be no more than two members of the Board representing any one carrier. In determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. ~~The voting rights to determine initial Board membership shall be weighted based upon net group health benefit plan premium derived from this State in the previous calendar year. Thereafter, voting~~ Voting rights shall be based on net group health benefit plan premium derived from small employer business. The Board shall at all times, to the extent possible, include at least one domestic insurance company licensed to transact accident and health insurance, one HMO, one nonprofit hospital or medical service plan. ~~Six~~ Four of the members of the Board shall be small employer carriers. In approving selection of the Board, the Commissioner shall assure that all members are fairly represented."

SECTION 6. G.S. 58-54-45(a) reads as rewritten:

"**§ 58-54-45. By reason of disability.**

(a) 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 Plans A, C, and J 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. For those persons that are retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration, the application must be submitted within a six-month period beginning with the month in which the person receives notification of the retroactive eligibility decision."

SECTION 7. G.S. 58-3-100(c) reads as rewritten:

"**§ 58-3-100. Insurance company licensing provisions.**

...

(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after receiving written or electronic 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 one of the following:

(1) A statement made to the claimant or to the claimant's legal representative advising that the claim is being investigated.

(2) Payment of the claim.

(3) A bona fide written offer of settlement.

(4) A written denial of the claim.

A claimant includes an insured, a beneficiary of a life or annuity contract, a health care provider, or a health care facility that is responsible for directly making the claim with an insurer, HMO, service corporation, or MEWA. With respect to a claim under an accident, health, or disability policy, if the acknowledgement sent to the claimant

indicates that the claim remains under investigation, within 45 days after receipt by the insurer of the initial claim, the insurer shall send a claim status report to the insured and every 45 days thereafter until the claim is paid or denied. The report shall give details sufficient for the insured to understand why processing of the claim has not been completed and whether the insurer needs additional information to process the claim. If the claim acknowledgement includes information about why processing of the claim has not been completed and indicates whether additional information is needed, it may satisfy the requirement for the initial claim status report. This subsection does not apply to HMOs, service corporations, MEWAs or insurers subject to G.S. 58-3-225."

SECTION 8. G.S. 58-50-61(a) is amended by adding the following new subdivision to read:

"**§ 58-50-61. Utilization review.**

(a) Definitions. – As used in this section, in G.S. 58-50-62, and in Part 4 of this Article, the term:

...

(2a) 'Certificate of coverage' includes a policy of insurance issued to an individual person or a franchise policy issued pursuant to G.S. 58-51-90.

..."

SECTION 9. Sections 1 through 4 of this act become effective January 1, 2006, and apply to policies or certificates issued or renewed on or after that date. The remainder of this act is effective when it becomes law and applies to policies or certificates issued or renewed on or after that date.

Attachment II

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 737 DATE 4/19/05

S. B. No. _____ Amendment No. _____

Proposed Comm Sub. (to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.) Sutton

)

Sen.)

1 moves to amend the bill on page 1, line 18

2 ( ) WHICH CHANGES THE TITLE

3 by deleting ~~AAAAA~~ ~~AAA~~ "SIX" and

4 substituting "FIVE".

5

6

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SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

Attachment III

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — April 19, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cam Cave	BPMHL
Kim Eshleman	BPMHL
Mike Causey	Causey Associates
[illegible]	NCAHP
Hoag Kaplan	"
[illegible]	"
Lee Hodge	KCCH
[illegible]	Nationwide
BILL HARE	ACLI
[illegible] PASCHAL	Young, Moore
Ken Wright	BCBSNC
Lori Ann Harris	NAHU

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — April 19, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Abby Emanuelson	NMSS
Barbara Morales Burke	NC DOI

Attachment IV

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 654
PROPOSED COMMITTEE SUBSTITUTE H654-CSRC-19 [v.1]

4/19/2005 9:47:38 AM

Short Title: Confidential Insurance Mkt./Financial Doc.-AB (Public)

Sponsors:

Referred to:

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO ENHANCE THE CONFIDENTIAL TREATMENT OF INSURANCE MARKET CONDUCT ANALYSIS AND FINANCIAL ANALYSIS FILES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 2 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-2-240. Market conduct analysis, financial analysis, and related information not public record.**

(a) Notwithstanding Chapter 132 of the General Statutes, all market analysis, documents arising from market conduct action, and financial analysis documents, ratios, programs, findings and other information in the custody of the Department are confidential, are not open for public inspection, and are not discoverable or admissible in evidence in a civil action against ~~an entity~~ person regulated by the Department, its directors, officers, or employees, unless the court finds that the interests of justice require that the documents be discoverable or admissible in evidence.

(b) As used in this ~~section~~ Article:

(1) 'Market analysis' means a process whereby individuals employed or contracted by the Commissioner collect and analyze information from filed schedules, surveys, required reports and other sources in order to develop a baseline understanding of the marketplace and to identify patterns or practices of insurers that deviate significantly from the norm or that may pose a potential risk to the insurance consumer.

(2) 'Market conduct action' means any of the full range of activities that the Commissioner may initiate to assess and address the market practices of insurers, beginning with market analysis. Additional market conduct actions, including those taken subsequent to market analysis as a result of the findings of or indications from market analysis include: correspondence with insurer; insurer interviews,

information gathering; policy and procedure reviews; interrogatories; and review of insurer self evaluation and compliance programs, including membership in a best-practice organization; ~~desk examinations~~. The Commissioner's activities to resolve an individual consumer complaint or other report of a specific instance of misconduct are not market conduct actions for purposes of this act."

SECTION 2. G.S. 58-2-132(f) reads as rewritten:

"(f) All working papers, information, documents, and copies thereof produced by, obtained by, or disclosed to the Commissioner or any other person in connection with an ~~examination~~ examination, market conduct action, or financial analysis shall be given confidential treatment, are not subject to subpoena, and shall not be made public by the Commissioner or any other person. The Commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties."

SECTION 3. This act becomes effective October 1, 2005.

Attachment V

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 654

S. B. No. _____

COMMITTEE SUBSTITUTE X

DATE 4/19/05

Amendment No. _____ (to be filled in by Principal Clerk)

(Rep.) Sen.) Holliman

moves to amend the bill on page 1, line 13

( ) WHICH CHANGES THE TITLE

by inserting between the words against and an, the following:

"brought by a party other than the Department.";

and on page 1, line 13 by deleting the phrase "an entity" and substituting "a person";

and on page 1, line 19, by inserting after the word "reports" the following:

"other than periodic reports specifically required by statute";

and on page 1, line 27 by deleting the word "activities" and substituting "activities, other than an examination";

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

Att. V

(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.)

moves to amend the bill on page 2, line 1

( ) WHICH CHANGES THE TITLE

by inserting after "interrogatories" the word "and";

and on page 2 by deleting the phrase "desk examination";

and by deleting the semi-colon and substituting a period.;

and on page 2, line 10, by inserting between examination, and market, the phrase "market analysis";

and on page 1, line 16, by deleting "section" and inserting "Article",

and on pg. 2, line 6, by deleting act and substituting "section."

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

MINUTES

HOUSE COMMITTEE ON INSURANCE
April 21, 2005

The House Committee on Insurance met at 11:10 AM on Tuesday, April 21, 2005 in Room 1228. The following Representatives attended, Chairman Hugh Holliman, Vice Chair Ed Jones, Members: Julia Howard, Ronnie Sutton, William Wainwright and Tom Wright.

Chairman Holliman called the meeting to order and welcomed Jim Long, Commissioner of Insurance, House Pages, Sgt-At-Arms and visitors to the meeting. Attachment I.

Chairman Holliman ask for a motion to accept the PCS on HB 655 – Better Insurance/Annuity Disclosure.-AB. A motion was made to accept the PCS and the motion passed. Frank Folger, Legislative Counsel for the Department of Insurance was called on to explain the changes from the original bill. Rep. Howard moved for a favorable report to accept the PCS and motion carried. Attachment II.

Mr. Folger was ask to speak on HB 733 - License Insurance Statistical Organizations.-AB
He explained the changes that were made from the original bill. Attachment III. Rep. Wainwright made a motion for a favorable report and the motioned carried unanimously.

The Meeting adjourned at 11:25 AM.

Representative L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **Thursday, April 21, 2005**

TIME: **11:00 AM**

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB655 - Better Insurance/Annuity Disclosure.-AB – Rep. Holliman

HB 733 - License Insurance Statistical Organizations.-AB – Rep. Holliman

HB 735 - Accident & Health Insur./Rate Stabilization.-AB – Rep. Wright and Rep. Holliman

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 12:30 **PM on April 19, 2005.**

___Principal Clerk
___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

HOUSE INSURANCE COMMITTEE

April 21, 2005
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

HB655 - Better Insurance/Annuity Disclosure.-AB – Rep. Holliman

HB 733 - License Insurance Statistical Organizations.-AB – Rep. Holliman

HB 735 - Accident & Health Insur./Rate Stabilization.-AB – Rep. Wright and Rep. Holliman

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative **HOLLIMAN** (Chair) for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 655 A BILL TO BE ENTITLED AN ACT TO REORGANIZE ARTICLE 60 OF CHAPTER 58 OF THE GENERAL STATUTES AND AMEND CURRENT DISCLOSURE REQUIREMENTS FOR SOLICITATION OF LIFE INSURANCE PRODUCTS AND ANNUITIES; REQUIRE INSURERS TO NOTIFY EMPLOYEES OF THE EXISTENCE OF EMPLOYER-OWNED LIFE INSURANCE POLICIES WITHIN THIRTY DAYS AFTER THE EFFECTIVE DATE OF COVERAGE; AND REQUIRE GROUP ANNUITY INSURERS TO ISSUE INDIVIDUAL CERTIFICATES OF COVERAGE TO EACH ANNUITANT.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☒ With a favorable report as to the committee substitute bill ~~(#); ☐ which changes the title~~, unfavorable as to (the original bill) ~~(Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on)~~

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

03/19/03

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative **HOLLIMAN** (Chair) for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 733 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR THE LICENSING OF STATISTICAL ORGANIZATIONS BY THE DEPARTMENT OF INSURANCE.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☒ With a favorable report as to the committee substitute bill ~~(#), ☐ which changes the title~~, unfavorable as to (the original bill) ~~(Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on)~~

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

03/19/03

HOUSE COMMITTEE ON INSURANCE

April 21, 2005
11:00 AM
Room 1228 Legislative Building

Pages:

Name (please print clearly)	County	Representative
Katie Easter	Davidson Co.	Holliman
Keith Dunn-Harnett	Franklin, Halifax and Nash Co	Lewis
Lucas Elliott	Franklin Co	Lucy Allen

Sergeant-At-Arms (please print)

MARTHA GADISON

CHARLES WILLIAMS

JAY CALLAWAY

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — April 21, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Canales	NFSS
David Stoller	State Farm
Robt Pasichak	Young, Moore
Joe Stevens	IFNC
Marlene Nosted	NCAHP
Lee Hoke	KCCH
Susan Valeur	Nationwide
John McCulloch	NFOC
Bill Hoke	ACCI
John Meegan	NMRS
Stephen Sumpter	NCAR

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 655
PROPOSED COMMITTEE SUBSTITUTE H655-CSRC-20 [v.2]

4/20/2005 8:52:33 PM

Short Title: Better Insurance/Annuity Disclosure.-AB (Public)

Sponsors:

Referred to:

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO REORGANIZE ARTICLE 60 OF CHAPTER 58 OF THE GENERAL STATUTES AND AMEND CURRENT DISCLOSURE REQUIREMENTS FOR SOLICITATION OF LIFE INSURANCE PRODUCTS AND ANNUITIES; REQUIRE INSURERS TO NOTIFY EMPLOYEES OF THE EXISTENCE OF EMPLOYER-OWNED LIFE INSURANCE POLICIES WITHIN THIRTY DAYS AFTER THE EFFECTIVE DATE OF COVERAGE; AND REQUIRE GROUP ANNUITY INSURERS TO ISSUE INDIVIDUAL CERTIFICATES OF COVERAGE TO EACH ANNUITANT.

The General Assembly of North Carolina enacts:

PART I. DISCLOSURES FOR ANNUITIES AND LIFE INSURANCE

SECTION 1. The title of Article 60 of Chapter 58 of the General Statutes reads as rewritten:

"Article 60.

~~Regulation of Life Insurance Solicitation.~~Standards of Disclosure for Annuities and Life Insurance."

SECTION 1.1. Article 60 of Chapter 58 of the General Statutes is amended by designating G.S. 58-60-1 through G.S. 58-60-35 as:

"Part 1. Regulation of Life Insurance Solicitation."

SECTION 1.2. G.S. 58-60-1 reads as rewritten:

"**§ 58-60-1. ~~Purpose of Article.~~ Short title; purpose.**

(a) This Part may be cited as the "Life Insurance Disclosure Act".

(b) The purpose of this ~~Article~~ Part is to require insurers to deliver to purchasers of life insurance, information which will improve the buyer's ability to select the most appropriate plan of life insurance for ~~their~~ the buyer's needs, improve the buyer's understanding of the basic features of the policy which has been purchased or which is under consideration and to improve the ability of the buyer to evaluate the relative costs of similar plans of life insurance.

This ~~Article~~ Part does not prohibit an insurer ~~to use~~ from using additional material ~~which~~ that is not in violation of Articles 1 through 64 of this Chapter nor any other statute or regulation."

SECTION 1.3. G.S. 58-60-5 reads as rewritten:

"**§ 58-60-5. ~~Scope of Article;~~ Scope; exemptions.**

(a) Except as otherwise provided in this ~~Article,~~ Part, this ~~Article~~ Part applies to any solicitation, negotiation or procurement of life insurance occurring within this State. This ~~Article~~ Part applies to any issuer of a life insurance contract, including fraternal benefit societies.

(b) Unless otherwise specifically included, this ~~Article~~ Part does not apply to:

(1) ~~Annuities,~~Individual group annuity contracts.

(2) Credit life ~~insurance,~~insurance.

(3) Group life ~~insurance,~~insurance (except for disclosures relating to preneed funeral contracts or prearrangements; these disclosure requirements shall extend to the issuance or delivery of certificates as well as to the master policy).

(4) Life insurance policies issued in connection with pension and welfare plans as defined by and that are subject to the federal Employee Retirement Income Security Act of 1974 ~~(ERISA),~~(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~~ Part is not required for policies that are sold subject to rules adopted by the Commissioner for life insurance illustrations."

SECTION 1.4. G.S. 58-60-10 reads as rewritten:

"**§ 58-60-10. Definitions.**

Unless the context of use indicates a different meaning, for the purposes of this ~~Article,~~ Part, the following definitions shall apply:

. . . "

SECTION 1.5. G.S. 58-60-10(7)k. reads as rewritten:

"k. The date on which the Policy Summary is prepared.

The Policy Summary must consist of a separate document. All information required to be disclosed must be set out in such a manner as to not minimize or render any portion thereof obscure. Any amounts which remain level for two or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in subparagraph e of this paragraph shall be listed in total, not on a per thousand nor per unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or for each class of insureds if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space. If the insurer makes

a material revision in the terms and conditions under which it will limit its right to change any nonguaranteed factor, it shall, no later than the first policy anniversary following the revision, advise each affected policy owner residing in this State."

SECTION 1.6. G.S. 58-60-20(a) reads as rewritten:

"(a) Each insurer subject to this ~~Article~~ Part shall maintain at its home office or principal office a complete file containing one copy of each document authorized by the insurer for use pursuant to this ~~Article.~~Part. Such file shall contain one copy of each authorized form for a period of three years following the date of its last authorized use."

SECTION 1.7. G.S. 58-60-20(i) reads as rewritten:

"(i) For the purposes of this ~~Article,~~Part, the annual premium for a basic policy or rider, for which the insurer reserves the right to change the premium, shall be the maximum annual premium."

SECTION 1.8. G.S. 58-60-25 reads as rewritten:

"**§ 58-60-25. Adoption of Buyer's Guide; requirements.**

Any insurer soliciting life insurance in this State on or after December 1, 1979, shall adopt and use a Buyer's Guide, and the adoption and use by an insurer of the Buyer's Guide promulgated by the National Association of Insurance Commissioners in the NAIC Model Life Insurance Solicitation Regulations shall be in compliance with the requirements of this ~~Article.~~Part."

SECTION 1.9. Article 60 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 2. Regulation of Home Service Life Insurance Solicitation.

"**§ 58-60-40. Title and reference.**

This Part may be cited as the "Home Service Disclosure Act".

"**§ 58-60-45. Purpose.**

The purpose of this Part is to establish standards that ensure that meaningful information is provided to the purchasers of insurance policies distributed through the home service distribution system.

"**§ 58-60-50. Definitions.**

As used in this Part:

(1) "Home service distribution system" means a system in which insurance products are marketed, sold, or serviced by agents in person in the home or business of the insured, owner, or premium payor in assigned territories and may be identified as "debits". The policies are issued on a monthly or more frequent premium payment basis and agents are charged with the responsibilities of servicing the debit, which may include the collection of premium payments in the home or designated location on a monthly or more frequent basis, along with other services normally rendered.

(2) "Small face amount life insurance policy" means an insurance policy or certificate with a face amount of fifteen thousand dollars ($15,000) or less.

"**§ 58-60-55. General disclosure requirements.**

(a) In accordance with the disclosure simplification standards set forth in G.S. 58-60-80 and at the time an insurance policy is issued through the home service distribution system, the insurer shall disclose:

(1) Whether the policyholder is allowed to change the method of premium payment and any conditions for that change.

(2) Whether or not at a subsequent date a policyholder may combine multiple policies from the same insurance company, its affiliates, and its subsidiaries into one policy in order to provide like or enhanced coverage at a comparable or reduced premium to eliminate duplicate administrative costs associated with each policy and, if the option is available:

a. Whether a policyholder will be subject to underwriting when combining multiple policies into one policy; and

b. Whether a policyholder will be subject to a new contestable period, waiting periods, etc., when combining multiple policies into one policy.

(b) An insurer issuing a small face amount life insurance policy through the home service distribution system shall provide the current disclosure included in Appendix A of the NAIC's Home Service Disclosure Model if at any point in time over the term of the policy the cumulative premiums paid may exceed the face amount of the policy at that point in time. The required disclosure shall be provided to the policy owner or certificate holder no later than at the time the policy or certificate is delivered. The disclosure shall not be attached to the policy but may be delivered with the policy.

If, for a particular policy form, the cumulative premiums may exceed the face for some demographic or benefit combination but not for all combinations, the insurer may choose to either:

(1) Provide the disclosure only in those circumstances where the premiums may exceed the face amount; or

(2) Provide the disclosure for all demographic and benefit combinations.

Cumulative premiums shall include premiums paid for riders. However, the face amount shall not include the benefit attributable to the riders.

If an illustration has been provided that satisfies the requirements of Title 11, Chapter 4, Section .0500 of the North Carolina Administrative Code, the disclosure requirements of subsection (b) of this section are deemed to have been met.

"**§ 58-60-60. Disclosure of payment methods.**

At the time an insurance policy is issued through the home service distribution system, the insurer shall disclose:

(1) What premium savings may be realized by a different method or less frequent mode of premium payment.

(2) That premiums are still due and payable by the person responsible for premium payments even when an agent does not collect the premiums.

(3) The mailing address for payment of premiums to the company.

(4) That the consumer is entitled to receive a receipt for premium payments when premium payments are made in cash or in person.

"§ 58-60-65. Evidence of payment.

For every premium collected on a policy of life or disability insurance marketed, sold, or serviced through the home service distribution system in this State, the agent, solicitor, or broker, or any employee acting on the agent, solicitor, or broker's behalf, collecting or receiving the premium in person shall:

(1) Maintain and furnish to the policyholder a receipt indicating payment of premiums, which shall provide the payor with clearly understandable, written evidence of payment at the time the premium is collected. At a minimum the receipt shall clearly show:
   a. The name of the payor.
   b. The name of the insured under each policy covered by the premium.
   c. The amount paid.
   d. The date paid.
   e. The date paid-to status of the policy.
   f. The policy number.
   g. The face amount and type of policy for which the payment will be credited.
   h. The signature of the agent.
   i. The agent's printed name and unique identification number.
   j. The name, complete address, and phone number of the insurer.

(2) Remit to the insurer's home office or applicable district office, or deposit in a fiduciary account, the premium collected on behalf of the policyholder within 10 days of receipt from the premium payor or policy owner. In the event that the insurer utilizes an accounting system based on a monthly list bill, all premiums collected shall be credited from the date of collection. The premium shall be fully applied to that particular account.

"§ 58-60-70. Proof of policy delivery.

If an insurance policy marketed, sold, or serviced through the home service distribution system is delivered by an agent, solicitor, or broker, or an employee acting on the agent, solicitor, or broker's behalf, a receipt shall be signed by the purchaser and the agent acknowledging delivery to the purchaser of the policy or contract and the disclosures required by this Part. The receipt shall contain the name of the purchaser, the policy or contract number, the amount of the initial premium payment, and the date the delivery was completed. A policy shall be deemed to have been received six months after the date of issuance if the insured has paid premiums pursuant to the contract. All delivery receipts required by this section shall be retained by the company for not less than three years following delivery and shall be available for inspection upon request of the Commissioner.

"§ 58-60-75. Company duties.

Each insurer engaged in the home service distribution system in this State shall make available to the Commissioner for review:

(1) Established written procedures to audit agencies engaged in the home service system of distribution of policies in this State; and

(2) Proof of audits conducted periodically that reasonably ensure that the premium payor's records accurately reflect the premium due date and premium paid-to status of the policy or policies purchased.

"**§ 58-60-80. Minimum disclosure language standards.**

All disclosure forms required under this Part shall comply with the readability standards in Article 38 of this Chapter. It is presumed the disclosure form in Appendix A of the NAIC's Home Service Disclosure Model Act complies with this Part."

SECTION 1.10. Article 60 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 3. Regulation of Small Face Amount Life Insurance Solicitation.

"**§ 58-60-90. Title and reference.**

This Part may be cited as the "Small Face Amount Life Insurance Disclosure Act".

"**§ 58-60-95. Purpose; intent; and scope.**

(a) The purpose of this Part is to establish standards that ensure meaningful information is provided to the purchasers of small face amount policies.

(b) This Part applies to any life insurance policy or certificate with an initial face amount of fifteen thousand dollars ($15,000) or less.

(c) This Part does not apply to:

(1) Variable life insurance.

(2) Individual and group annuity contracts.

(3) Credit life insurance.

(4) Group or individual policies of life insurance issued to members of an employer group or other permitted group where:

a. Every plan of coverage was selected by the employer or other group representative;

b. Some portion of the premium is paid by the group or through payroll deduction; and

c. Group underwriting or simplified underwriting is used.

(5) Policies and certificates where an illustration has been provided pursuant to the requirements of Title 11, Chapter 4, Section .0500 of the North Carolina Administrative Code.

"**§ 58-60-100. Disclosure requirements.**

(a) An insurer issuing a small face amount policy shall provide the current disclosure included in Appendix A of the NAIC Disclosure for Small Face Amount Life Insurance Policies Model Act if at any point in time over the term of the policy the cumulative premiums paid may exceed the face amount of the policy at that point in time. The required disclosure shall be provided to the policy owner or certificate holder no later than at the time the policy or certificate is delivered. The disclosure shall not be attached to the policy but may be delivered with the policy.

(b) If, for a particular policy form, the cumulative premiums may exceed the face amount for some demographic or benefit combination but not for all combinations, the insurer may choose to either:

(1) Provide the disclosure only in those circumstances where the premiums may exceed the face amount; or

(2) Provide the disclosure for all demographic and benefit combinations.

(c) Cumulative premiums shall include premiums paid for riders. However, the face amount shall not include the benefits attributable to the riders.

"**§ 58-60-105. Insurer duties.**

The insurer and its producers shall have a duty to provide information to policyholders or certificate holders that ask questions about the disclosure statement."

SECTION 1.11. Article 60 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 4. Regulation of Annuity Solicitation.

"**§ 58-60-120. Title and reference.**

This Part may be cited as the "Annuity Disclosure Act".

"**§ 58-60-125. Purpose; intent; scope.**

(a) The purpose of this Part is to provide standards for the disclosure of certain minimum information about annuity contracts to protect consumers and foster consumer education. This Part specifies the minimum information that must be disclosed and the method for disclosing it in connection with the sale of annuity contracts. The goal of this Part is to ensure that purchasers of annuity contracts understand certain basic features of annuity contracts.

(b) This Part applies to all group and individual annuity contracts and certificates except:

(1) Registered or nonregistered variable annuities or other registered products.

(2) Immediate and deferred annuities that contain no nonguaranteed elements.

(3) Annuities used to fund any of the following:

a. An employee pension plan, which is covered by the Employee Retirement Income Security Act (ERISA).

b. A plan described by section 401(a), 401(k), or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer.

c. A governmental or church plan defined in section 414 or a deferred compensation plan of a state or local government or a tax exempt organization under section 457 of the Internal Revenue Code.

d. A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

e. Structured settlement annuities.

f. Charitable gift annuities.

g. Funding agreements.

(c) This Part shall apply to annuities used to fund a plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, and where the insurance company has been notified that plan

participants may choose from among two or more fixed annuity providers and there is a direct solicitation of an individual employee by a producer for the purchase of an annuity contract. As used in this subsection, direct solicitation shall not include any meeting held by a producer solely for the purpose of educating or enrolling employees in the plan or arrangement.

"**§ 58-60-130. Definitions.**

As used in this Part:

(1) "Annuity buyer's guide" or "buyer's guide" means the current NAIC Model Buyer's Guide to Fixed Deferred Annuities, including any appendix thereto.

(2) "Charitable gift annuity" means a transfer of cash or other property by a donor to a charitable organization in return for an annuity payable over one or two lives, under which the actuarial value of the annuity is less than the value of the cash or other property transferred and the difference in value constitutes a charitable deduction for federal tax purposes but does not include a charitable remainder trust or a charitable lead trust or other similar arrangement where the charitable organization does not issue an annuity and incur a financial obligation to guarantee annuity payments.

(3) "Contract owner" means the owner named in the annuity contract or certificate holder in the case of a group annuity contract.

(4) "Determinable elements" means elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion but where the values or amounts cannot be determined until some point after issue. These elements include the premiums, credited interest rates (including any bonus), benefits, values, noninterest-based credits, charges, or elements of formulas used to determine any of these. These elements may be described as guaranteed but not determined at issue. An element is considered determinable if it was calculated from underlying determinable elements only or from both determinable and guaranteed elements.

(5) "Disclosure document" means the document the contents of which are described in G.S. 58-60-140.

(6) "Funding agreement" means an agreement for an insurer to accept and accumulate funds and to make one or more payments at future dates in amounts that are not based on mortality or morbidity contingencies.

(7) "Generic name" means a short title descriptive of the annuity contract being applied for or illustrated such as "single premium deferred annuity".

(8) "Guaranteed elements" means the premiums, credited interest rates, including any bonus, benefits, values, noninterest-based credits, charges, or elements of formulas used to determine any of these, that are guaranteed and determined at issue. An element is considered

guaranteed if all of the underlying elements that go into its calculation are guaranteed.

(9) "Nonguaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, noninterest-based credits, charges, or elements of formulas used to determine any of these that are subject to company discretion and are not guaranteed at issue. An element is considered nonguaranteed if any of the underlying nonguaranteed elements are used in its calculation.

(10) "Structured settlement annuity" means a "qualified funding asset" as defined in section 130(d) of the Internal Revenue Code or an annuity that would be a qualified funding asset under section 130(d) but for the fact that it is not owned by an assignee under a qualified assignment.

"**§ 58-60-135. Standards for the disclosure document and buyer's guide.**

(a) Where the application for an annuity contract is taken in a face-to-face meeting, the applicant, at or before the time of application, shall be given both the disclosure document described in G.S. 58-60-140 and a copy of the buyer's guide.

(b) Where the application for an annuity contract is taken by means other than in a face-to-face meeting, the applicant shall be sent both the disclosure document and the buyer's guide no later than five business days after the completed application is received by the insurer.

(1) With respect to an application received as a result of a direct solicitation through the mail:

a. Providing a buyer's guide in a mailing inviting prospective applicants to apply for an annuity contract shall be deemed to satisfy the requirement that the buyer's guide be provided no later than five business days after receipt of the application.

b. Providing a disclosure document in a mailing inviting a prospective applicant to apply for an annuity contract shall be deemed to satisfy the requirement that the disclosure document be provided no later than five business days after receipt of the application.

(2) With respect to an application received via the Internet:

a. Taking reasonable steps to make the buyer's guide available for viewing and printing on the insurer's Web site shall be deemed to satisfy the requirement that the buyer's guide be provided no later than five business days after receipt of the application.

b. Taking reasonable steps to make the disclosure document available for viewing and printing on the insurer's Web site shall be deemed to satisfy the requirement that the disclosure document be provided no later than five business days after receipt of the application.

(3) A solicitation for an annuity contract provided in other than a face-to-face meeting shall include a statement that the proposed applicant may contact the Department for a free annuity buyer's guide.

In lieu of the foregoing statement, an insurer may include a statement that the prospective applicant may contact the insurer for a free annuity buyer's guide.

(c) Where the buyer's guide and disclosure document are not provided at or before the time of application, a free-look period of no less than 15 days shall be provided for the applicant to return the annuity contract without penalty. This free-look period shall run concurrently with any other free-look period provided under State law or regulation.

"**§ 58-60-140. Contents of disclosure document.**

At a minimum, all of the following information shall be included in the disclosure document required under this Part:

(1) The generic name of the contract, the company product name, if different, and form number, and the fact that it is an annuity.

(2) The insurer's name and address.

(3) A description of the contract and its benefits, emphasizing its long-term nature, including the following, if appropriate:

a. The guaranteed, nonguaranteed, and determinable elements of the contract, and their limitations, if any, and an explanation of how they operate.

b. An explanation of the initial crediting rate, specifying any bonus or introductory portion, the duration of the rate, and the fact that rates may change from time to time and are not guaranteed.

c. Periodic income options both on a guaranteed and nonguaranteed basis.

d. Any value reductions caused by withdrawals from or surrender of the contract.

e. How values in the contract can be accessed.

f. The death benefit, if available, and how it will be calculated.

g. A summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract.

h. The impact of any rider, such as a long-term care rider.

(4) The specific dollar amount or percentage charges and fees with an explanation of how they apply.

(5) Information about the current guaranteed rate for new contracts that contains a clear notice that the rate is subject to change.

Insurers shall define terms used in the disclosure statement in language that facilitates the understanding by a typical person within the segment of the public to which the disclosure statement is directed.

"**§ 58-60-145. Report to contract owners.**

For annuities in the payout period with changes in nonguaranteed elements and for the accumulation period of a deferred annuity, the insurer shall provide each contract owner with a report, at least annually, on the status of the contract that contains at least all of the following information:

(1) The beginning and end date of the current report period.
(2) The accumulation and cash-surrender value, if any, at the end of the previous report period and at the end of the current report period.
(3) The total amounts, if any, that have been credited, charged to the contract value, or paid during the current report period.
(4) The amount of outstanding loans, if any, as of the end of the current report period."

PART II. EMPLOYER-OWNED LIFE INSURANCE DISCLOSURE

SECTION 2. G.S. 58-58-75 reads as rewritten:

"**§ 58-58-75. Insurable interest in life and physical ability of employee or agent.**

(a) An employer, whether a partnership, joint venture, business trust, mutual association, corporation, any other form of business organization, or one or more individuals, or any religious, educational, or charitable corporation, institution or body, has an insurable interest in and the right to insure the physical ability or the life, or both the physical ability and the life, of an employee for the benefit of such employer. Any principal shall have a life insurable interest in and the right to insure the physical ability or the life, or both the physical ability and the life, of an agent for the benefit of such principal.

(b) An employee described in subsection (a) of this section shall be insured for the benefit of an employer described in subsection (a) of this section only if the employee receives written notification from the insurer of the existence of the coverage or that coverage will be purchased. The notice shall be provided to the employee in connection with the application for coverage within 30 days after the effective date of the coverage and shall include a statement that the employer may maintain the life insurance coverage on the employee even after employment is terminated.

(c) For non-key or nonmanagerial employees, the aggregate amount of coverage shall be reasonably related to the benefits provided to the employees in the aggregate.

(d) With respect to employer-provided pension and welfare plans, the life insurance coverage purchased to finance the plans may only cover the lives of those employees and retirees who, at the time their lives were first insured under the plan, either are participants, or would be eligible to participate, upon the satisfaction of age, service, or similar eligibility criteria in the plan."

PART III. GROUP ANNUITY CONTRACTS

SECTION 3. G.S. 58-58-145 reads as rewritten:

"**§ 58-58-145. Group annuity contracts defined; ~~requirements.~~requirements; issuance of individual certificates.**

(a) Any policy or contract, except a joint, reversionary or survivorship annuity contract, whereby annuities are payable to more than one person, is a group annuity contract. The person, firm or corporation to whom or to which ~~such~~ the contract is issued, ~~as herein provided,~~ is the holder of the contract. The term "annuitant" means any person to whom or which payments are made under the group annuity contract. No authorized insurer shall deliver or issue for delivery in this State any group annuity contract except upon a group of annuitants that conforms to the following: under a contract issued to an employer, or to the trustee of a fund established by an employer or

two or more employers in the same industry or kind of business, the stipulated payments on which shall be paid by the holder of ~~such~~ the contract either wholly from the employer's funds or funds contributed by ~~him,~~ the employer, or partly from ~~such~~ the funds and partly from funds contributed by the employees covered by such contract, and providing a plan of retirement annuities under a plan which permits all of the employees of such employer or of any specified class or classes thereof to become annuitants. Any such group of employees may include retired employees, and may include officers and managers as employees, and may include the employees of subsidiary or affiliated corporations of a corporation employer, and may include the individual proprietors, partners and employees of affiliated individuals and firms controlled by the holders through stock ownership, contract or otherwise.

(b) The insurer of a group annuity contract shall issue to the policyholder, within 30 days of the effective date of the group annuity contract, an individual certificate for delivery to each annuitant which:

(1) Identifies the annuity to which the annuitant is entitled.

(2) States the name of the person to whom the annuity is payable.

(3) Discloses all of the rights and obligations of the insurer, the policyholder, the annuitant, and the persons to whom the annuity is payable with respect to the group annuity contract.

G.S. 58-3-150 applies to the form of the individual certificate required by this subsection.

(c) Each group annuity contract shall include a provision that the insurer will issue to the policyholder within 30 days of the effective date of the contract, for delivery to each annuitant, an individual certificate setting forth the information described in subsection (b) of this section."

PART IV. EXPLANATION OF HEADINGS AND EFFECTIVE DATE.

SECTION 4. 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.

SECTION 5. This act becomes effective January 1, 2006, and applies to policies or certificates issued or renewed on or after that date.

HOUSE BILL 655:
Better Insurance/Annuity Disclosure.-AB

BILL ANALYSIS

Committee:	House Insurance	**Date:**	April 20, 2005
Introduced by:	Rep. Holliman	**Summary by:**	Kory Goldsmith KG
Version:	First Edition		Committee Counsel
	H655-CSRC-20[v.2]		

SUMMARY: ***See the attached summary prepared by Frank Folger, Legislative Counsel, Department of Insurance.***

The Proposed Committee Substitute makes additional conforming changes to Part 1 of Article 60 of Chapter 58. It also clarifies that an employer who plans to purchase a life insurance policy insuring an employee for the benefit of the employer must inform the employee.

H0655e1-SMRC-CSRC-20v2

HOUSE BILL 655

BETTER INSURANCE/ANNUITY DISCLOSURE

PART I. DISCLOSURES FOR ANNUITIES AND LIFE INSURANCE

Sections 1. through 1.11. Adopts the new NAIC model act/regulation on Annuity, Home Service Life Insurance and Small Face Amount Life Insurance Disclosure and updates our current life insurance disclosure provisions in Article 60 of Chapter 58 to reflect the current NAIC Life Insurance Disclosure model act. This Part reorganizes Article 60 to create a life insurance and annuity product disclosure article, with separate parts for each different product disclosure requirement. Each model specifically addresses disclosure requirements to assist the consumer when making a purchasing decision by requiring notice of the feature, including potentially negative aspects of each product. For example: (1) sellers of small face life insurance (insurance with a face amount less than $15,000) would have to disclose up front that premiums paid-in could exceed the face value of the policy, if that is a possibility at any time; (2) sellers of life insurance through the home service distribution system must disclose whether the policyholder is allowed to change the method of premium payment, whether the policyholder can combine multiple policies from the same company or its affiliates or subsidiaries into one policy and what the impact, if any, such a consolidation would have regarding underwriting, waiting periods, contestable periods and the like, and they would have to provide and maintain evidence of payment of premiums; and (3) sellers of annuities would have to provide to the applicant for an annuity a copy of the NAIC Model Guide to Fixed Deferred Annuities and a disclosure document, containing information on the insurer, specifics of the contract including its long-term nature, the specific amount of charges applicable to the contract, and information on the variability of guaranteed rates and the current guaranteed rate.

Part II. EMPLOYER-OWNED LIFE INSURANCE DISCLOSURE

Section 2. Amends G.S. 58-58-75 to require employers that purchase life insurance policies on the lives of their employees for the benefit of the employer to disclose to its employees that it has purchased or will purchase coverage on that employee and that disclosure must occur in connection with the application for coverage or within 30 days after the effective date of the coverage and, if applicable, that these employer-owned life insurance (sometimes referred to as COLI for "corporate-owned life insurance") policies can be maintained after the employment has terminated.

PART III. GROUP ANNUITY CONTRACTS

Section 3. Amends G.S. 58-58-145 requires group annuity insurers to issue certificates of coverage to each annuitant via the policyholder on a form approved by the Commissioner.

PART IV. EXPLANATION OF HEADINGS, SEVERABILITY AND EFFECTIVE DATES

Sections 4. and 5. Contain a proviso on the naming of headings for parts and makes the act effective January 1, 2006.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 733*
PROPOSED COMMITTEE SUBSTITUTE H733-CSRG-12 [v.1]

4/21/2005 10:34:45 AM

Short Title: License Insurance Statistical Organizations.-AB (Public)

Sponsors:

Referred to:

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE LICENSING OF STATISTICAL ORGANIZATIONS BY THE DEPARTMENT OF INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-2-190 reads as rewritten:

"**§ 58-2-190. Commissioner may require special reports.**

The Commissioner may also address to any authorized insurer, ~~rating organization, advisory organization,~~ statistical organization, joint underwriting or joint reinsurance organization, or the North Carolina Rate Bureau or Motor Vehicle Reinsurance Facility, or its officers any inquiry in relation to its transactions or condition or any matter connected therewith. Every corporation or person so addressed shall reply in writing to ~~such~~ the inquiry promptly and truthfully, and ~~such~~ the reply shall be verified, if required by the Commissioner, by such individual, or by such officer or officers of a corporation, as he shall designate."

SECTION 2. G.S. 58-40-1 reads as rewritten:

"**§ 58-40-1. Purposes.**

The purposes of this Article are

(1) To promote the public welfare by regulating rates to the end that they shall not be excessive, inadequate, or unfairly discriminatory;

(2) To authorize the existence and operation of qualified ~~rating organizations and advisory~~ statistical organizations and require that specified ~~rating~~ services of ~~such rating~~ the organizations be generally available to all admitted insurers;

(3) To encourage, as the most effective way to produce rates that conform to the standards of subsection (1) of this section, independent action by and reasonable price competition among insurers;

(4) To authorize cooperative action among insurers in the rate-making process, and to regulate such cooperation in order to prevent practices

that tend to bring about monopoly or to lessen or destroy competition; and

(5) To encourage the most efficient and economic marketing practices."

SECTION 3. G.S. 58-40-5 reads as rewritten:

"**§ 58-40-5. Definitions.**

As used in this Article:

~~(1) "Advisory organization" means every person, other than an admitted insurer, whether located within or outside this State, who prepares policy forms or makes underwriting rules incident to but not including the making of rates, or rating plans or rating systems, or which collects and furnishes to admitted insurers or rating organizations loss or expense statistics or other statistical information and data and acts in an advisory, as distinguished from a rate-making, capacity. No duly authorized attorney-at-law acting in the usual course of his profession shall be deemed to be an advisory organization.~~

(2) Repealed by Session Laws 1991, c. 720, s. 6.

(3) "Inland marine insurance" shall be deemed to include insurance now or hereafter defined by statute, or by interpretation thereof, or if not so defined or interpreted, by ruling of the Commissioner or as established by general custom of the business, as inland marine insurance.

(4) "Member," unless otherwise apparent from the context, means an insurer who participates in or is entitled to participate in the management of a ~~rating, advisory or other~~ statistical organization.

~~(5) "Rating organization" means every person, other than an admitted insurer, whether located within or outside this State, who has as his object or purpose the making of rates, rating plans, or rating systems. Two or more insurers which act in concert for the purpose of making rates, rating plans, or rating systems, and which do not operate within the specific authorizations contained in G.S. 58-40-60, 58-40-65, 58-40-70 and 58-40-75, shall be deemed to be a rating organization. No single insurer shall be deemed to be a rating organization.~~

(5a) "Statistical organization" means every person, other than an admitted insurer, whether located within or outside this State, who performs one or more of the following functions:

a. Prepares policy forms or makes underwriting rules incident to, but not including, the making of rates, or rating plans or rating systems.

b. Collects and furnishes to admitted insurers or statistical organizations loss or expense statistics or other statistical information and data and acts in an advisory rather than a rate-making capacity. No duly authorized attorney-at-law acting in the usual course of his profession shall be deemed to be a statistical organization.

c. Makes rates, rating plans, or rating systems or develops loss costs. Two or more insurers that act in concert for the purpose of making rates, rating plans, or rating systems or developing loss costs and that do not operate within the specific authorizations contained in G.S. 58-40-60, 58-40-65, 58-40-70, and 58-40-75 shall be deemed to be a statistical organization.

d. Collects data and statistics from insurers and provides reports from these statistics to the Commissioner for the purpose of fulfilling the statistical reporting obligations of those insurers.

(5b) "Statistical plan" means the document used by a statistical organization to set forth which data elements are to be reported to the statistical organization and to describe the format in which the data must be reported.

(6) "Subscriber," unless otherwise apparent from the context, means an insurer which is furnished at its request (i) with rates and rating manuals by a ~~rating~~ statistical organization of which it is not a member, or (ii) with advisory services by ~~an advisory~~ a statistical organization of which it is not a member.

(7) "Willful" means in relation to an act or omission which constitutes a violation of this Article with actual knowledge or belief that such act or omission constitutes such violation and with specific intent to commit such violation.

(8), (9) Repealed by Session Laws 1987, c. 864, s. 66."

SECTION 4. G.S. 58-40-30(a) reads as rewritten:

"(a) With the exception of inland marine insurance that is not written according to manual rates and rating plans, every admitted insurer and every licensed ~~rating~~ statistical organization, which has been designated by any insurer for the filing of rates under G.S. 58-40-40, shall file with the Commissioner all rates and all changes and amendments thereto made by it for use in this State prior to the time they become effective."

SECTION 5. G.S. 58-40-40 reads as rewritten:

"**§ 58-40-40. Delegation of rate making and rate filing obligation.**

(a) An insurer may itself establish rates based on the factors in G.S. 58-40-25 or it may use rates prepared by a ~~rating~~ statistical organization, with average expense factors determined by the ~~rating~~ statistical organization or with such modification for its own expense and loss experience as the credibility of that experience allows.

(b) An insurer may discharge its obligation under G.S. 58-40-30 by giving notice to the Commissioner that it uses rates prepared by a designated ~~rating~~ statistical organization, with such information about modifications thereof as are necessary to fully inform the Commissioner. The insurer's rates shall be those filed from time to time by the ~~rating~~ statistical organization, including any amendments thereto as filed, subject, however, to the modifications filed by the insurer."

SECTION 6. G.S. 58-40-45(c) reads as rewritten:

"(c) No person shall willfully withhold information required by this Article from or knowingly furnish false or misleading information to the Commissioner, any statistical ~~agency~~ organization designated by the Commissioner, ~~any rating or advisory organization,~~ or any insurer, which information will affect the rates, rating plans, loss costs, classifications, or policy forms subject to this Article."

SECTION 7. G.S. 58-40-50 reads as rewritten:

"**§ 58-40-50. ~~Rating~~ Statistical organizations.**

(a) No ~~rating~~ statistical organization shall ~~provide any service relating to rates subject to this Article~~ conduct its operations in this State, and no insurer shall utilize the service of such organization for ~~such~~ any purpose enumerated in G.S. 58-40-5 unless the organization has obtained a license from the Commissioner.

(b) No ~~rating~~ statistical organization shall refuse to supply any services for which it is licensed in this State to any insurer admitted to do business in this State and offering to pay the fair and usual compensation for the services.

(c) A ~~rating~~ statistical organization applying for a license shall include with its application:

(1) A copy of its constitution, charter, articles of organization, agreement, association, or incorporation, and a copy of its bylaws, plan of operation, and any other rules or regulations governing the conduct of its ~~business;~~business, all duly certified by the custodian of the originals thereof.

(2) A list of its members and subscribers;

(3) The name and address of one or more residents of this State upon whom notices, process affecting it, or orders of the Commissioner may be served;

(4) A statement showing its technical qualifications for acting in the capacity for which it seeks a license; and

(5) Any other relevant information and documents that the Commissioner may require.

(d) If the Commissioner ~~finds~~ determines that the applicant and the natural persons through whom it acts are qualified to provide the services proposed, and that all requirements of law are met, he shall issue a license specifying the authorized activity of the applicant. He shall not issue a license if the proposed activity would tend to create a monopoly or to lessen or to destroy price competition. Licenses issued pursuant to this section shall remain in effect until the licensee withdraws from the State or until the license is suspended or revoked.

(e) Any change in or amendment to any document required to be filed under this section shall be promptly filed with the Commissioner.

~~(f) Every rating organization providing services in this State on September 1, 1977, may continue to provide services thereafter as a rating organization, subject to the provisions of this Article and pending its application to the Commissioner for a license to provide services as a rating organization, which application shall be made within 30 days after September 1, 1977.~~

(g) Every statistical organization shall file a statistical plan with the Commissioner for approval for each line of insurance for which the organization requests to be licensed. The Commissioner may, in the Commissioner's discretion, modify the plan to collect additional types of data.

(h) No statistical organization shall engage in any unfair or unreasonable practice with respect to its activities."

SECTION 8. G.S. 58-40-55 is repealed.

SECTION 9. G.S. 58-40-65 reads as rewritten:

"**§ 58-40-65. Insurers authorized to act in concert.**

Subject to and in compliance with the provisions of Articles 1 through 64 of this Chapter authorizing insurers to be members or subscribers of ~~rating or advisory organizations~~ statistical organizations or to engage in joint underwriting or joint reinsurance, two or more insurers may act in concert with each other and with others with respect to any matters pertaining to the making of rates or rating systems, the preparation or making of insurance policy or bond forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss or expense statistics or other information and data, the creation, administration, or termination of a market assistance program, or carrying on of research."

SECTION 10. G.S. 58-40-75 reads as rewritten:

"**§ 58-40-75. Agreements to adhere.**

No insurer shall assume any obligation to any person, other than a policyholder or other insurers with which it is under common control or management or is a member of a market assistance program or of a joint underwriting or joint reinsurance organization, to use or adhere to certain rates or rules; and no other person shall impose any penalty or other adverse consequence for failure of an insurer to adhere to certain rates or rules. This section does not apply to mandatory or voluntary risk sharing plans established under Article 42 of this Chapter or apportionment agreements among insurers approved by the Commissioner pursuant to G.S. 58-40-95. Provided, however, that members and subscribers of ~~rating or advisory~~ statistical organizations may use the rates, rating systems, underwriting rules, or policy or bond forms of such organizations either consistently or intermittently. The fact that two or more admitted insurers, whether or not members or subscribers of a ~~rating or advisory~~ statistical organization, consistently or intermittently use the rates or rating systems made or adopted by a ~~rating~~ statistical organization, or the underwriting rules or policy or bond forms prepared by a ~~rating or advisory~~ statistical organization, shall not be sufficient in itself to support a finding that an agreement to so adhere exists, and it may be used only for the purpose of supplementing or explaining direct evidence of the existence of any such agreement."

SECTION 11. G.S. 58-40-80 reads as rewritten:

"**§ 58-40-80. Exchange of information or experience data; consultation with ~~rating~~ statistical organizations and insurers.**

~~Rating~~ Statistical organizations licensed pursuant to G.S. 58-40-50 and admitted insurers are authorized to exchange information and experience data between and among themselves in this State and with ~~rating~~ statistical organizations and insurers in

other states and may consult with them with respect to rate making and the application of rating systems."

SECTION 12. G.S. 58-40-85 reads as rewritten:

"**§ 58-40-85. Recording and reporting of experience.**

The Commissioner shall promulgate or approve reasonable rules, including rules providing statistical plans, for use thereafter by all insurers in the recording and reporting of loss and expense experience, in order that the experience of such insurers may be made available to him. ~~No insurer shall be required to record or report its experience on a classification basis inconsistent with its own rating system.~~ The Commissioner may designate one or more ~~rating~~ statistical organizations to assist him in gathering and making compilations of such experience. All insurers, for lines of insurance that require data to be reported, shall report their data to one of these designated statistical organizations."

SECTION 13. G.S. 58-40-90 reads as rewritten:

"**§ 58-40-90. Examination of rating, joint underwriting, and joint reinsurance organizations.**

The Commissioner shall, at least once every three years, make or cause to be made an examination of each ~~rating~~ statistical organization licensed pursuant to ~~G.S. 58-40-50 and each advisory organization licensed pursuant to G.S. 58-40-55.~~ G.S. 58-40-50. The Commissioner may, as often as deemed expedient, make or cause to be made, an examination of each group, association, or other organization referred to in G.S. 58-40-60. This examination shall relate only to the activities conducted pursuant to this Article and to the organizations licensed under this Article. The officers, manager, agents and employees of any such organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents or agreements governing its method of operation. In lieu of any such examination, the Commissioner may accept the report of an examination made by the insurance advisory official of another state, pursuant to the laws of that state."

SECTION 14. 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~~ statistical organization may request 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. 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~~ statistical 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 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 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 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 15. G.S. 58-40-110 reads as rewritten:

"**§ 58-40-110. Suspension of license.**

(a) Repealed by Session Laws 1985, c. 666, s. 36.

(b) ~~The~~ Subject to the requirements of this Article and of G.S. 58-2-70, the Commissioner may suspend or revoke the license of any ~~rating~~ statistical organization or insurer ~~that~~ or impose a monetary penalty against any statistical organization or insurer where (i) the Commissioner has reason to believe that any statistical organization or insurer has violated any provision of this Chapter, or (ii) the statistical agent fails to comply with an order of the Commissioner within the time limited by such order, or within any extension thereof that the Commissioner may grant. The Commissioner shall not suspend the license of any ~~rating~~ statistical organization or insurer for failure to comply with an order until the time prescribed for an appeal there from has expired or, if an appeal has been taken, until ~~such~~ the order has been affirmed. The Commissioner may determine when a suspension of a license shall become effective, and ~~such~~ the suspension shall remain in effect for the period fixed by him unless he modifies or rescinds ~~such~~ the suspension, or until the order upon which ~~such~~ the suspension is based is modified, rescinded, or reversed.

(c) No license shall be suspended or revoked, and no monetary penalty shall be imposed except upon a written order of the Commissioner stating his findings, made after a hearing held upon not less than 10 days' written notice to ~~such~~ the person or organization, and specifying the alleged violation."

SECTION 16. G.S. 58-40-130 reads as rewritten:

"**§ 58-40-130. Financial disclosure; rate modifications; reporting requirements.**

(a) The Commissioner may require each insurer subject to this Article to report, on a form prescribed by the Commissioner, its loss and expense experience, investment income, administrative expenses, and other data that he may require, for kinds of insurance or classes of risks that he designates. These reports are in addition to financial or other statements required by Articles 1 through 64 of this Chapter.

(b) The Commissioner may designate one or more ~~rating organizations or advisory~~ statistical organizations to gather and compile the experience and data referred to in subsection (a) of this section for their member companies.

(c) Whereas the provisions enacted by the General Assembly in 1986 regarding modifications in North Carolina civil law may have a prospective effect upon the loss experience of insurers subject to this Article, the Commissioner is authorized to review each company's rates by type of insurance that are in effect on and after January 1, 1987, and, when and where appropriate, require modification of ~~such~~ those rates.

(d) Each insurer subject to this Article shall record the experience and data referred to in subsection (a) of this ~~section arising from causes of action arising against its insureds on and after January 1, 1987.~~section. Such experience and data shall be reported to the Commissioner ~~by March 31, 1988, which report shall be~~ on a form

prescribed by the Commissioner ~~reflecting such experience and data for the one-year period beginning on January 1, 1987. Subsequently, such experience and data shall be reported to the Commissioner~~ by March 31 of each year for each one-year period ending on December 31 of the previous year.

(e) On or before July 1, 1988, and annually thereafter, the Commissioner shall report to the General Assembly the effects, if any, of changes in North Carolina civil law statutes on the experience of insurers subject to this section."

SECTION 17. G.S. 143B-472.96(b) reads as rewritten:

"(b) Rate Standards. – The rate standards in G.S. 58-40-20 apply to premiums set by the Authority under this section. The Authority may also use the forms and rates of ~~rating or advisory~~ statistical organizations licensed under ~~G.S. 58-40-50 or G.S. 58-40-55.~~ G.S. 58-40-50. The Authority may vary from these rates in order to broaden participation by small businesses that are unable to obtain adequate financing and bonding assistance in connection with contracts. The premiums set and forms developed by the Authority under this section must be approved by the Commissioner of Insurance before they may be used."

SECTION 18. Article 36 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-36.4. Statistical organizations; licensing; recording and reporting; examination; suspension of license; financial disclosure.**

(a) For purposes of this Article:

(1) "Statistical organization" means every person, other than an admitted insurer, whether located within or outside this State, who performs one or more of the following functions:

a. Prepares policy forms or makes underwriting rules incident to, but not including, the making of rates, rating plans, or rating systems.

b. Collects and furnishes to admitted insurers or statistical organizations loss or expense statistics or other statistical information and data and acts in an advisory rather than a rate-making capacity. No duly authorized attorney-at-law acting in the usual course of that person's profession shall be deemed to be a statistical organization.

c. Makes rates, rating plans, or rating systems or develops loss costs. Two or more insurers that act in concert for the purpose of making rates, rating plans, or rating systems or developing loss costs and that do not operate within the specific authorizations contained in this Article shall be deemed to be a statistical organization.

d. Collects data and statistics from insurers and provides reports from these statistics to the Commissioner for the purpose of fulfilling the statistical reporting obligations of those insurers.

(2) "Statistical plan" means the document used by a statistical organization to set forth which data elements are to be reported to the statistical organization and to describe the format in which the data must be reported.

(b) No statistical organization shall conduct its operations in this State and no insurer shall utilize the service of that organization for any purpose enumerated in this Article unless the organization has obtained a license from the Commissioner. No statistical organization shall refuse to supply any services for which it is licensed in this State to any insurer admitted to do business in this State and offering to pay the fair and usual compensation for the services. A statistical organization applying for a license shall include with its application:

(1) A copy of its constitution, charter, articles of organization, agreement, association, or incorporation, and a copy of its bylaws, plan of operation, and any other rules or regulations governing the conduct of its business, all duly certified by the custodian of the originals thereof;

(2) A list of its members and subscribers;

(3) The name and address of one or more residents of this State upon whom notices, process affecting it, or orders of the Commissioner may be served;

(4) A statement showing its technical qualifications for acting in the capacity for which it seeks a license; and

(5) Any other relevant information and documents that the Commissioner may require.

If the Commissioner determines that the applicant and the natural persons through whom it acts are qualified to provide the services proposed, and that all requirements of law are met, the Commissioner shall issue a license specifying the authorized activity of the applicant. The Commissioner shall not issue a license if the proposed activity would tend to create a monopoly or to lessen or to destroy price competition. Licenses issued pursuant to this section shall remain in effect until the licensee withdraws from the State or until the license is suspended or revoked. Any change in or amendment to any document required to be filed under this section shall be promptly filed with the Commissioner. Every statistical organization shall file a statistical plan with the Commissioner for approval for each line of insurance for which the organization requests to be licensed. The Commissioner may, in the Commissioner's discretion, modify the plan to collect additional types of data. No statistical organization shall engage in any unfair or unreasonable practice with respect to its activities.

(c) Statistical organizations licensed pursuant to subsection (b) of this section and admitted insurers are authorized to exchange information and experience data between and among themselves in this State and with statistical organizations and insurers in other states and may consult with them with respect to rate making and the application of rating systems.

(d) The Commissioner shall adopt or approve reasonable rules, including rules providing statistical plans, for use thereafter by all insurers in the recording and reporting of loss and expense experience, in order that the experience of those insurers

may be made available to the Commissioner. The Commissioner may designate one or more statistical organizations to assist him or her in gathering and making compilations of the experience. All insurers, for lines of insurance that require data to be reported, shall report their data to one of the designated statistical organizations.

(e) The Commissioner shall, at least once every three years, make or cause to be made an examination of each statistical organization licensed pursuant to subsection (b) of this section. This examination shall relate only to the activities conducted pursuant to this Article and to the organizations licensed under this Article. The officers, manager, agents, and employees of any statistical organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation. In lieu of any examination, the Commissioner may accept the report of an examination made by the insurance advisory official of another state, pursuant to the laws of that state.

(f) Subject to the requirements of this Article and of G.S. 58-2-70, the Commissioner may suspend or revoke the license of any statistical organization or impose a monetary penalty against any statistical organization where (i) the Commissioner has reason to believe that any statistical organization has violated any provision of this Chapter, or (ii) the statistical organization fails to comply with an order of the Commissioner within the time limited by the order, or within any extension thereof that the Commissioner may grant. The Commissioner shall not suspend the license of any statistical organization for failure to comply with an order until the time prescribed for an appeal from the order has expired or, if an appeal has been taken, until the order has been affirmed. The Commissioner may determine when a suspension of a license shall become effective, and the suspension shall remain in effect for the period fixed by the Commissioner unless the Commissioner modifies or rescinds the suspension, or until the order upon which the suspension is based is modified, rescinded, or reversed. No license shall be suspended or revoked and no monetary penalty shall be imposed except upon a written order of the Commissioner stating the Commissioner's findings, made after a hearing held upon not less than 10 days' written notice to the person or organization, and specifying the alleged violation."

SECTION 19. G.S. 58-37(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~~ statistical 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". For the purpose of this Article, a "clean risk" 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. 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, the Commissioner shall issue an order specifying in what respect it is deficient and stating when, within a reasonable period thereafter, the rate is no longer effective. The order is subject to judicial review as set out in Article 2 of this Chapter. Pending judicial review of said 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. The order shall not affect any contract or policy made or issued 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" 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 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 20. G.S. 58-41-50(b) reads as rewritten:

"(b) With the exception of inland marine insurance that is not written according to manual rates and rating plans, all rates or prospective loss cost multipliers by licensed fire and casualty companies or their designated ~~rating~~ statistical organizations must be filed with the Commissioner at least 60 days before they may be used in this State. Any filing may become effective on a date earlier than that specified in this subsection upon agreement between the Commissioner and the filer."

SECTION 21. G.S. 58-42-10(a) reads as rewritten:

"(a) Each plan shall require participation:

(1) By all insurers licensed in this State to write the kinds of insurance covered by the specific plan;

(2) By all agents licensed to represent those insurers for that kind of insurance; and

(3) By every ~~rating~~ statistical organization that makes rates for that kind of insurance."

SECTION 22. G.S. 58-42-25 reads as rewritten:

"**§ 58-42-25. Basis for participation.**

Each plan shall specify the basis for participation by insurers, agents, ~~rating~~ statistical organizations, and other participants and shall specify the conditions under which risks shall be accepted and underwritten by the plan."

SECTION 23. This act becomes effective October 1, 2005.

HOUSE BILL 733 –
LICENSE INSURANCE STATISTICAL ORGANIZATIONS

This bill is primarily intended to:
1) Clarify, via consolidation, the licensing requirements for rating organizations, advisory organizations and statistical agents by defining all three under the category of "statistical organization" and licensing them as such.
2) License such organizations that are collecting and disseminating data for Rate Bureau lines of coverage (private personal auto, residential homeowners, workers compensation) in addition to other commercial lines of coverage;
3) Make such licensure meaningful by providing the Commissioner specific authority and grounds to revoke or suspend such licenses where necessary; and
4) Strengthen the reporting requirements for both the commercial and Rate Bureau lines.

The majority of the sections (Sections 1-2, 4-5, 9, 11, 13-14, 16-17, and 19-22) simply replace references to "rating organization" and "advisory organization" with "statistical organization". The remaining sections, among other technical things,:

- Define "statistical organization" by essentially consolidating the definitions in current law of "rating organization" and "advisory organization" and adding the duties performed by a statistical agent within that definition and deleting the terms "rating organization" and "advisory organization" and their accompanying definitions. (Section 3)
- Add specific reference to loss costs in a provision that prohibits a person from willfully withholding information or knowingly furnishing false or misleading information to an insurer, a statistical organization, and the Commissioner. (Section 6)
- Clarify that no statistical organization may operate in this State without a license, that copies of a statistical organization's corporate organizational documents currently required to be submitted to the Commissioner be duly certified, that each statistical organization file a statistical plan with the Commissioner for each line of insurance for which it requests to be licensed, that the Commissioner may modify that plan to collect additional types of date, and that no statistical organization may engage in any unfair or unreasonable practice. (Section 7)
- Require insurers, for lines of insurance that require data to be reported, report their data to one of the designated statistical organizations.(Section 12)
- Authorize license revocation and monetary penalty imposition pursuant to G.S. 58-2-70 for violations by a statistical organization. (Section 15)

- Apply the same licensure requirements and regulations to statistical organizations that service coverage lines under the jurisdiction of the Rate Bureau. (Section 18)

2005-2006

HOUSE INSURANCE

COMMITTEE MINUTES

MINUTES

HOUSE COMMITTEE ON INSURANCE
April 26, 2005

The House Committee on Insurance met at 11:00 AM on Tuesday, April 26, 2005 in Room 1228. The following Representatives attended, Chairman Hugh Holliman, Vice Chairs Bill Faison, Ed Jones, Members: Lucy Allen, Carey Allred, David Almond, Jeff Barnhart, Harold Brubaker, William Current, Linda Johnson, Deborah Ross, Drew Saunders, Fred Steen, Ron Sutton, William Wainwright and Tom Wright.

Chairman Holliman called the meeting to order and welcomed the House Pages, Sgt-At-Arms and visitors to the meeting. Attachment I.

Chairman Holliman ask Frank Folger, Legislative Counsel for the Department of Insurance to explain HB 653 – CREDIT INSURANCE CHANGES. -AB. Mr. Folger explained the changes from the original bill. Rep. Wainwright made a motion for a favorable report and the motion passed. Attachment II.

Mr. Folger was ask to speak on HB 734 – IMPROVE MANAGED CARE STATUTES.-AB. An amendment deleting Section 2 was proposed and passed. He explained the changes in Section 3 from the original bill. Attachment III. Rep. Sutton moved for a favorable report as amendment and rolled into a new PCS. The motion carried.

Rep. Wright and Mr. Folger spoke about the language changes in HB 735 – ACCIDENT & HEALTH INSUR./RATE STABILIZATION.-AB. A motion for an amendment was made to correct changes and motion carried. After much discussion, Rep. Wright motioned for a favorable report as amendment and roll into a PCS. The motioned carried unanimously. Attachment IV.

The Meeting adjourned at 11:28 AM.

Representative. L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **Tuesday, April 26, 2005**

TIME: **11:00 AM**

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 653 – CREDIT INSURANCE CHANGES.-AB –
Rep. Holliman

HB 656 – WORKERS' COMP/SELF-INSURED GUARANTY ASSOC.-AB
Rep. Holliman

HB 734 – IMPROVE MANAGED CARE STATUTES.-AB
Rep. Holliman and Rep. Wright

HB 735 – ACCIDENT & HEALTH INSUR./RATE STABILIZATION.-AB
Rep. Holliman and Rep. Wright

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **1:30 PM on April 21, 2005.**

___Principal Clerk
___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

HOUSE INSURANCE COMMITTEE

April 26, 2005
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

HB 653 – CREDIT INSURANCE CHANGES.-AB –
Rep. Holliman

HB 734 – IMPROVE MANAGED CARE STATUTES.-AB
Rep. Holliman and Rep. Wright

HB 735 – ACCIDENT & HEALTH INSUR./RATE STABILIZATION.-AB
Rep. Holliman and Rep. Wright

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative **HOLLIMAN** (Chair) for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 734 A BILL TO BE ENTITLED AN ACT TO REMOVE FROM THE UNIFORM CREDENTIALING STATUTE AN UNNECESSARY PROVISION; CLARIFY THAT SERVICES COVERED ONLY FOR CERTAIN MEDICAL CONDITIONS OR DIAGNOSES MUST BE TREATED AS UTILIZATION REVIEW DECISIONS WHEN IT IS NECESSARY TO REVIEW THE COVERED PERSON'S CONDITION OR DIAGNOSIS IN ORDER TO DETERMINE IF THE SERVICE IS EXCLUDED OR COVERED; ENSURE THAT COVERED PERSONS RECEIVING EXTERNAL REVIEW KNOW WHAT INFORMATION THEIR INSURER PROVIDES TO THE EXTERNAL REVIEW ORGANIZATION PERFORMING THE REVIEW; AND ELIMINATE EXTERNAL REVIEW OUTSIDE OF NORMAL BUSINESS HOURS.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☒ With a favorable report as to the committee substitute ~~bill (#), ☐ which changes the~~ title, unfavorable as to (the original bill) ~~(Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on)~~.

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

03/19/03

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative **HOLLIMAN** (Chair) for the Committee on **INSURANCE**.

☐ Committee Substitute for
H.B. 735 A BILL TO BE ENTITLED AN ACT TO REQUIRE ANNUAL FILING AND ACTUARIAL CERTIFICATION OF RATES FOR INSURERS PROVIDING INDIVIDUAL ACCIDENT AND HEALTH INSURANCE BENEFITS AND TO BETTER PROTECT CONSUMERS FROM THE HARMFUL IMPACT OF BLOCKS OF BUSINESS BEING CLOSED.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to the committee substitute bill ~~(#), ☐ which changes the title~~, unfavorable as to (the original bill) ~~(Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on)~~.

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

03/19/03

ATTACHMENT I

HOUSE COMMITTEE ON INSURANCE

April 26, 2005
11:00 AM
Room 1228 Legislative Building

Pages:

Name (please print clearly)	County	Representative
Ariane Belisle	Ottawa, Canada	Speaker Black.
Jonathan Furras	Rowan	Rep. Coates
Alyssa Klaus	Rowan	Rep. Coates

Sergeant-At-Arms (please print)

Martha Gadison

Charles Williams

H

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — April 26, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robert Paschal	Young, Moore
Karen Johnson	Smith Anderson
Jim Blackburn	NC Association of County Commissioners
Mike Causey	Causey + Associates
Fred Bone	Bone & Assoc.
Barbara Carolan	Regis
John Bowdish	AstraZeneca
Cam Cole	BPOHL
Marlowe Foster	NCAHIP
Mary Reagan	NMIRS
Dennis McClees	McClees Consulting, Inc.

H

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — April 26, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Khanor Walker	NC Insider
[illegible]	BCBSNC
[illegible]	NCAHP
[illegible]	NCAHP
Barry Salahuddin	GSK
[illegible] Horne	NCMS
[illegible]	KCCH
VL McBride	NCTA
Linda Murphy	NCMS society
Virginia Rash Pleas	NMSS Asheville, NC
[illegible]	S.A.

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VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — April 26, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DAVID BARNES	Poyner Spruill LLP

ATTACHMENT 1

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 1

HOUSE BILL 653*

Short Title:	Credit Insurance Changes.-AB	(Public)
Sponsors:	Representative Holliman.	
Referred to:	Insurance.	

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE CREDIT INSURANCE LAWS TO DEFINE "CRITICAL PERIOD COVERAGE"; CLARIFY THE APPROPRIATE REFUND OF PREMIUMS METHOD WHEN A POLICY OR GROUP CERTIFICATE IS TERMINATED PRIOR TO THE SCHEDULED MATURITY DATE OF THE SUBJECT DEBT; ALLOW CREDIT CARD COVERAGE FROM OUT-OF-STATE FINANCIAL INSTITUTIONS; PROVIDE THAT INSURERS MUST ACKNOWLEDGE TO THE CLAIMANT ANY CLAIMS NOT PAID WITHIN THIRTY DAYS; CLARIFY THAT INSURERS CAN REQUIRE REGISTRATION WITH THE STATE UNEMPLOYMENT OFFICE TO QUALIFY FOR CREDIT UNEMPLOYMENT INSURANCE BUT CANNOT IMPOSE A TIME LIMIT ON THAT REGISTRATION NOR CONDITION QUALIFICATION FOR BENEFITS UNDER A POLICY UPON QUALIFICATION FOR STATE UNEMPLOYMENT BENEFITS; CLARIFY THAT, WITH RESPECT TO CREDIT UNEMPLOYMENT INSURANCE, THE REFUND SHALL EQUAL THE PRO RATA UNEARNED GROSS PREMIUM; AND PROVIDE THE COMMISSIONER OF INSURANCE WITH THE AUTHORITY TO ENFORCE THE LAWS GOVERNING CREDIT INSURANCE CONSISTENT WITH THE COMMISSIONER'S GENERAL ENFORCEMENT AUTHORITY AS SET FORTH IN CHAPTER 58 OF THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-57-5 is amended by adding a new subdivision to read:

"(5a) "Critical period coverage" means insurance coverage for which benefits are limited to a stated number of payments or the payments end with the expiration of the policy, whichever is less."

SECTION 2. G.S. 58-57-50(b) reads as rewritten:

"(b) The refund of premiums for decreasing term credit life insurance shall be equal to the premium that would be charged for the remaining term and amount of

coverage in the policy. The refund of premiums for ~~decreasing term credit life insurance in transactions of 60 months duration or less and the refund of premiums for~~ single interest credit property insurance and single interest physical damage insurance shall be equal to the amount computed by the sum of digits formula known as the "Rule of 78." ~~The refund of premiums for decreasing term credit life insurance in transactions of more than 60 months duration shall be equal to the premium that would be charged for the remaining term and amount of coverage in the policy.~~ The refund of premiums for level term credit life insurance and dual interest credit property insurance and dual interest physical damage insurance shall be equal to the pro rata unearned gross premiums."

SECTION 3. G.S. 58-57-55 reads as rewritten:

"**§ 58-57-55. Issuance of policies.**

All policies of credit life insurance and credit accident and health insurance shall be issued only by an insurer authorized to do business in this State and shall be issued only through holders of licenses or authorizations issued by the Commissioner. With the exception of credit insurance issued in accordance with G.S. 58-57-105, all ~~All~~ policies of credit life insurance and credit accident and health insurance shall be delivered or issued for delivery in this ~~State only by an insurer authorized to do an insurance business therein, and shall be issued only through holders of licenses or authorizations issued by the Commissioner.~~ State. The enrollment of debtors under a group policy issued to a creditor and authorized under this Article shall not constitute the issuance of a policy of insurance."

SECTION 4. G.S. 58-57-60 is amended by adding a new subsection to read:

"(d) A claim acknowledgment shall be sent to the claimant within 30 days after receiving written or electronic notice of the claim. Acknowledgment shall include the following:

(1) A statement made to the insured or the claimant advising that the claim is being investigated.

(2) Payment of the claim.

(3) A bona fide written offer of settlement.

(4) A written denial of the claim."

SECTION 5. G.S. 58-57-110 reads as rewritten:

"**§ 58-57-110. Credit unemployment insurance rate standards; policy provisions.**

(a) Each year the Commissioner shall prescribe a minimum incurred loss ratio standard requirement to develop a premium rate reasonable in relation to the benefits provided by credit unemployment insurance coverage. The following requirements must be met:

(1) Coverage is provided or offered, with or without underwriting, to all debtors regardless of age who are working for salary, wages, or other employment income for at least 30 hours per week and have done so for 12 consecutive ~~months;~~ months.

(2) Coverage sets forth a definition of involuntary unemployment as a loss of employment income that may include, but is not limited to, loss caused by layoff, general strike, termination of employment, or ~~lockout;~~ lockout.

(3) Coverage does not contain any exclusion except: debts with irregular monthly payments; voluntary forfeiture of salary, wages, or other employment income; resignation; retirement; sickness, disease, or normal pregnancy; or loss of income due to termination as a result of willful misconduct that is a violation of some established, definite rule of conduct, a forbidden act, or willful dereliction of duty, or criminal misconduct.

(4) As long as there is no required time period limitation for registration, the insured may be required to register with the State unemployment office in order to qualify for benefit payments under the credit unemployment coverage. Qualification for State unemployment benefits shall not be required in order to qualify for benefit payments under the credit unemployment coverage.

(b) The Commissioner may approve other policy provisions and coverages consistent with the purposes of unemployment coverage.

(c) Joint coverage rates for credit unemployment insurance shall be one and two-thirds (1 2/3) times the approved single rate of coverage.

(d) The refund provision for credit unemployment insurance shall be equal to the pro rata unearned gross premium."

SECTION 6. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-57-71. Enforcement and penalties.**

(a) The Commissioner may, after notice and opportunity for a hearing, impose civil penalties or petition for restitution under G.S. 58-2-70, revoke, suspend, or restrict 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 or any of the insurer's officers, directors, employees, or other representatives refuse to submit to any examination authorized by 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 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 or electronic notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgment of the claim shall be one of the following:

(1) A statement made to the claimant or to the claimant's legal representative advising that the claim is being investigated.

(2) Payment of the claim.

(3) A bona fide written offer of settlement.

(4) A written denial of the claim. With respect to a claim under an accident, health, or disability policy, if the acknowledgment sent to the claimant indicates that the claim remains under investigation, within 45 days after receipt by the insurer of the initial claim, the insurer shall send a claim status report to the insured and every 45 days thereafter until the claim is paid or denied. The report shall give details sufficient for the insured to understand why processing of the claim has not been completed and whether the insurer needs additional information to process the claim. If the claim acknowledgment includes information about why processing of the claim has not been completed and indicates whether additional information is needed, it may satisfy the requirement for the initial claim status report.

(d) If a foreign insurance company's license is suspended or revoked, the Commissioner shall cause written notification of the suspension or revocation to be given to all of the company's agents in this State. Until the Commissioner restores the company's license, 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 the insurer's policyholders or creditors."

SECTION 7. G.S. 58-57-70 and G.S. 58-57-80 are repealed.

SECTION 8. This act becomes effective January 1, 2006, and applies to policies or certificates issued or renewed on or after that date.

HOUSE BILL 653:
Credit Insurance Changes.-AB

BILL ANALYSIS

Committee:	House Insurance	**Date:**	April 25, 2005
Introduced by:	Rep. Holliman	**Summary by:**	Shawn Parker
Version:	First Edition		Committee Staff

SUMMARY: House Bill 653 amends Article 57 "Regulation of Credit Insurance" of Chapter 58 of the General Statutes by clarifying statutory requirements, codifying Departmental policy and making the Commissioner's authority to impose monetary penalties on credit insurers consistent with the Commissioner's general enforcement authority.

The bill would become effective January 1, 2006 and apply to policies or certificates issued or renewed on or after that date.

BILL ANALYSIS: House Bill 653 makes technical changes that codify Departmental policy and clarify statutory requirements. **Section 1** adds the definition of "critical period coverage" which reflects the definition presently permitted by the Department. **Section 2** sets an appropriate refund method for decreasing term credit life insurance. **Section 3** allows credit card insurance to be provided through out-of state insurance contracts to account for current market conditions. **Section 4** requires acknowledgment of credit insurance claims not paid within 30 days. Current law does not require this acknowledgment and the changes would make credit insurance uniform with other lines regarding acknowledgment of a claim. **Section 5** allows a requirement of registration with the state unemployment office for involuntary unemployment benefits under a credit unemployment policy and prohibits the placing of a deadline for that registration or qualification for state unemployment benefits to qualify for the insurance benefits. **Section 6** makes the Commissioner's authority to impose monetary penalties on credit insurers consistent with the authority regarding other insurers. Current law only allows the Commissioner to impose a penalty if the company fails to implement an order of the Commissioner. **Section 7** repeals the provision on enforcement and civil and criminal penalties relating to credit insurance (G.S. 58-57-70 and G.S. 58-57-80). These provisions now appear in G.S. 58-57-71 as it appears in Section 6 of this bill. **Section 8** makes the act effective on January 1, 2006 and applies to policies or certificates issued or renewed on or after that date.

H0653e1-SMSQ

HOUSE BILL 653 –
CREDIT INSURANCE CHANGES

Amends G.S. 58-57-5, 58-57-50(b), 58-57-55, 58-57-60, and 58-57-110 in Article 57 (Credit Insurance) to codify Departmental policy or to clarify statutory requirements, and amends NCGS 58-57-80 penalties to be in line with NCGS 58-2-70, the Commissioner's general enforcement authority.

The amendments:

- Define "critical period coverage" – This is a definition presently permitted by the Department. (Section 1)
- Set an appropriate refund method for decreasing term credit life insurance; (Section 2)
- Allow credit card credit insurance to be provided through out-of-state insurance contracts (consistent with existing market conditions) - Credit card coverages are almost exclusively provided through out-of-state contracts because the large credit card companies are not located in North Carolina. This amendment will allow the continued availability of this type of insurance in North Carolina; (Section 3)
- Require acknowledgement of credit insurance claims not paid within 30 days – Currently there are no provisions in the credit insurance provisions to require acknowledgement of a claim. This would bring credit insurance in uniformity with other lines regarding acknowledgement of a claim; (Section 4)
- Allow a requirement of registration with the state unemployment office for involuntary unemployment benefits under a credit unemployment policy but prohibit the placing of a deadline for that registration or qualification for state unemployment benefits to qualify for the insurance benefits – Some Involuntary Unemployment Insurance (IUI) insurers have submitted forms that require an insured to register with the state unemployment office within 15 or 30 days of the loss of employment in order to qualify for credit involuntary unemployment benefits under the coverage. This deadline for registering would restrict payment of an otherwise valid claim. This amendment prohibits IUI insurers from imposing a deadline for registration with the state unemployment office, prohibits conditioning benefits upon qualification for state unemployment benefits but allows a requirement of registration (without deadline) with the state unemployment office in order to qualify for benefits. This section also statutorily provides that the refund for credit unemployment insurance shall equal the pro-rata unearned gross premium. The refund provision is added to formally state the refund provision that we already require for this coverage. (Section 5)
- Makes the Commissioner's authority to impose monetary penalties on credit insurers consistent with the authority regarding other insurers. Currently G.S. 58-57-80 only allows the Commissioner to impose a penalty if the company fails to implement an order of the Commissioner. (Section)

As amended

Attachment III

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 1

HOUSE BILL 734*

Short Title:	Improve Managed Care Statutes.-AB	(Public)
Sponsors:	Representatives Holliman and Wright (Primary Sponsors).	
Referred to:	Insurance.	

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO REMOVE FROM THE UNIFORM CREDENTIALING STATUTE AN UNNECESSARY PROVISION; CLARIFY THAT SERVICES COVERED ONLY FOR CERTAIN MEDICAL CONDITIONS OR DIAGNOSES MUST BE TREATED AS UTILIZATION REVIEW DECISIONS WHEN IT IS NECESSARY TO REVIEW THE COVERED PERSON'S CONDITION OR DIAGNOSIS IN ORDER TO DETERMINE IF THE SERVICE IS EXCLUDED OR COVERED; ENSURE THAT COVERED PERSONS RECEIVING EXTERNAL REVIEW KNOW WHAT INFORMATION THEIR INSURER PROVIDES TO THE EXTERNAL REVIEW ORGANIZATION PERFORMING THE REVIEW; AND ELIMINATE EXTERNAL REVIEW OUTSIDE OF NORMAL BUSINESS HOURS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-230(a) reads as rewritten:

"**§ 58-3-230. Uniform provider credentialing.**

(a) An insurer that provides a health benefit plan and that credentials providers for its networks shall maintain a process to assess and verify the qualifications of a licensed health care ~~practitioner, or applicant for licensure as a health care practitioner,~~ provider within 60 days of receipt of a completed provider credentialing application form approved by the Commissioner. When a health care practitioner joins a practice that is under contract with an insurer to participate in a health benefit plan, the effective date of the health care practitioner's participation in the health benefit plan network shall be the date the insurer approves the practitioner's credentialing application."

~~**SECTION 2.** G.S. 58-50-61(a)(13) reads as rewritten:~~

"**§ 58-50-61. Utilization review.**

(a) Definitions. – As used in this section, in G.S. 58-50-62, and in Part 4 of this Article, the term:

...

(13) "Noncertification" means a determination by an insurer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of emergency services in G.S. 58-3-190, and the requested service is therefore denied, reduced, or terminated. A "noncertification" is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of ~~coverage.~~coverage, and a decision about a covered person's condition is not necessary to determine whether the requested service is excluded. A "noncertification" includes any situation in which an insurer or its designated agent makes a decision about a covered person's condition to determine whether a requested treatment is excluded, experimental, investigational, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision."

SECTION 3.(a) G.S. 58-50-80(b)(4) reads as rewritten:

"**§ 58-50-80. Standard external review.**

...

(b) Upon receipt of a request for an external review under subsection (a) of this section, the Commissioner shall, within 10 business days, complete all of the following:

...

(4) Notify the insurer in writing whether the request for external review has been accepted. If the request has been accepted, the notice shall direct the insurer or its designee utilization review organization to provide to the assigned ~~organization,~~organization and to the covered person or authorized representative who made the request for external review on behalf of the covered person, within seven days of receipt of the notice, the documents and any information considered in making the noncertification appeal decision or the second-level grievance review decision."

SECTION 3.(b) G.S. 58-50-82(c) reads as rewritten:

"**§ 58-50-82. Expedited external review.**

...

(c) As soon as possible, but within the same day of receiving notice under subdivision (b)(2) of this section that the request has been assigned to a review organization, the insurer or its designee utilization review organization shall provide or transmit all documents and information considered in making the noncertification appeal decision or the second-level grievance review decision to the assigned review organization electronically or by telephone or facsimile or any other available expeditious method. A copy of the same information shall be sent by the same means or

other expeditious means to the covered person or the covered person's representative who made the request for expedited external review."

SECTION 4. The first sentence of G.S. 58-50-82(b) reads as rewritten:

"**§ 58-50-82. Expedited external review.**

...

(b) Within three business days of receiving a request for an expedited external review, the Commissioner shall complete all of the following:".

SECTION 5. G.S. 58-50-82(e) reads as rewritten:

"**§ 58-50-82. Expedited external review.**

...

(e) As expeditiously as the covered person's medical condition or circumstances require, but not more than four business days after the date of receipt of the request for an expedited external review, the assigned organization shall make a decision to uphold or reverse the noncertification, noncertification appeal decision, or second-level grievance review decision and notify the covered person, the covered person's provider who performed or requested the service, the insurer, and the Commissioner of the decision. In reaching a decision, the assigned organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or internal grievance process under G.S. 58-50-61 and G.S. 58-50-62."

SECTION 6. This act becomes effective October 1, 2005, and applies to policies or certificates issued or renewed on or after that date.

HOUSE BILL 734:
Improve Managed Care Statutes.-AB

BILL ANALYSIS

Committee:	House Insurance	**Date:**	April 25, 2005
Introduced by:	Reps. Holliman, Wright	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 734 would make a series of largely technical changes to current managed care statutes. The bill would clarify the time frame for the submission of a request for external review of a noncertification decision and for the external review organization to decide to uphold or overturn the noncertification decision; would eliminate superfluous language; and would require that information provided by an insurer to an external review organization be provided to the insured person.***

CURRENT LAW: Part 2 of Article 50 of Chapter 58 of the General Statutes sets forth the "General Accident and Health Insurance Regulations" for Preferred Provider Organizations (PPOs), and includes guidelines for creating this form (PPO) of managed care arrangement. Part 4 of Article 50 – Health Benefit Plan External Review provides standards for the establishment, maintenance and conduct of an external review process for insured persons to contest benefit plan decisions regarding coverage of services.

BILL ANALYSIS: House Bill 734 makes a number of largely technical changes to existing managed care statutes to clarify existing policies and procedures. **Section 1** would eliminate superfluous language in G.S. 58-3-230 relating to provider credentialing. **Section 2** would clarify the utilization review process with regards to "noncertification" of an admission or other health care service based on a clear exclusion of the specific service in the relevant certificate of coverage, regardless of what the covered person's condition may be. **Section 3(a)** would address 'standard external review' procedures, requiring the insurer or its designee utilization review organization to provide the covered person or their authorized representative with a copy of, "...the documents and any information considered in making the noncertification appeal decision..."[1] **Section 3(b)** would similarly require the insurer or its designee utilization review organization to provide the covered person or their authorized representative with a copy of, "...all documents and information considered in making the noncertification appeal decision..." when the request is part of an 'expedited external review'.[2] **Section 4** would clarify that the three-day time frame for the Commissioner to complete an expedited external review, is three *business* days.[3] **Section 5** would clarify that the time frame for deciding whether to uphold or reverse a noncertification decision is four *business* days after the date of receipt of a request for an expedited external review.[4]

EFFECTIVE DATE: The act would become effective on October 1, 2005 and would apply to policies or certificates issued or renewed on or after that date.

BACKGROUND: House Bill 734 is an Agency Bill proposed by the Department of Insurance and is accompanied by the attached bill summary, prepared by Department legislative counsel.

H0734e1-SMSS

[1] G.S. 58-50-80(b)(4).
[2] G.S. 58-50-82(c).
[3] G.S. 58-50-82(b).
[4] G.S. 58-50-82(e).

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

III

EDITION No. _____

H. B. No. 734 DATE 4/26/05

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

(Rep.) Holliman and Wright
(Sen.)

moves to amend the bill on page 1, line 24 through page 2, line 19
( ) WHICH CHANGES THE TITLE
by deleting section 2 and renumbering the remaining sections accordingly; and

and further amends the bill by on page 1, line 3 through line 7 by rewriting those lines to read as follows:

"UNNECESSARY PROVISION;"

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

ATTACHMENT IV

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H 1

HOUSE BILL 735

Short Title:	Accident & Health Insur./Rate Stabilization.-AB	(Public)
Sponsors:	Representatives Holliman and Wright (Primary Sponsors).	
Referred to:	Insurance.	

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO REQUIRE ANNUAL FILING AND ACTUARIAL CERTIFICATION OF RATES FOR INSURERS PROVIDING INDIVIDUAL ACCIDENT AND HEALTH INSURANCE BENEFITS AND TO BETTER PROTECT CONSUMERS FROM THE HARMFUL IMPACT OF BLOCKS OF BUSINESS BEING CLOSED.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 58-51-95(f) reads as rewritten:

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

...

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

rating, or both; policy reserves used in rating; and other recognized actuarial principles of the NAIC, the American Academy of Actuaries, and the Society of Actuaries."

SECTION 1.(b) G.S. 58-51-95 is amended by adding the following new subsections to read:

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

...

(g) Every policy that is subject to this section and that provides individual accident and health insurance benefits to a resident of this State shall return to policyholders benefits that are reasonable in relation to the premium charged. The Commissioner may adopt rules or utilize existing rules to establish minimum standards for loss ratios of policies on the basis of incurred claims experience and earned premiums in accordance with accepted actuarial principles and practices to assure that the benefits are reasonable in relation to the premium charged. Every insurer providing policies in this State subject to this section shall not less than annually file for approval its rates, rating schedules, and supporting documentation to demonstrate compliance with the applicable loss ratio standards of this State as adopted by the Commissioner. All filings of rates and rating schedules shall demonstrate that the actual and expected losses in relation to premiums comply with the standards adopted by the Commissioner. The filing shall include a certification by an individual who is either a Fellow or an Associate of the Society of Actuaries or a Member of the American Academy of Actuaries that the rates are not excessive, not inadequate, and not unfairly discriminatory; and that the rates exhibit a reasonable relationship to the benefits provided by the policy. This subsection does not apply to any long-term care policy issued in this State on or after February 1, 2003, and noncancellable accident and health insurance.

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

(1) Provide to the Commissioner an actuarial certification listing all of its long-term care policy forms available for sale in this State as of December 31 of the prior year, stating that the current premium rate schedule for each form is sufficient to cover anticipated costs under moderately adverse experience and stating that the premium rate schedule is reasonably expected to be sustainable over the file of the form with no future premium increases anticipated.

(2) For any policy form for which the statement in subdivision (1) of this subsection cannot be made or is qualified, submit a plan of corrective action to the Commissioner for approval.

(i) For purposes of this section, accident and health insurance means insurance against death or injury resulting from accident or from accidental means and insurance against disablement, disease, or sickness of the insured. This includes Medicare supplemental insurance, long-term care, nursing home, or home health care insurance, or any combination thereof, specified disease or illness insurance, hospital indemnity or other fixed indemnity insurance, short-term limited duration health insurance, dental

insurance, vision insurance, and medical, hospital, or surgical expense insurance or any combination thereof."

SECTION 2. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-275. Closure of a block of business.**

(a) An insurer that determines to create a closed block of business in this State shall:

(1) Within five business days of making the determination to close a block of business, notify the Commissioner in writing of the insurer's decision to cease sales of the policy and of the expected impact on future premiums.

(2) Within 20 days of making the determination to close a block of business, inform each agent and broker selling the product of the decision and cease all marketing activities regarding that business.

(3) Within 30 days, notify all policyholders of the determination and of its expected impact on future premiums. Notice shall comply with any rules adopted pursuant to subsection (b) of this section.

(b) The Commissioner may adopt rules to carry out the purposes and provisions of this section, including rules establishing the language, content, format, and methods of distribution of the notices required by this section.

(c) As used in this section, the term:

(1) 'Accident and health insurance' means insurance against death or injury resulting from accident or from accidental means and insurance against disablement, disease, or sickness of the insured. This includes Medicare supplemental insurance, long-term care, nursing home, or home health care insurance, or any combination thereof, specified disease or illness insurance, hospital indemnity or other fixed indemnity insurance, short-term limited duration health insurance, dental insurance, vision insurance, and medical, hospital, or surgical expense insurance or any combination thereof.

(2) 'Block of business' means a particular policy form or contract of individual accident and health insurance issued by an insurer, which includes distinct benefits or marketing methods.

(3) 'Closed block of business' means a block of business for which an insurer ceases to actively market, sell, and issue new contracts under a particular policy form in this State.

(4) 'Insurer' includes 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.

(d) This section does not apply when an insurer makes a decision to discontinue a particular policy form or contract of accident and health insurance coverage subject to

Article 68 of this Chapter, cancels or renews the coverage, and offers replacement coverage pursuant to G.S. 58-68-65(c)(1)."

SECTION 3. G.S. 58-65-2 reads as rewritten:

"**§ 58-65-2. Other laws applicable to service corporations.**

The following provisions of this Chapter are applicable to service corporations that are subject to this Article:

G.S. 58-2-125.	Authority over all insurance companies; no exemptions from license.
G.S. 58-2-155.	Investigation of charges.
G.S. 58-2-160.	Reporting and investigation of insurance and reinsurance fraud and the financial condition of licensees; immunity from liability.
G.S. 58-2-162.	Embezzlement by insurance agents, brokers, or administrators.
G.S. 58-2-185.	Record of business kept by companies and agents; Commissioner may inspect.
G.S. 58-2-190.	Commissioner may require special reports.
G.S. 58-2-195.	Commissioner may require records, reports, etc., for agencies, agents, and others.
G.S. 58-2-200.	Books and papers required to be exhibited.
G.S. 58-3-50.	Companies must do business in own name; emblems, insignias, etc.
G.S. 58-3-115.	Twisting with respect to insurance policies; penalties.
G.S. 58-50-35.	Notice of nonpayment of premium required before forfeiture.
G.S. 58-51-25.	Policy coverage to continue as to mentally retarded or physically handicapped children.
G.S. 58-51-95(g),(h), (i).	Approval by Commissioner of forms, classification and rates; hearings; exceptions."

SECTION 4. This act becomes effective July 1, 2006, and applies to policies or certificates issued, renewed, or reinstated on or after that date.

HOUSE BILL 735:
Accident & Health Insur./Rate Stabilization.-AB

BILL ANALYSIS

Committee:	House Insurance	**Date:**	April 24, 2005
Introduced by:	Reps. Holliman, Wright	**Summary by:**	Tim Hovis
Version:	First Edition		Committee Counsel

SUMMARY: House Bill 735 makes changes to the statutes governing accident and health insurance benefits and includes a new provision governing the closing of blocks of business

Section 1 the bill make the following changes:

- ***Require all accident and health insurance policies (except long-tem care policies) to provide benefits that are reasonable to the premium charged.***
- ***Authorize the Commissioner to adopt rules establishing minimum standards for loss ratios on the basis incurred claims experience and earned premiums; Require all accident and health insurers (except long–term care insurers) to annually file rates, rating schedules, and supporting documentation, including actuarial certification, for the Commissioner's approval to demonstrate compliance with these loss ratios.***
- ***Require long-term care insurers to provide an actuarial certification listing all long-term care policy forms in the State stating that the current premium rate schedule is sufficient to cover anticipated costs; Submit a plan of corrective action for the Commissioner's approval if the certification cannot be made or is qualified.***

This section would apply to hospital, medical, and dental service corporations, including Blue Cross and Blue Shield and Delta Dental.

Section 2 of the bill would add a new section to Chapter 58 governing the closing of blocks of business by accident and health insurers. This section would:

- ***Require an insurer to notify the Commissioner within five days of making a determination to close a block of business.***
- ***Require the insurer to notify each agent and broker selling the product within 20 days of the determination. The insurer must also cease all marketing activities of the product.***
- ***Require the insurer to notify all policyholders within 30 days of the determination and the expected impact of the closing on future premiums.***

Under the bill, a closed block of business is defined as "a block of business for which an insurer ceases to actively market, sell, and issue new contracts under a particular policy form in the State."

EFFECTIVE DATE: House Bill 735 becomes effective July 1, 2006 and applies to policies or certificates issued, renewed, or reinstated on or after that date.

H0735e1-SMRG

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

IV

EDITION No. 1st

H. B. No. 735 DATE 4/26/05

S. B. No. Amendment No. (to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE

Page 1 of 2

Rep.) Wright

Sen.)

moves to amend the bill on page 2, line s 18-19

( ) WHICH CHANGES THE TITLE

by delcting the following:

"demonstrate that the actual and expected losses in relation to premiums";

and on page 3, lines 32-33

by rewriting the lines to read:

"individual accident and health insurance issued by an insurer.";

and on page 4, line 1

by deleting the word "renews" and substituting the word "non-renews";

and on page 2, line 24

by inserting after the word "policy." the following sentence:

"Nothing in this subsection shall require an

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. 1st

H. B. No. 735 DATE 4/26/05

S. B. No. Amendment No. (to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE

Rep.)
)
Sen.)

Page 2 of 2

moves to amend the bill on page , line

( ) WHICH CHANGES THE TITLE

by

insurer to provide certification with respect to a previous rate period, or to require an insurer to reduce properly filed and approved rates before the end of a rate period.";

and on page 4, lines 30-31 by rewriting the lines to read:

"SECTION 4. This act becomes effective July 1, 2006."

SIGNED

ADOPTED X FAILED TABLED

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

MINUTES
HOUSE COMMITTEE ON INSURANCE
May 3, 2005

The House Committee on Insurance met at 11:00 AM on Tuesday, May 3, 2005 in Room 1228. The following Representatives attended, Chairman Hugh Holliman, Vice Chairs Bill Faison, Ed Jones, Ed Nye and Mitchell Setzer. Members: Lucy Allen, Carey Allred, David Almond, Harold Brubaker, William Current, Robert Grady, Julia Howard, Deborah Ross, Drew Saunders, Fred Steen, Ron Sutton, William Wainwright and Tom Wright.

Chairman Holliman called the meeting to order and welcomed the House Pages, Sgt-At-Arms and visitors to the meeting. Attachment I.

Chairman Holliman ask Kory Goldsmith to explain the PCS for HB 658 – Code Officials Professionalism.-AB. Rep. Saunders made a motion to accept the PCS for purposes of discussion and the motion passed. Rep. Holliman offered an amendment and Frank Folger, Legal Counsel with DOI explained that the amendment corrected some language from the original bill. Wanda Edwards with DOI explained the cost factor, who pays and the importance of continuing education. The amendment passed. After much discussion, Rep. Wright made a motion for a favorable report to the PCS as amended and rolled into a new committee substitute, unfavorable to the original bill. Fred Bone with Bone and Associates was recognized and spoke in support of this legislation. The motion was repeated by Rep. Holliman and passed unanimously. Attachment II.

Rep. L. Allen made a motion to accept for purposes of discussion the PCS on HB 672 – Reduce Holding Period for Unclaimed Property.-AB. Motion passed. Kory Goldsmith, Staff Attorney explained the changes in the PCS from the original bill. Alan Martin, Audit Manager, with the Treasurer's office clarified some language and explained how system works in locating property owners. Doug Johnson, Attorney General's office spoke in support of the bill. Rep. Wainwright made a motion for a favorable report to the PCS, unfavorable to the original bill. The motion carried. Attachments III.

The Meeting adjourned at 11:46 AM.

Representative. L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

Carol Bowers (Rep. Holliman)

From: Carol Bowers (Rep. Holliman)
Sent: Monday, May 02, 2005 1:17 PM
Subject: 5-3-05 House Committee on Insurance meeting

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE:	**Tuesday, May 3, 2005**
TIME:	**11:00 AM**
LOCATION:	**1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 658 -Code Officials Professionalism.-AB
Representative Holliman

HB 672 - Reduce Holding Period for Unclaimed Property.-AB
Representative Holliman

HB 728 - Ensure PEO Licensing Oversight.-AB
Representative Holliman

HB 1526 - No Comprehensive Deductible on Windshields.
Representatives Frye and Jones

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **1:00 PM on May 2, 2005**.

___Principal Clerk

5/2/2005

HOUSE INSURANCE COMMITTEE

May 3, 2005
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

HB 658 -Code Officials Professionalism.-AB
Representative Holliman

HB 672 - Reduce Holding Period for Unclaimed Property.-AB
Representative Holliman

HB 1526 - No Comprehensive Deductible on Windshields.
Representatives Frye and Jones

Pulled from calendar

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Holliman (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for
HB 658 A BILL TO BE ENTITLED AN ACT TO ESTABLISH A PROFESSIONAL DEVELOPMENT PROGRAM FOR CODE-ENFORCEMENT OFFICIALS, TO AUTHORIZE THE USE OF FUNDS FROM THE INSURANCE REGULATORY FUND FOR PROFESSIONAL DEVELOPMENT OF CODE-ENFORCEMENT OFFICIALS, AND TO APPROPRIATE FUNDS FROM THE INSURANCE REGULATORY FUND FOR THAT PURPOSE.

☒ With a favorable report as to the committee substitute bill, which changes the title, unfavorable as to the original bill.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Holliman (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 672 A BILL TO BE ENTITLED AN ACT TO REDUCE THE HOLDING PERIOD FOR CERTAIN UNCLAIMED PROPERTY HELD AS STOCK OR OTHER EQUITY INTERESTS IN A BUSINESS ASSOCIATION, INCLUDING CASH DISTRIBUTIONS OF A DEMUTUALIZED INSURANCE COMPANY.

☒ With a favorable report as to the committee substitute bill, unfavorable as to the original bill.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

Attachment 1

HOUSE COMMITTEE ON INSURANCE

May 3, 2005
11:00 AM
Room 1228 Legislative Building

Pages:

Name (please print clearly)	County	Representative
Kymberly Rumley	Wake	Rep Dollar
Kevin Myers	Johnston	Rep. Langdon

Sergeant-At-Arms (please print)

Martha Gadison
Charles Williams

Allen Martin - Treasurer
Doug Johnson - AG's Office

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 3, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cam Cree	BPMH
Susan Valauri	Nationwide
FRANK W. FOUR	NCDOI
Hayley Reed	NCLOA
Ron Wright	BCBSNC
Jack Bone	Bone & Assoc.
Wanda Edwards	NCDOI
BILL HALE	ACLI
Jim Stewart	IFNC
Dave Reddick	NAMIC
Kathleen Edwards	UNC-CH Legis. Reporting Service

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 3, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mike Causey	Causey + Associates
Steve Woodson	NC Farm Bureau
Dan Johnston	NC Dept State Treasurer
Ally Hunter	NC Dept State Treasurer
Raymond Bee	Bee & Assoc
STEVE KEENE	NC MEDICAL SOCIETY
Colleen Kocharek	IGONC / ITRPNC
Lee Hoke	KCLK

Attachment I

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 1

HOUSE BILL 658

Short Title:	Code Officials Professionalism.-AB	(Public)
Sponsors:	Representative Holliman.	
Referred to:	Insurance, if favorable, Appropriations.	

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A PROFESSIONAL DEVELOPMENT PROGRAM FOR CODE-ENFORCEMENT OFFICIALS, TO AUTHORIZE THE USE OF FUNDS FROM THE INSURANCE REGULATORY FUND FOR PROFESSIONAL DEVELOPMENT OF CODE-ENFORCEMENT OFFICIALS, AND TO APPROPRIATE FUNDS FROM THE INSURANCE REGULATORY FUND FOR THAT PURPOSE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 9C of Chapter 53 of the General Statutes is amended by adding a new section to read:

"**§ 143-151.13A. Professional development program for officials.**

(a) As used in this section, "official" means a qualified Code-enforcement official as that term is defined in G.S. 143-151.8.

(b) The Board may establish professional development requirements for officials as a condition of the renewal or reactivation of their certificates. The purposes of these professional development requirements are to assist officials in maintaining professional competence in their enforcement of the Code and to assure the health, safety, and welfare of the citizens of North Carolina. An official subject to this section shall present evidence to the Board at each certificate renewal after initial certification, that during the 12 months before the certificate expiration date, the official has completed the required number of credit hours in courses approved by the Board. Annual continuing education hour requirements shall be determined by the Board but shall not be more than six credit hours.

(c) The Board may require an individual who earns a certificate under programs established in G.S. 143-151.13 to complete professional development courses, not to exceed six hours in each technical area of certification, within one year after that individual is first employed by a city or county inspection department.

(d) As a condition of reactivating a standard or limited certificate, the Board may require the completion of professional development courses within one year after reemployment as an official as follows:

(1) An individual who has been on inactive status for more than two years and who has not been continuously employed by a city or county inspection department during the period of inactive status shall complete professional development courses not to exceed 12 hours for each technical area in which the individual is certified.

(2) An individual who has been on inactive status for more than two years and who has been continuously employed by a city or county inspection department during the period of inactive status shall complete professional development courses not to exceed six hours for each technical area in which the individual is certified.

(3) An individual who has been on inactive status for two years or less and who has been continuously employed by a city or county inspection department during the period of inactive status shall complete professional development courses not to exceed four hours for each technical area in which the individual is certified.

(e) The Board may, for good cause shown, grant extensions of time to officials to comply with these requirements. An official who, after obtaining an extension under this subsection, offers evidence satisfactory to the Board that the official has satisfactorily completed the required professional development courses, is in compliance with this section.

(f) The Board may adopt rules to give purpose and effect to the professional development requirements, including rules that govern:

(1) The content and subject matter of professional development courses.

(2) The criteria, standards, and procedures for the approval of courses, course sponsors, and course instructors.

(3) The methods of instruction.

(4) The computation of course credit.

(5) The ability to carry forward course credit from one year to another.

(6) The waiver of or variance from the professional development required for hardship or other reasons.

(7) The procedures for compliance and sanctions for noncompliance."

SECTION 2. G.S. 58-6-25(d) reads as rewritten:

"(d) Use of Proceeds. – The Insurance Regulatory Fund is created in the State treasury, under the control of the Office of State Budget and Management. The proceeds of the charge levied in this section and all fees collected under Articles 69 through 71 of this Chapter and under Articles 9 and 9C of Chapter 143 of the General Statutes shall be credited to the 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 may be spent only pursuant to appropriation by the General Assembly and in accordance with the line item budget enacted by the General Assembly. The Fund is subject to the provisions of the Executive Budget Act, except that no unexpended

surplus of the Fund shall revert to the General Fund. All money credited to the Fund shall be used to reimburse the General Fund for the following:

(1) Money appropriated to the Department of Insurance to pay its expenses incurred in regulating the insurance industry and other industries in this State.

(2) Money appropriated to State agencies to pay the expenses incurred in regulating the insurance industry, in certifying statewide data processors under Article 11A of Chapter 131E of the General Statutes, and in purchasing reports of patient data from statewide data processors certified under that Article.

(3) Money appropriated to the Department of Revenue to pay the expenses incurred in collecting and administering the taxes on insurance companies levied in Article 8B of Chapter 105 of the General Statutes.

(4) Money appropriated for the office of Managed Care Patient Assistance Program established under G.S. 143-730 to pay the actual costs of administering the program.

(5) Money appropriated to the Department of Insurance for the implementation and administration of independent external review procedures required by Part 4 of Article 50 of this Chapter.

(6) Money appropriated to the Department of Justice to pay its expenses incurred in representing the Department of Insurance in its regulation of the insurance industry and other related programs and industries in this State that fall under the jurisdiction of the Department of Insurance.

(7) Money appropriated to the Department of Insurance to pay its expenses incurred in connection with providing staff support for State boards and commissions, including the North Carolina Manufactured Housing Board, State Fire and Rescue Commission, North Carolina Building Code Council, North Carolina Code Officials Qualification Board, Public Officers and Employees Liability Insurance Commission, North Carolina Home Inspector Licensure Board, and the Volunteer Safety Workers' Compensation Board.

(8) Money appropriated to the Department of Insurance to pay its expenses incurred in connection with continuing education programs under Article 33 of this Chapter and in connection with the purchase and sale of copies of the North Carolina State Building Code.

(9) Money appropriated to the Department of Insurance for the Code-enforcement officials professional development requirements under G.S. 143-151.13A."

SECTION 3. There is appropriated from the Insurance Regulatory Fund established in G.S. 58-6-25 to the Department of Insurance the sum of one hundred thousand dollars ($100,000) for the 2005-2006 fiscal year for the Code Officials Qualification Board for the purpose of developing and implementing the Code officials professional development program established in G.S. 143-151.13A.

SECTION 4. The Code Officials Qualification Board shall initiate development of the Code officials professional development program established pursuant to this act by June 1, 2005. The program shall be developed for implementation effective October 1, 2005.

SECTION 5. Section 1 of this act becomes effective October 1, 2005, and applies to certificates issued or renewed on or after that date. Section 3 of this act becomes effective July 1, 2005, only if the Code Officials Qualification Board has begun development of the Code officials professional development program by that date. The remainder of this act is effective when it becomes law.

11

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H **D**

HOUSE BILL 658
PROPOSED COMMITTEE SUBSTITUTE H658-CSSQ-10 [v.4]

5/3/2005 10:04:25 AM

Short Title: Code Officials Professionalism.-AB (Public)

Sponsors:

Referred to:

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A PROFESSIONAL DEVELOPMENT PROGRAM FOR CODE-ENFORCEMENT OFFICIALS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 9C of Chapter 53 of the General Statutes is amended by adding a new section to read:

"**§ 143-151.13A. Professional development program for officials.**

(a) As used in this section, "official" means a qualified Code-enforcement official as that term is defined in G.S. 143-151.8.

(b) The Board may establish professional development requirements for officials as a condition of the renewal or reactivation of their certificates. The purposes of these professional development requirements are to assist officials in maintaining professional competence in their enforcement of the Code and to assure the health, safety, and welfare of the citizens of North Carolina. An official subject to this section shall present evidence to the Board at each certificate renewal after initial certification, that during the 12 months before the certificate expiration date, the official has completed the required number of credit hours in courses approved by the Board. Annual continuing education hour requirements shall be determined by the Board but shall not be more than six credit hours.

(c) The Board may require an individual who earns a certificate under programs established in G.S. 143-151.13 to complete professional development courses, not to exceed six hours in each technical area of certification, within one year after that individual is first employed by a city or county inspection department.

(d) As a condition of reactivating a standard or limited certificate, the Board may require the completion of professional development courses within one year after reemployment as an official as follows:

(1) An individual who has been on inactive status for more than two years and who has not been continuously employed by a city or county

inspection department during the period of inactive status shall complete professional development courses not to exceed 12 hours for each technical area in which the individual is certified.

(2) An individual who has been on inactive status for more than two years and who has been continuously employed by a city or county inspection department during the period of inactive status shall complete professional development courses not to exceed six hours for each technical area in which the individual is certified.

(3) An individual who has been on inactive status for two years or less and who has been continuously employed by a city or county inspection department during the period of inactive status shall complete professional development courses not to exceed four hours for each technical area in which the individual is certified.

(e) The Board may, for good cause shown, grant extensions of time to officials to comply with these requirements. An official who, after obtaining an extension under this subsection, offers evidence satisfactory to the Board that the official has satisfactorily completed the required professional development courses, is in compliance with this section.

(f) The Board may adopt rules to implement this section, including rules that govern:

(1) The content and subject matter of professional development courses.

(2) The criteria, standards, and procedures for the approval of courses, course sponsors, and course instructors.

(3) The methods of instruction.

(4) The computation of course credit.

(5) The ability to carry forward course credit from one year to another.

(6) The waiver of or variance from the professional development required for hardship or other reasons.

(7) The procedures for compliance and sanctions for noncompliance."

SECTION 2. The Code Officials Qualification Board shall initiate development of the Code officials professional development program established pursuant to this act no later than October 1, 2005. The program shall be developed for implementation no later than January 1, 2006.

SECTION 3. This act is effective when it becomes law and applies to certificates issued or renewed on or after January 1, 2006.

HOUSE BILL 658:
Code Officials Professionalism.-AB

BILL ANALYSIS

Committee:	House Insurance	**Date:**	May 2, 2005
Introduced by:	Rep. Holliman	**Summary by:**	Shawn Parker
Version:	PCS to First Edition H658-CSSQ-10		Committee Staff

SUMMARY: ***House Bill 658 creates a professional development program for code-enforcement officials, authorizes the North Carolina Code Officials Qualification Board to establish requirements as a condition of renewal or reactivation of a code enforcement official's certificate.***

The Proposed Committee Substitute removes appropriations language and changes the effective dates.

CURRENT LAW: Article 9C in Chapter 143 of the North Carolina General Statutes regulates the North Carolina Code Officials Qualification Board. Current standards require possession of a standard certificate, a limited certificate, or a probationary certificate for persons engaging in Code enforcement.[1] A certificate is valid as long as the certified individual annually renews the license, pays the corresponding renewal fee[2], and maintains employment in the following capacity:

- As a Code enforcement official with the State of North Carolina, or any political subdivision thereof;
- As a Code enforcement official inspecting tribal lands under G.S. 153A-350.1 employed by a federally recognized Indian Tribe.[3]

BILL ANALYSIS: House Bill 658 creates a professional development program for code-enforcement officials.

Section 1 authorizes the North Carolina Code Officials Qualification Board to adopt rules to implement professional development requirements as a condition of renewal or reactivation of a code enforcement official's certificate. In establishing annual continuing education requirements, the Board will require certified individuals to complete within one year, not more than six credit hours. The Board is authorized to grant time extensions to enable compliance.

Section 2 directs the Board to begin implementation of the professional development program by October 1, 2005, and to have the program implemented by January 1, 2006.

EFFECTIVE DATE: The act would be effective when it becomes law and applies to certificates issued or renewed on or after January 1, 2006.

H0658e1-SMSQ-CSSQ-10

[1] G.S.143-151.13
[2] G.S.143-151.16
[3] G.S.143-151.15

NORTH CAROL[illegible]ENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

11

EDITION No. _____

H. B. No. 658

S. B. No. _____

COMMITTEE SUBSTITUTE X

Rep.)
Sen.)

DATE 5/3/05

Amendment No. _____
(to be filled in by Principal Clerk)

1 moves to amend the bill on page 2, lines 9-11

2 ( ) WHICH CHANGES THE TITLE

3 by deleting the phrase "and who has been continuously employed by a city

4 or county inspection department

5 during the period of inactive

6 status".

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SIGNED [signature]

ADOPTED X FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

ATTACHMENT III

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 672*
PROPOSED COMMITTEE SUBSTITUTE H672-CSRC-33 [v.1]

5/3/2005 10:19:06 AM

Short Title: Reduce Holding Period for Unclaimed Property.-AB (Public)

Sponsors:

Referred to:

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO REDUCE THE HOLDING PERIOD FOR CERTAIN UNCLAIMED PROPERTY HELD AS STOCK OR OTHER EQUITY INTERESTS IN A BUSINESS ASSOCIATION, INCLUDING CASH DISTRIBUTIONS OF A DEMUTUALIZED INSURANCE COMPANY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 116B-53(c) reads as rewritten:

"(c) Property is presumed abandoned if it is unclaimed by the apparent owner during the time set forth below for the particular property:

(1) Traveler's check, 15 years after ~~issuance;~~ issuance.

(2) Time deposit, including a deposit that is automatically renewable, 10 years after the later of initial maturity or the date of the last indication by the owner of interest in the ~~property;~~ property.

(3) Money order, cashier's check, teller's check, and certified check, seven years after ~~issuance;~~ issuance.

(4) Stock or other equity interest in a business association, including a security entitlement under Article 8 of the Uniform Commercial Code, Chapter 25 of the General Statutes, ~~five~~ three years after the earlier of:

a. The date of a cash dividend or other cash distribution unclaimed by the apparent owner, ~~or~~

b. The date a second consecutive mailing, notification, or communication from the holder to the apparent owner is returned to the holder as unclaimed by or undeliverable to the apparent owner;

c. The date the holder discontinued mailings, notifications, or communications to the apparent owner.

For purposes of distributions of a demutualized insurance company under this subdivision, the date of demutualization or reorganization shall be the date of the order of demutualization or reorganization that is rendered by the Department of Insurance and from which no further appeal can be taken or for which the time for noting an appeal has expired. Property, subject to the requirements of this subdivision, shall include only the property described in the order of demutualization or reorganization that is rendered by the Department of Insurance and from which no further appeal can be taken or for which the time for noting an appeal has expired.

This subdivision applies to both the underlying stock, share, or other intangible ownership interest of an owner, and any stock, share or other intangible interest of which the business association is in possession of the certificate or other evidence or indicia of ownership, and to the stock, share, or other ownership interest of dividend and non-dividend paying business associations whether or not the interest is represented by a certificate.

(5) Debt of a business association, ~~other than a~~ including debt evidenced by a matured or called bearer bond or an original issue discount bond, ~~five~~ three years after the date of an interest or principal payment unclaimed by the apparent ~~owner;~~ owner.

(5a) Any dividend, profit, distribution, interest, redemption, payment on principal, cash compensation (including amounts from a demutualized insurance company), or other sum held or owing by a business association for or to its shareholder, certificate holder, policy holder, member, bondholder, or other security holder, who has not claimed it, or corresponded in writing with the business association concerning it, within three years after the date prescribed for payment or delivery.

(6) Demand or savings deposit, five years after the date of the last indication by the owner of interest in the ~~property;~~ property.

(7) Money or credits owed to a customer as a result of a retail business transaction, three years after the obligation ~~accrued;~~ accrued.

(8) Any gift certificate or electronic gift card bearing an expiration date and remaining unredeemed or dormant for more than three years after the gift certificate or electronic gift card was sold is deemed abandoned. The amount abandoned is deemed to be sixty percent (60%) of the unredeemed portion of the face value of the gift certificate or the electronic gift ~~card;~~ card.

(9) Amount owed by an insurer on a life or endowment insurance policy or an annuity that has matured or terminated, three years after the obligation to pay arose or, in the case of a policy or annuity payable upon proof of death, three years after the insured has attained, or would have attained if living, the limiting age under the mortality table on which the reserve is ~~based;~~ based.

(10) Property distributable by a business association in a course of dissolution, one year after the property becomes ~~distributable;~~ distributable.

(11) Property received by a court as proceeds of a class action, and not distributed pursuant to the judgment, one year after the distribution ~~date;~~ date.

(12) Property held by a court, government, governmental subdivision, agency, or instrumentality, one year after the property becomes ~~distributable;~~ distributable.

(13) Wages or other compensation for personal services, two years after the compensation becomes ~~payable;~~ payable.

(14) Deposit or refund owed to a subscriber by a utility, one year after the deposit or refund becomes ~~payable;~~ payable.

(15) Property in an individual retirement account, defined benefit plan, or other account or plan that is qualified for tax deferral under the income tax laws of the United States, three years after the earliest of the date of the distribution or attempted distribution of the property, the date of the required distribution as stated in the plan or trust agreement governing the plan, or the date, if determinable by the holder, specified in the income tax laws of the United States by which distribution of the property must begin in order to avoid a tax ~~penalty; and~~ penalty.

(16) All other property, five years after the owner's right to demand the property or after the obligation to pay or distribute the property arises, whichever first occurs."

SECTION 2. This act becomes effective October 1, 2005.

Attachment 11

HOUSE BILL 672: Reduce Holding Period for Unclaimed Property.- AB

BILL ANALYSIS

Committee:	House Insurance	**Date:**	May 3, 2005
Introduced by:	Rep. Holliman	**Summary by:**	Kory Goldsmith
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 672 would reduce, from 5 to 3 years, the amount of time a holder of unclaimed stocks, other equity interests, or debt of a business association would have to wait before the holder could consider the property abandoned and turn it over to the State Treasurer's Office for deposit into the Escheats Fund. It also clarifies when a distribution from a demutualized insurance company is deemed to have been made.***

The bill would become effective October 1, 2005.

CURRENT LAW: Section 10 of Article IX of the North Carolina Constitution provides all property that escheats to the State shall be used "to aid worthy and needy students who are residents of this State and enrolled in public institutions of higher education in this State." The method, amount, and type of distribution are governed by law.

Chapter 116B of the General Statutes outlines the laws relating to abandoned and escheated property. Any person who is obligated to hold or deliver property to the owner, or is obligated to pay money to the owner is considered a "holder" under G.S. 116B-52(5). An owner is a person who has a legal or equitable interest in property or the person' legal representative. G.S. 116B-52(10). Property is considered unclaimed if the apparent owner has not communicated with the holder concerning the property and has not otherwise indicated an interest in the property. G.S. 116B-53(c) outlines how long a holder must hold the property before it is considered by law to be abandoned. G.S. 116B-5 provides that all escheated or abandoned property shall be paid into Escheat Fund in the Treasurer's Office.

Currently, the holder of stocks or other equity interests in a business association must hold the unclaimed property for five years before they become abandoned property. The term "business association" means a corporation, joint stock company, investment company, partnership, unincorporated association, joint venture, limited liability company, business trust, trust company, land bank, safe deposit company, safekeeping depository, financial organization, insurance company, mutual fund, utility, or other business entity consisting of one or more persons, whether or not for profit. G.S. 116B-52(2).

BILL ANALYSIS: House Bill 672 amends G.S. 116B-53(c)(4) and (c)(5) to provide that any stock or equity interest in, or debt of a business association must be held by the holder for three years before it is considered abandoned.

G.S. 116B-53(c)(4) is amended to provide that for purposes of a distribution from a demutualized insurance company, the date of demutualization shall be considered the date the Department of Insurance issued the order of demutualization or reorganization, provided there has been no appeal of that order or the date for making an appeal of that order has expired. Only property that was described in the order of demutualization or reorganization is subject to this time limitation. Finally, it claries G.S. 116B-53(c)(5) to provide that unclaimed debt of a business association includes debt evidenced by a natured or called bearer bond.

BACKGROUND: A mutual insurance company has no shareholders, it is owned by its policyholders. Mutual companies sometimes seek to convert to a stock form of ownership for various reasons usually because the company wishes to raise capital and enhance the financial strength of the organization. When a mutual company "demutualizes" and becomes a stock company, its surplus, or net worth is generally distributed o the policy holders in the form of stock. The distribution may also be made in the form of cash, or policy credits. A large number of mutual insurance companies "demutualized" during the period between 1999 and 2001. However, insurance companies found that a material amount of demutualization proceeds could not be delivered to policyholders, because the policyholders could not be located.

H0672e1-SMRC

March 17, 2005

H 672. REDUCE HOLDING PERIOD FOR UNCLAIMED PROPERTY. *TO REDUCE THE HOLDING PERIOD FOR CERTAIN UNCLAIMED PROPERTY HELD AS STOCK OR OTHER EQUITY INTERESTS IN A BUSINESS ASSOCIATION, INCLUDING CASH DISTRIBUTIONS OF A DEMUTUALIZED INSURANCE COMPANY.* Amends GS 116B-53(c) as follows: Provides that stock or other equity interest in business association is abandoned and escheated three rather than five years after the earlier of date that cash dividend was unclaimed or date of second consecutive communication from the holder to the apparent owner is returned unclaimed or undeliverable. Specifies how to determine date of demutualization for purposes of distributions of demutualized insurance company. Provides that debts of business associations, including debt evidence by a matured or called bearer bond or original issue discount bond, are deemed abandoned three rather than five years after the date of an interest or principal payment unclaimed by the apparent owner. Effective October 1, 2005.

Intro. by Holliman.

Ref. to Insurance GS 116B

MINUTES
HOUSE COMMITTEE ON INSURANCE
May 5, 2005

The House Committee on Insurance met at 9:00 AM on Thursday, May 5, 2005 in Room 1228. The following Representatives attended, Chairman Hugh Holliman, Vice Chairs Bill Faison, Ed Jones, Ed Nye and Mitchell Setzer. Members: Lucy Allen, William Current, Julia Howard, Deborah Ross, Drew Saunders, Fred Steen and Ron Sutton.

Chairman Holliman called the meeting to order and welcomed the House Pages, Sgt-At-Arms and visitors to the meeting. Attachment I.

Rep. Setzer was asked to chair the meeting since Chairman Holliman is a sponsor of the bill being heard.

Rep. Setzer called on Rep. Verla Insko, bill co-sponsor to present HB 1535 - Establish NC Health Insurance Risk Pool. Rep. Insko explained this legislation creates NC high-risk pool as a non-profit entity, establishes a tax credit for insurers, and names a board of directors and administrator. Ben Popkin, Staff Attorney, was asked to explain the bill by sections. Attachment II. Rep. Holliman pointed out that 9,000-10,000 citizens would be eligible for the pool.

Rep. Saunders spoke in support of the bill and added he has questions about cost and appointments. Rep. Sutton asked where DOI stood on this issue. Frank Folger, Counsel with DOI reported that the department supported the bill with possible technical changes.

After much discussion from the committee, Terri Pritchard, President of Senior Solutions of the Carolinas explained why there is a 12-month waiting period for people with pre-existing conditions.

No action was taken on HB 1535 and the meeting adjourned at 9:50 AM

Representative. L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **Thursday, May 5, 2005**

TIME: **11:00 AM**

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 1535 - Establish NC Health Insurance Risk Pool.
Representatives Holliman and Insko

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **4:30 PM on May 3, 2005**.

___Principal Clerk
___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

Carol Bowers (Rep. Holliman)

From: Carol Bowers (Rep. Holliman)
Sent: Wednesday, May 04, 2005 8:18 AM
Subject: TIME CHANGE 5-5-05 House Committee on Insurance meeting

PLEASE NOTE MEETING TIME CHANGE

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

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Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **4:30 PM on May 3, 2005**.

5/4/2005

HOUSE INSURANCE COMMITTEE

May 5, 2005
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

HB 1535 - Establish NC Health Insurance Risk Pool.
Representatives Holliman and Insko

ATTACHMENT I

HOUSE COMMITTEE ON INSURANCE

May 5, 2005
11:00 AM
Room 1228 Legislative Building

Pages:

Name (please print clearly)	County	Representative
Ariel Butters	Wake	Rep. Russell Capps
Ashley Winders	Wayne	Rep. Louis Pate
Lonai Leach	Robeson	Rep. Pierce

Sergeant-At-Arms (please print)

JAY CALLAWAY

CHARLES WILLIAMS

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 5, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
ANN LORE	DOI
Roz Savitt	NCCR
John Bowdish	AstraZeneca
BRIAN SHANK	AstraZeneca
Lu Hodge	KCLH
Abby Emanuelson	NMSS
Elizabeth Page	NMSS
[illegible]	NMSS
Courtney A Crowder	NCDOI
FRANK Folger	NC DOI
Kathleen Edwards	UNC-CH Legis. Reporting Service

H

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 5, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Laura Holley	313 Springfork Dr. Cary 27513 League of Women Voters
JUDIE BURKE	League of Women Voters Orange / Durham / Chatham
David Reddick	NAMIC
Marlene Foster	NCAHP
Jenna Lewis	JDA, AL, PA
Scott Cogen	NMRS
K Wright	BCBS NC
Ed Daleno	AP
BILL HALE	ACLI
Barbara Carsley	BSCGA
Edith Davis	NC Reinsurance Facility

H

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 5, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amy Zepp	NCAHP
JEERI B. Pritchard	NCAHU
Jimmy Jo Horne	NCMS
Kevin Le Count	SEANC
Susan Valcarcel	Nationwide
Bill Rustin	ACP
Colleen Kochanek	Holt York McDarris & High
Bill Scoggin	KCLH
Patrice Roesler	NCACC
Al Ripley	NC Justice Ctr
Chad Hinton	Civitas Institute
	NCRB

ATTACHMENT II

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H 1

HOUSE BILL 1535

Short Title:	Establish NC Health Insurance Risk Pool.	(Public)
Sponsors:	Representatives Insko, Holliman (Primary Sponsors); B. Allen, Goodwin, and Harrison.	
Referred to:	Insurance.	

April 21, 2005

A BILL TO BE ENTITLED

AN ACT TO CREATE THE NORTH CAROLINA HEALTH INSURANCE RISK POOL TO MEET THE NEEDS OF INDIVIDUALS WHO CANNOT OBTAIN HEALTH INSURANCE BECAUSE OF HIGH-RISK HEALTH CONDITIONS AND UNAFFORDABLE PREMIUMS; AND TO PROVIDE A TAX CREDIT AGAINST THE GROSS PREMIUMS TAX FOR ASSESSMENTS PAID BY INSURERS TO THE NORTH CAROLINA HEALTH INSURANCE RISK POOL.

The General Assembly of North Carolina enacts:

SECTION 1. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 6. North Carolina Health Insurance Risk Pool.

"**§ 58-50-160. Definitions.**

For the purposes of this Part:

(1) "Administrator" means the Pool Administrator selected by the Board in accordance with this Part.

(2) "Benefit plan" means coverage offered by the Pool to eligible individuals.

(3) "Board" means the Board of Directors of the Pool.

(4) "Covered person" means any individual resident of this State, excluding dependents, who is eligible to receive health benefits from any insurer.

(5) "Church plan" has the meaning given that term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(6) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

a. A group health plan.

b. 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)).

A period of creditable coverage shall not be counted, with respect to the enrollment of an individual who seeks coverage under this Part, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

(7) "Dependent" means a resident spouse or unmarried child under the age of 19 years, a child who is a full-time student under the age of 23 years and who is financially dependent upon the parent, a child who is over 18 years of age and for whom a person may be obligated to pay child support, or a child of any age who is disabled and dependent upon the parent.

(8) "Family member" means a parent, grandparent, brother, sister, or child of a dependent residing with the insured.

(9) "Federally defined eligible individual" means an individual:

a. For whom, as of the date on which the individual seeks coverage under this Part, the aggregate of the periods of creditable coverage is 18 or more months;
b. Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with such a plan;
c. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (Medicare), or a State plan under Title XIX of the Act (Medicaid), or any successor program, and who does not have other health insurance coverage;
d. With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e. Who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected this coverage; and
f. Who has exhausted continuation coverage under this provision or program, if the individual elected the continuation coverage described in sub-subdivision e. of this subdivision.

(10) "Governmental plan" has the meaning given under section 3(32) of the Employee Retirement Income Security Act of 1974 and any governmental plan established or maintained for its employees by the government of the United States or by an agency or instrumentality of the government of the United States.

(11) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, including items and services paid for as medical care to employees or their dependents, as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(12) "Health insurance coverage" means any hospital and medical expense incurred policy, nonprofit health care services contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise.

"Health insurance coverage" does not include one or more, or any combination of, the following:

a. Coverage only for accident or disability income insurance, or any combination thereof.
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 issued pursuant to P.L. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
i. Limited-scope dental or vision benefits.
j. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.
k. Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act.
l. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services – CHAMPUS).
m. Similar supplemental coverage provided to coverage under a group health plan.

(13) "Insurance arrangement" means a plan, program, contract, or other arrangement through which health care services are provided by an

employer to its officers or employees, but does not include health care services covered through an insurer.

(14) "Insured" means an individual who is a resident of this State and a citizen of the United States, and who is eligible to receive benefits from the Pool. The term "insured" includes dependents and family members, as applicable.

(15) "Insurer" means any entity that provides health insurance coverage in this State. For the purposes of this Part, insurer includes an insurance company, a hospital or medical service corporation, a health maintenance organization, a multiple employer welfare arrangement, or any other nongovernmental entity providing a health benefit plan subject to State insurance regulation.

(16) "Medical care" means amounts paid for:

a. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

b. Transportation primarily for and essential to medical care referred to in sub-subdivision a. of this subdivision; and

c. Insurance covering medical care referred to in sub-subdivisions a. and b. of this subdivision.

(17) "Plan of operation" means the articles, bylaws, and operating rules and procedures adopted by the Board in accordance with this Part.

(18) "Pool" means the North Carolina Health Insurance Risk Pool.

(19) "Resident" means an individual who:

a. Has been legally domiciled in this State for a period of at least 30 days, except that for a federally defined eligible individual, there shall not be a 30-day requirement;

b. Is legally domiciled in this State on the date of application to the Pool and who is eligible for enrollment in the Pool as a result of the Health Insurance Portability and Accountability Act of 1996; or

c. Is legally domiciled in this State on the date of application to the Pool and is eligible for the credit for health insurance costs under section 35 of the Internal Revenue Code of 1986.

(20) "Significant break in coverage" means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

"**§ 58-50-165 Risk Pool established; board of directors; plan of operation.**

(a) High-Risk Pool Established. – There is hereby created a nonprofit entity to be known as the North Carolina Health Insurance Risk Pool. The Pool shall operate under the supervision and control of the Board of Directors of the Pool.

(b) Board of Directors Appointment; Membership. – The Board of Directors of the North Carolina Health Insurance Risk Pool shall consist of the Commissioner of

Insurance, who shall serve as an ex officio nonvoting member of the Board, and seven members appointed as follows:

(1) One member of the general public appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives. The appointee shall be an individual who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider. An individual whose only affiliation with health insurance or health care coverage is as a covered member may be appointed as a member of the general public.

(2) One member of the general public appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate. The appointee shall be an individual who can reasonably be expected to qualify for coverage in the Pool.

(3) Five members appointed by the Commissioner of Insurance, as follows:

a. Two who are insurers, at least one of whom covers the largest number of persons in the State.

b. One who is licensed to sell health insurance in this State.

c. One who represents the medical provider community, as recommended by the North Carolina Medical Society.

d. One who represents small business, as recommended by the North Carolina Citizens for Business and Industry.

Two representatives of the general public who are not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, and can reasonably be expected to qualify for coverage in the Pool. Representatives of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member.

(c) Board of Directors; Terms of Appointment; Vacancies; Compensation. – The initial Board members shall be appointed as follows: two of the members to serve a term of three years; three of the members to serve a term of one year; and two of the members to serve a term of two years. Subsequent Board members shall serve for terms of three years. A Board member's term shall continue until the member's successor is appointed. The Commissioner shall appoint a chair to serve for the initial two years of the Plan's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms. The Commission shall fill vacancies in membership and may remove members from the Board for cause. Board members shall not be compensated in their capacity as Board members but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties.

(d) Plan of Operation. – The Board shall submit to the Commissioner a Plan of Operation for the Pool and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Plan of Operation. The Plan of Operation shall become effective upon approval in writing by the Commissioner

consistent with the date on which the coverage under this Part must be made available. If the Board fails to submit a suitable Plan of Operation within 180 days after the appointment of the Board of Directors, or at any time thereafter fails to submit suitable amendments to the Plan of Operation, the Commissioner shall adopt temporary rules necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the Commissioner or superseded by a Plan of Operation submitted by the Board and approved by the Commissioner. The Plan of Operation shall:

(1) Establish procedures for operation of the Pool.

(2) Establish procedures for selecting a Pool administrator in accordance with G.S. 58-50-185.

(3) Establish procedures to create a fund for administrative expenses, which shall be managed by the Board.

(4) Establish procedures for the collection, handling, accounting, and auditing of assets, monies, and claims of the Pool and the Pool administrator.

(5) Develop and implement a program to publicize the existence of the Pool, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the Pool.

(6) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the Board. The grievances shall be reported to the Board after completion of the review. The Board shall retain all written complaints regarding the Pool for at least three years.

(7) Provide for other matters as may be necessary and proper for the execution of the Board's powers, duties, and obligations under this Part.

(h) The Pool shall have the general powers and authority granted under the laws of this State to health insurers and the specific authority to do all of the following:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Part, including the authority, with the approval of the Commissioner, to enter into contracts with similar plans of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions.

(2) Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the Pool.

(3) Take legal action as necessary to:

a. Avoid the payment of improper claims against the Pool or the coverage provided by or through the Plan.

b. Recover any amounts erroneously or improperly paid by the Plan.

c. Recover any amounts paid by the Pool as a result of mistake of fact or law.

d. Recover other amounts due the Pool.

(4) Establish rates and rate schedules in accordance with this Part.

(5) Issue policies of insurance in accordance with the requirements of this Part.

(6) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the Pool, policy, and other contract design, and any other function within the Pool's authority.

(7) Borrow money to effect the purposes of the Pool. Any notes or other evidence of indebtedness of the Pool not in default are legal investments for insurers and may be carried as admitted assets.

(8) Establish rules, conditions, and procedures for reinsuring risks of participating insurers desiring to issue Pool coverage in their own name. Provision of reinsurance shall not subject the Pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

(9) Employ and fix the compensation of employees.

(10) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public.

(11) Provide for reinsurance of risks incurred by the Pool.

(12) Issue additional types of health insurance policies to provide optional coverage, including Medicare supplemental insurance coverage.

(13) Provide for and employ cost containment measures and requirements including preadmission screening, second surgical opinion, concurrent utilization review, disease management, individual case management, and other commonly used benefit plan design features for the purpose of making health insurance coverage offered by the Pool more cost-effective.

(14) Design, utilize, contract, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

(15) Adopt bylaws, policies, and procedures as may be necessary or convenient for the implementation of this Part and the operation of the Pool.

(i) The Board shall operate the Pool in a manner so that the estimated cost of providing health insurance coverage during any fiscal year will not exceed the total income the Pool expects to receive from policy premiums and other revenue available to the Pool. The financing mechanisms recommended to and approved by the General Assembly shall provide for a means to adjust those mechanisms annually, or more frequently if necessary, in order to assure that the Pool has the financial capacity to insure the projected number of enrollees.

(j) The Board shall make an annual report to the Commissioner, to the Speaker of the House of Representatives, and to the President Pro Tempore of the Senate. The

report shall summarize the activities of the Pool in the preceding calendar year, including the net written and earned premiums, benefit plan enrollment, the expense of administration, and the paid and incurred losses.

(k) Neither the Board nor its employees are liable for any obligations of the Pool. No current or former member or employee of the Board is liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this Part, unless such act or omission constitutes willful or wanton misconduct. The Board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

"**§ 58-50-170. Administrator.**

(a) The Board shall select through a competitive bidding process one or more insurers or a third-party administrator to administer the Pool. The Board shall evaluate bids submitted based on criteria established by the Board. The criteria shall allow for the comparison of information about each bidding administrator and selection of a Pool Administrator based on at least the following:

(1) Proven ability to handle health insurance coverage to individuals.

(2) Efficiency and timeliness of the claim processing procedures.

(3) Estimated total charges for administering the Pool.

(4) Ability to apply effective cost containment programs and procedures and to administer the Pool in a cost-efficient manner.

(5) Financial condition and stability.

(b) The Administrator shall serve for a period specified in the contract between the Pool and the Administrator subject to removal for cause and subject to any terms, conditions, and limitations of the contract between the Pool and the Administrator. At least one year before the expiration of each period of service by an Administrator, the Board shall invite eligible entities, including the current Administrator, to submit bids to serve as the Administrator. Selection of the Administrator for the succeeding period shall be made at least six months before the end of the current period.

(c) The Administrator shall perform such functions relating to the Pool as may be assigned to it, including:

(1) Determination of eligibility.

(2) Payment of claims.

(3) Establishment of a premium billing procedure for collection of premiums from individuals covered under the Pool.

(4) Other necessary functions to assure timely payment of benefits to covered persons under the Pool.

(d) The Administrator shall submit regular reports to the Board regarding the operation of the Pool. The contract between the Board and the Administrator shall specify the frequency, content, and form of the report.

(e) Following the close of each calendar year, the Administrator shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the Board and the Commissioner on a form prescribed by the Commissioner.

(f) The Administrator shall be paid as provided in the contract between the Board and the Administrator.

"**§ 58-50-175. Risk Pool rates.**

(a) The Pool shall adopt and modify, as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of the Pool. Rates and rate schedules may be adjusted for appropriate factors such as age, sex, and geographic variation in claim cost and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices.

(b) The Pool shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques, and shall reflect anticipated experience and expenses for the coverage. Initial Pool rates may not be less than one hundred twenty-five percent (125%) and may not exceed one hundred fifty percent (150%) of rates established as applicable for individual standard rates. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in this subsection. In no event shall Pool rates exceed one hundred fifty percent (150%) of rates applicable to individual standard risks.

(c) The Pool shall submit all rates and rate schedules to the Commissioner for approval, and the Commissioner must approve the rates and rate schedules before the Pool may use them. The Commissioner, in evaluating the rates and rate schedules, shall consider the factors provided in this section.

"**§ 58-50-180. Eligibility for Pool coverage.**

(a) Any individual who is and continues to be a resident of this State is eligible for Pool coverage if evidence is provided of:

(1) A notice of rejection or refusal to issue substantially similar insurance for health reasons by two insurers. A rejection or refusal by an insurer offering only stop-loss, excess loss, or reinsurance coverage with respect to the applicant is not sufficient evidence of eligibility;

(2) Two offers to issue insurance only with conditional riders;

(3) A refusal by an insurer to issue insurance except at a rate exceeding the Pool rate;

(4) Diagnosis of the individual with one of the medical or health conditions listed by the Board in accordance with this section. An individual diagnosed with one or more of these conditions is eligible for Pool coverage without applying for other health insurance coverage;

(5) In the case of an individual who is eligible for coverage under the Health Insurance Portability and Accountability Act of 1996, the individual's maintenance of health insurance coverage, of which the most recent coverage was through an employer-sponsored plan, for the

previous 18 months with no gap in coverage greater than 63 days and exhaustion of any available COBRA or State continuation benefits; or

(6) An individual who is legally domiciled in this State and is eligible for the credit for health insurance costs under the Trade Adjustment Assistance Reform Act of 2002, section 35 of the Internal Revenue Code of 1986.

(b) The Board shall adopt a list of medical or health conditions for which a person shall be eligible for Pool coverage without applying for health insurance pursuant to subsection (a) of this section. Persons who can demonstrate the existence or history of any medical or health conditions on the list adopted by the Board shall not be required to provide the evidence specified in subsection (a) of this section. The Board may amend the list as the Board considers appropriate.

(c) Each dependent of an individual who is eligible for Pool coverage shall also be eligible for Pool coverage.

(d) An individual is not eligible for coverage under the Pool if:

(1) The individual has or obtains health insurance coverage substantially similar to or more comprehensive than a Pool policy, or would be eligible to have coverage if the person elected to obtain it; except that:

a. An individual may maintain other coverage for the period of time the individual is satisfying any preexisting condition waiting period under a Pool policy; and

b. An individual may maintain Pool coverage for the period of time the individual is satisfying a preexisting conditions waiting period under another health insurance policy intended to replace the Pool policy.

(2) The individual is determined to be eligible for enrollment in the State Medical Assistance Plan.

(3) The individual has previously terminated Pool coverage unless 12 months have lapsed since the termination, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual.

(4) The Pool has paid out the lifetime maximum benefits, which is one million dollars ($1,000,000) on behalf of the individual.

(5) The individual is an inmate or resident of a public institution, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual.

(6) The individual's premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider.

(7) The individual has in effect on the date Pool coverage takes effect health insurance coverage from an insurer or insurance arrangement.

(e) Coverage under the Pool shall cease:

(1) On the date an individual is no longer a resident of this State.
(2) On the date an individual requests coverage to end.
(3) Upon the death of the covered individual.
(4) On the date State law requires cancellation of the Pool policy.
(5) At the option of the Pool, 30 days after the Pool makes any inquiry concerning the individual's eligibility or residence to which the individual does not reply.

(f) Except as provided in subsection (e) of this section, an individual who ceases to meet the eligibility requirements of this section may be terminated at the end of the Pool period for which the necessary premiums have been paid.

"**§ 58-50-185. Unfair referral to Pool.**

It is an unfair trade practice under Article 63 of this Chapter for an insurer, insurance producer, as defined in G.S. 58-33-10(7), or third-party administrator to refer an individual employee to the Pool or arrange for an individual employee to apply to the Pool for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

"**§ 58-50-190. Minimum Pool benefits.**

(a) The Pool shall offer at least two types of health insurance coverage for individuals eligible under G.S. 58-50-175. The covered services and benefit levels may vary between the types of coverage, but at least two types of coverage must, at a minimum, cover the benefits and services outlined in the National Association of Insurance Commissioners' Model Health Pool for Uninsurable Individuals Act and consistent with comprehensive coverage generally available to persons who are eligible for health insurance other than Medicare.

(b) Subject to approval by the Commissioner, the Board shall establish the health insurance coverage issued by the Pool, including the coverage's schedule of benefits, exclusions, and other limitation of the coverage.

"**§ 58-50-195. Preexisting conditions.**

(a) Pool coverage shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage as to any condition for which medical advice, care, or treatment was recommended or received as to such conditions during the 12-month period immediately preceding the effective date of coverage, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual.

(b) Subject to subsection (a) of this section, the preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage that was involuntarily terminated; provided, that:

(1) Application for Pool coverage is made not later than 63 days following the involuntary termination, and in such case coverage in the Pool shall be effective from the date on which the prior coverage was terminated; and
(2) The applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to Pool coverage.

"**§ 58-50-200. Nonduplication of benefits.**

(a) The Pool shall be payor of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under coverage shall be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or no-fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any State or federal law or program.

(b) The Pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the Pool may be reduced or refused as a setoff against any amount recoverable under this subsection.

"**§ 58-50-205. Assessments.**

(a) For the purposes of providing the funds necessary to carry out the powers and duties of the Pool, the Board shall assess member insurers at such time and for such amounts as the Board finds necessary. Assessments shall be due in not less than 30 days after prior written notice to the member insurers and shall accrue interest at twelve percent (12%) per annum on and after the due date.

(b) Each insurer shall be assessed in an amount not to exceed two dollars ($2.00) per covered individual insured or reinsured by each insurer per month. The assessment will be based on actual and expected losses, actuarially appropriate reserves, and administrative expenses in excess of expected and collected premiums and federal loss reimbursements, if any, received by the Pool. There shall be no assessment on any insurer or policies or contracts insuring federal or State employees.

(c) The Board shall make reasonable efforts designed to ensure that each covered individual is counted only once with respect to any assessment. For that purpose, the Board shall require each insurer that obtains excess or stop-loss insurance to include in its count of covered individual all individuals whose coverage is insured (including by way of excess or stop-loss coverage) in whole or in part. The Board shall allow a reinsurer to exclude from its number of covered individuals those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop-loss insurer for the purposes of determining its assessment under this section.

(d) The Board may verify each insurer's assessment based on annual statements and other reports deemed to be necessary by the Board. The Board may use any reasonable method of estimating the number of covered individuals of an insurer if the specific number is unknown.

(e) If assessments and other receipts by the Pool, Board, or administering insurer exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the Board to offset future losses or to reduce plan premiums. Future losses include reserves for claims incurred but not reported.

(f) The Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any member insurer that fails to pay an assessment. As an alternative, the Commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture may not exceed

five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100.00) per month.

"**§ 58-50-210. Complaint procedures.**

An applicant or participant in coverage from the Pool is entitled to have complaints against the Pool reviewed by a grievance committee appointed by the Board. The grievance committee shall report to the Board after completion of the review of each complaint. The Board shall retain all written complaints regarding the Pool at least until the third anniversary of the date the Pool received the complaint. An applicant or participant may file for external review of the applicant's grievance after having exhausted the Pool's internal grievance procedure. External review shall be conducted in accordance with Part 4 of this Article.

"**§ 58-50-215. Audit.**

The State Auditor shall conduct annually a special audit of the Pool. The State Auditor's report shall include a financial audit and an economic and efficiency audit. The State Auditor shall report the cost of each audit conducted under this Part to the Board and the Comptroller, and the Board shall remit that amount to the Comptroller for deposit to the General Fund.

"**§ 58-50-220. Taxation.**

The Pool established under this Part is exempt from any and all taxes.

"**§ 58-50-225. Rules.**

The Commissioner may adopt rules, including temporary rules, to implement this Part.

"**§ 58-50-230. Collective action.**

The participation in the Pool as participating insurers, the establishment of rates, forms, or procedures, and any other joint or collective action required by this Part may not be the basis of any legal action or criminal or civil liability or penalty against the Pool or any participating insurer."

SECTION 2. The Board of Directors of the North Carolina Health Insurance Risk Pool, as appointed under Section 1 of this act, shall recommend a method or methods for financing the Pool that will provide a stable funding source and allow for its continued operation. In developing its recommendation for financing, the Board shall review coverage available under health insurance high-risk pools enacted in other states, the National Association of Insurance Commissioners' Model Health Pool for Uninsurable Individuals Act, including proposed amendments to that model act, and actuarial and other information necessary for the development and financing of a fair, reasonable, and equitable comprehensive health insurance benefit plan. No later than April 1, 2006, the Board shall submit a report of its findings and recommendations, including proposed legislative changes, to the Commissioner of Insurance and the General Assembly. The report shall include the following:

(1) The Board's recommended method or methods for financing the Pool and the rationale for the recommendation. In developing a recommendation for financing, the Board shall consider and choose one or more of the following:

a. Premium rates, coinsurance, deductibles, lifetime coverage, and other limitations that provide for a reasonable and affordable benefit plan.
b. Assessments of insurers and reinsurers in this State in a manner that fairly and reasonably spreads the cost of covering high-risk individuals.
c. Assessments on admissions to hospitals and other health care facilities in a manner that fairly and reasonably spreads the cost of covering high-risk individuals.
d. Methods of financing used in other states for high-risk pool coverage and the adequacy of those methods.

(2) Recommendations of supplementary sources of funding, such as funds obtained from public and private not-for-profit foundations, or other appropriate and available State or non-State funds.

(3) Information on all of the following:
a. The estimated number of individuals in this State who are uninsured as of a date certain because of high-risk conditions.
b. The estimated number of those individuals who would qualify for coverage under the Pool based on G.S. 58-50-175 and its Plan of Operation.
c. The cost of coverage under each of the health insurance plans developed by the Board, including administrative costs.
d. The effective date upon which Pool coverage can be offered based upon the recommended financing for the Plan.

SECTION 3. There is appropriated from the General Fund to the Department of Insurance the sum of two hundred thousand dollars ($200,000) for the 2005-2006 fiscal year. These funds shall be placed in a Special Reserve for the North Carolina Health Insurance Risk Pool in the Department of Insurance and shall be allocated for the reasonable expenses of the Board in conducting its duties under Section 2 of this act.

SECTION 4. G.S. 58-6-25(d) reads as rewritten:

"(d) Use of Proceeds. – The Insurance Regulatory Fund is created in the State treasury, under the control of the Office of State Budget and Management. The proceeds of the charge levied in this section and all fees collected under Articles 69 through 71 of this Chapter and under Articles 9 and 9C of Chapter 143 of the General Statutes shall be credited to the 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 may be spent only pursuant to appropriation by the General Assembly and in accordance with the line item budget enacted by the General Assembly. The Fund is subject to the provisions of the Executive Budget Act, except that no unexpended surplus of the Fund shall revert to the General Fund. All money credited to the Fund shall be used to reimburse the General Fund for the following:

(1) Money appropriated to the Department of Insurance to pay its expenses incurred in regulating the insurance industry and other industries in this State.

(2) Money appropriated to State agencies to pay the expenses incurred in regulating the insurance industry, in certifying statewide data processors under Article 11A of Chapter 131E of the General Statutes, and in purchasing reports of patient data from statewide data processors certified under that Article.

(3) Money appropriated to the Department of Revenue to pay the expenses incurred in collecting and administering the taxes on insurance companies levied in Article 8B of Chapter 105 of the General Statutes.

(4) Money appropriated for the office of Managed Care Patient Assistance Program established under G.S. 143-730 to pay the actual costs of administering the program.

(5) Money appropriated to the Department of Insurance for the implementation and administration of independent external review procedures required by Part 4 of Article 50 of this Chapter.

(6) Money appropriated to the Department of Insurance for the Special Reserve for the North Carolina Health Insurance Risk Pool."

SECTION 5.(a) Article 8B of Chapter 105 of the General Statutes is amended by adding a new section to read:

"**§ 105-228.5B. Credit against gross premium tax for assessments paid to the North Carolina Health Insurance Risk Pool.**

(a) The following definitions apply in this section:

(1) Assessment. – An assessment as described in G.S. 58-50-205.

(2) Member insurer. – An insurer as defined in G.S. 58-50-160.

(3) Pool. – The North Carolina Health Insurance Risk Pool as established under Part 6 of Article 50 of Chapter 58 of the General Statutes.

(b) Credit. – A member insurer who pays an assessment is allowed as a credit against the tax imposed under G.S. 105-228.5 an amount equal to twenty percent (20%) of the amount of the assessment in each of the five taxable years following the year in which the assessment was paid. In the event a member insurer ceases doing business, all assessments for which it has not taken a credit under this section may be credited against its premium tax liability for the year in which it ceases doing business. The amount of the credit allowed by this section may not exceed the member insurer's premium tax liability for the taxable year."

SECTION 5.(b) This section is effective for taxable years beginning on or after January 1, 2005.

SECTION 6. The North Carolina Health Insurance Risk Pool shall not offer or provide coverage under Section 1 of this act until the effective date of an act of the General Assembly that establishes a method or methods for financing the Pool as specified in Section 2 of this act.

SECTION 7. This act is effective when it becomes law.

E

HOUSE BILL 1535:
Establish NC Health Insurance Risk Pool

BILL ANALYSIS

Committee:	House Insurance	**Date:**	April 27, 2005
Introduced by:	Reps. Insko, Holliman	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: House Bill 1535 would enact a new Part of Article 50 of Chapter 58 of the General Statues. Part 6 of Article 50 would establish the North Carolina Health Insurance Risk Pool, a nonprofit entity intended to meet the needs of individuals who cannot obtain health insurance because of high-risk health conditions and exorbitant premiums. The bill would also provide a tax credit to insurers paying assessments to the North Carolina Health Insurance Risk Pool.

BILL ANALYSIS: Part 6 of Article 50 of Chapter 58 of the General Statutes would create the North Carolina Health Insurance Risk Pool. The Pool would be a nonprofit entity subject to oversight of the Board of Directors of the Pool and administered by one or more insurers or a third-party administrator selected by the Board through a competitive bidding process. The Pool would operate according to a Plan of Operation developed by the Board and approved by the Commissioner of Insurance.

House Bill 1535 addresses the following areas relating to the creation and operation of the Pool:

Plan of Operation for the Pool. Specifies the content of the Board of Directors' Plan of Operation for the Pool and generally authorizes the Pool to perform all functions necessary to establish and administer the Pool. Requires that the Board submit a Plan of Operation for the Commissioner's approval. Also requires that Board submit an annual report to the Commissioner, to the Speaker of the House of Representatives, and to the President Pro Tempore of the Senate regarding earned premiums, plan enrollment, administrative expenses, and losses.

Eligibility for Pool coverage. G.S. 58-50-180 would provide that individuals be eligible for Pool coverage if evidence is provided of: (1) a notice of rejection from two insurers to provide substantially similar health insurance because of individual's health; (2) two offers to issue insurance only with conditional riders; (3) a refusal to issue insurance except at a rate exceeding the Pool rate; (4) individual's diagnosis of one of the medical or health conditions listed by the Board in accordance with this section; (5) individual's maintenance of health insurance coverage under federal criteria without a significant break in coverage and the exhaustion of COBRA or state continuation benefits; or (6) individual's legal domicile in State and eligiblity for health insurance costs under the Trade Adjustment Assistance Reform Act of 2002.

G.S. 58-50-180 would further provide that individuals be ineligible for Pool coverage if: (1) they have health insurance coverage substantially similar to that offered by Pool (with the exception of coverage during preexisting condition waiting period); (2) they are eligible for State Medical Assistance; (3) they have terminated Pool coverage within the past 12 months or have reached the lifetime maximum benefit ceiling of one million dollars; (4) they are an inmate or resident of a public institution or have their premiums paid by a government-sponsored program or government agency or health care provider; or (5) the individual has health insurance coverage from an insurer or insurance arrangement on the date Pool coverage takes effect.

Pool Rates/Exclusions. G.S. 58-50-170 would require that the Board select a Pool administrator through a competitive bidding process applying criteria set forth in statute and otherwise established by the Board. G.S. 58-50-175 would require that the Pool establish risk rates of at least 125% and not more than 150% of rates established by other health insurers as applicable for individual standard risks. G.S. 58-50-190 would provide that the Pool offer at least two types of coverage, both of which must provide benefits outlined in the National Association of Insurance Commissioners' Model Health Plan for Uninsurable Individuals Act and that would be consistent with comprehensive health insurance coverage generally available. G.S. 58-50-195 would provide that during the first 12 months of coverage, the Pool will not cover health conditions existing within 12 months prior to coverage (except for federally defined eligible individuals). Would allow for a waiver of exclusion where similar exclusions have been satisfied under another health insurance plan, and coverage lapsed for no more than 63 days and the applicant was ineligible for substantially similar continuation insurance. The Pool would be exempt from taxation.

Pool Financing/Complaint Procedures/Miscellaneous Provisions. G.S. 58-50-205 would require that the Board assess member insurers in the amount deemed necessary to fulfill the Board's duties. It would provide that each insurer's assessment would not exceed $2 per covered individual insured or reinsured by the insurer per month. It would appropriate $200,000 from the General Fund to the Department of Insurance for 2005-06 to cover Board expenses. It would establish a procedure for submission of complaints against the Board. It would require that the State Auditor conduct an annual special audit of the Pool. It would enact a new section, G.S. 105-228.5B, to provide insurers a gross premium tax credit in an amount equal to 20% of assessments paid by member insurer in each of the five taxable years following the year in which the assessment was paid, effective for tax years beginning January 1, 2005.

EFFECTIVE DATE: The bill would be effective when it becomes law.

BACKGROUND: The House Select Committee on the Rising Cost of Health Care reported in its 2004 report to the North Carolina House of Representatives that a crisis exists in the availability and affordability of adequate health insurance coverage for individuals and for small business and their employees in this State. The Committee recommended authorizing a study of the feasibility of establishing high-risk health insurance pools to enable individuals who have been denied health insurance coverage due to high-risk or preexisting health condition to purchase coverage at an affordable premium.

Currently, 31 states have established or are establishing high-risk health insurance pools. The Federal Trade Act of 2002 provided for a federal grant of up to $1,000, 000 to each state establishing new pools. This seed money went to the costs of creating the pool, not the actual financing of it. The act also provided for a matching federal grant of up to 50% of the losses incurred by a state in connection with the operation of the pool. $40,000,000 was appropriated for each fiscal year 2003 and 2004. In 2003, Congress passed legislation extending and providing addition federal funding through 2009.

H1535e1-SMSS

MINUTES
HOUSE COMMITTEE ON INSURANCE
May 10, 2005

The House Committee on Insurance met at 11:00 AM on Tuesday, May 10, 2005 in Room 1228. The following Representatives attended, Chairman Hugh Holliman, Vice Chairs Bill Faison, Ed Jones, and Mitchell Setzer. Members: Carey Allred, David Almond, Jeff Barnhart, Harold Brubaker, William Current, Julia Howard, Deborah Ross, Drew Saunders, and Ron Sutton.

Chairman Holliman called the meeting to order and welcomed the House Pages, Sgt-At-Arms and visitors to the meeting. Attachment I. Rep. Holliman reported that HB 1236 had been removed from the agenda temporally and announced a sub-committee had been formed to further discuss HB 1535 - Establish NC Health Insurance Risk Pool. Attachment II.
Rep. Setzer was asked to chair the meeting since Chairman Holliman is the sponsor of the bills being heard.

Rep. Setzer asked for a motion to accept the PCS for HB 645 - Amend Warranty/Service Agreement Co. Laws. -AB , for purposes of discussion. The motion carried. Frank Folger, Counsel with DOI was asked to explain the changes from the original bill. Mr. Folger sited the changes that protect the consumer and cleans up regulations. Rep. Ross motion for a favorable report to the PCS , unfavorable to the original bill and to re-refer the bill to Appropriations . Motion carried. See Attachments III.

Rep. Setzer asked for a motion to accept the PCS on HB 673 - Interstate Insurance Product Reg. Compact. -AB for purposes of discussion.
Motion carried . Mr. Folger with DOI explained that the Proposed Committee Substitute just changed the the citations from Article 90 to Article 91 throughout the bill . Rep. Saunders made a motion for a favorable report to the Proposed Committee Substitute, unfavorable to the original bill and motion passed unanimously. See Attachments IV.

The meeting adjourned at 11:35 AM

Representative. L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

CORRECTED NOTICE

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **Tuesday, May 10, 2005**

TIME: **11:00 AM**

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 645 - Amend Warranty/Service Agreement Co. Laws.-AB – Rep. Holliman

HB 673 - Interstate Insurance Product Reg. Compact.-AB – Rep. Holliman

HB 1236 - Insurance Bd. of Governors Membership. – Rep. Holliman

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **2:20 PM on May 9, 2005**.

___Principal Clerk
___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **Tuesday, May 10, 2005**

TIME: **11:00 AM**

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 645 - Amend Warranty/Service Agreement Co. Laws.-AB – Rep. Holliman

HB 656 -Workers' Comp/Self-Insured Guaranty Assoc.-AB – Rep. Holliman

HB 657 - Producer Comp. Transparency and Broker Duty.-AB- Rep. Holliman

HB 673 - Interstate Insurance Product Reg. Compact.-AB – Rep. Holliman

HB 1236 - Insurance Bd. of Governors Membership. – Rep. Holliman

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **11:10 AM on May 4, 2005**.

___Principal Clerk
___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

HOUSE INSURANCE COMMITTEE

May 10, 2005
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

HB 645 - Amend Warranty/Service Agreement Co. Laws.-AB – Rep. Holliman

HB 673 - Interstate Insurance Product Reg. Compact.-AB – Rep. Holliman

HB 1236 - Insurance Bd. of Governors Membership. – Rep. Holliman

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Holliman (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for
HB 645 A BILL TO BE ENTITLED AN ACT TO CLARIFY THAT MOTOR VEHICLE AND HOME APPLIANCE SERVICE AGREEMENT COMPANIES MUST FILE ALL SERVICE AGREEMENTS AND CONTRACTUAL LIABILITY POLICIES WITH THE COMMISSIONER, AND IF SUBMITTED ON PAPER, BE IN A SPECIFIED FORMAT; AUTHORIZE THE COMMISSIONER TO PROTECT CONSUMERS OF WARRANTY AND SERVICE AGREEMENTS UNDER JURISDICTION OF THE DEPARTMENT BY CEASE AND DESIST POWERS AND BY THE POWER TO EXAMINE AND SEIZE WARRANTY AND SERVICE AGREEMENT COMPANY VIOLATOR'S RECORDS; AND REORGANIZE AND ADD CLARIFYING DEFINITIONS REGARDING MECHANICAL SERVICE BREAKDOWN AGREEMENTS.

which changes the title

☒ With a favorable report as to the committee substitute bill, unfavorable as to the original bill, and recommendation that the committee substitute bill # be re-referred to the Committee on APPROPRIATIONS.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Holliman (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for
HB 673 A BILL TO BE ENTITLED AN ACT TO ESTABLISH NORTH CAROLINA AS A MEMBER OF THE INTERSTATE INSURANCE PRODUCT REGULATION COMPACT, TO REQUIRE THE COMMISSIONER OF INSURANCE TO REPORT WHETHER CONTINUED PARTICIPATION BY THIS STATE IN THE COMPACT IS IN THE BEST INTEREST OF THE CITIZENS AND POLICYHOLDERS OF THIS STATE, AND TO PROVIDE A SUNSET FOR PARTICIPATION IN THE COMPACT.

☒ With a favorable report as to the committee substitute bill, unfavorable as to the original bill.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

ATTACHMENT 1

HOUSE COMMITTEE ON INSURANCE

May 10, 2005
11:00 AM
Room 1228 Legislative Building

Pages:

Name (please print clearly)	County	Representative
Jessica Whelthe	Johnston	Langdon
Danielle Glaser	Wake	Cole

Sergeant-At-Arms (please print)

Martha Gadison

Charles Williams

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 10, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Susan Valauri	Nationwide
FRANK W. FOGLER	NCDOT
Robert Parham	Young, Moore
David Stoller	State Farm
Abby Emanuelson	NMSS
Curt Leonard	A.C.L.I 2668 Remington Green Ln. Tallahassee, FL 32308
Bill Haze	ACLI
Courtney Crowder	NCDOI
Joe Stewart	IFNC
Chad Essick	Poyner & Spruill, LLP
Glenn Morgan	GMAC Insurance

(1)

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 10, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John McHugh	Gov office
Bill Scoggin	KCCH
Bob Bird	I/ANC
Tray Farmer	AIA
Edith Davis	NC Reinsurance Facility
David Reddick	NAMIC
Kathleen Edwards	UNC-CH Legis. Reporting Service
	NMRS
Barbara Cansler	
Bill Rustin	ACLI
	BP
MR. KEN Melton	REVENUE MAN
Andy Ellen	NCAMP

E1

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 10, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kevin Leonard	DCSR
Ken Wright	BCBSNC

ATTACHMENT II

Carol Bowers (Rep. Holliman)

Subject: FW: Sub-Committee for HB 1535 - Establish NC Health Insurance Risk Pool

> Subject: Sub-Committee for HB 1535 - Establish NC Health Insurance Risk Pool
>
>
> A sub-committee has been establish to further study and discuss HB 1535.
> A meeting has been scheduled for Wednesday, May 11, 2005 at 8:00 AM in Room 1425 of the Legislative Building.
>
>
> Sub-Committee members are as follows: Rep. M. Setzer, Chairman
> Rep. D. Saunders
> Rep. J. Howard
> Rep. B. Current
> Rep. L. Allen
> Rep. H. Holliman
>
> Please advise to this e-mail of your attendance.
>
> Thank you
>
>
>
> Carol Bowers, Legislative Assistant
> Office of Representative L. Hugh Holliman
> 81st House District
> 919-715-0873
> hollimanla@ncleg.net
>
>

ATTACHMENT III

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H D

HOUSE BILL 645
PROPOSED COMMITTEE SUBSTITUTE H645-CSRC-40 [v.2]

5/9/2005 6:24:42 PM

Short Title: Amend Warranty/Service Agmt Laws/Study.-AB (Public)

Sponsors:

Referred to:

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THAT INSURANCE MAINTAINED BY WARRANTY COMPANIES AND MOTOR VEHICLE AND HOME APPLIANCE SERVICE AGREEMENT COMPANIES MUST BE PROVIDED BY EITHER A LICENSED INSURER OR AN ELIGIBLE SURPLUS LINES INSURER, TO AUTHORIZE A STUDY, AND TO APPROPRIATE FUNDS.

The General Assembly of North Carolina enacts:

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

"(a) Each company or person subject to this section shall maintain contractual liability insurance or service agreement reimbursement insurance with ~~an authorized insurer~~ either an insurer, as defined in G.S 58-3-165(a)(6), or an eligible surplus lines insurer, as defined in G.S. 58-21-10(3), for one hundred percent (100%) of claims exposure, including reported and incurred but not reported claims and claims expenses, on business written in this State unless the company or person:

(1) Maintains an audited net worth of one hundred million dollars ($100,000,000);

(2) Has offered service agreement contracts or warranties, as applicable to the respective company, its parent company, or person, for at least the preceding 10 years; and

(3) Either is required to file and has filed an SEC Form 10K or Form 20-F with the Securities and Exchange Commission (SEC) within the last calendar year or, if the company does not file with the SEC, can produce, upon request, a copy of the company's audited financial statements, which show a net worth of the company or person of at least one hundred million dollars ($100,000,000). A company or person may utilize its parent company's Form 10-K, Form 20-F, or audited financial statements to satisfy this requirement if the parent company agrees to guarantee the obligations of the company or person

relating to service agreement contracts or warranties, as applicable to the respective company or person, sold by the company or person in this State."

SECTION 2. The Department of Insurance shall study the issue of the appropriate and effective regulation of warranties and service agreements. The study shall include consideration of:

(i) The need for the regulation of motor vehicle protection product warranty agreements and of persons who are contractually obligated to warranty holders under those agreements.

(ii) The most effective means of providing meaningful regulatory oversight of warranty and service agreements and the entities that issue the agreements.

(iii) Any other issue related to warranty and service agreement companies deemed appropriate by the Department.

The Department shall report its findings, including any legislative recommendations, to the 2006 Regular Session of the 2005 General Assembly.

SECTION 3. There is appropriated from the General Fund to the Department of Insurance the sum of fifty thousand dollars ($50,000) for the 2005-2006 fiscal year to carry out the provisions of this act.

SECTION 4. Section 1 of this act becomes effective January 1, 2006. Sections 2 and 3 of this act become effective July 1, 2005. The remainder of this act is effective when it becomes law.

HOUSE BILL 645:
Amend Warranty/Service Agmt Laws/Study. - AB

BILL ANALYSIS

Committee:	House Insurance	**Date:**	May 10, 2005
Introduced by:	Rep. Holliman	**Summary by:**	Kory Goldsmith Committee Counsel
Version:	PCS to First Edition H645-CSRC-40		

SUMMARY: ***House Bill 645 would require companies that provide service agreement contracts on motor vehicles, home appliances, and warranty agreements for fixtures to real property to maintain contractual liability insurance or service agreement reimbursement insurance for up to 100% of claims exposure with an insurer licensed to write property or casualty insurance in North Carolina or an eligible surplus lines insurer. This requirement would not apply if the company showed an audited net worth of $100 Million dollars, had offered contracts or warranties for at least 10 years, or was required to file an SEC Form 10K in the last year.***

The PCS also authorizes a study by the Department of Insurance on the issue of the regulation of warranties and service agreements.

CURRENT LAW: G.S. 58-1-36(a) requires companies and persons who provide service agreement contracts on motor vehicles, home appliances, and warranty agreements for fixtures to real property to maintain a contractual liability insurance or service agreement reimbursement insurance with an "authorized insurer", unless the company can demonstrate its ability to pay 100% of its claims expose by other means specified in the statutes. These means are: the company showed an audited net worth of $100 Million dollars, had offered contracts or warranties for at least 10 years, or was required to file an SEC Form 10K in the last year.

BILL ANALYSIS:

Section 1 of the bill amends G.S. 58-1-36(a) by specifying what type of insurer may provide contractual liability insurance or service agreement reimbursement insurance for a company that provides service agreement contracts on motor vehicles, home appliances, and warranty agreements for fixtures to real property. These include any person authorized to write property or casualty insurance in this State, or a surplus lines carrier that meets the financial requirements of G.S. 58-21-20. These requirements would not apply if the company showed an audited net worth of $100 Million dollars, had offered contracts or warranties for at least 10 years, or was required to file an SEC Form 10K in the last year.

Section 2 directs the Department of Insurance to study the issue of the appropriate and effective regulation of warranties and service agreements. The study must include consideration of the need for regulation of motor vehicle protection product warranty agreements and the most effective means of providing meaningful regulator oversight. The Department would be required to report its findings and any legislative recommendations to the 2006 Session of the 2005 General Assembly.

Section 3 would appropriate $50,000 from the General Fund to the Department to implement the provisions of the act.

EFFECTIVE DATE: The changes to G.S. 58-1-36 would become effective January 1, 2006. Sections 2 and 3 would become effective July 1, 2005. The remainder of the act would become effective when the bill becomes law.

H0645e1-SMRC-CSRC-40

ATTACHMENT IX

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H D

HOUSE BILL 673*
PROPOSED COMMITTEE SUBSTITUTE H673-CSRC-41 [v.1]

5/9/2005 5:25:54 PM

Short Title: Interstate Insurance Product Reg. Compact.-AB (Public)

Sponsors:

Referred to:

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH NORTH CAROLINA AS A MEMBER OF THE INTERSTATE INSURANCE PRODUCT REGULATION COMPACT, TO REQUIRE THE COMMISSIONER OF INSURANCE TO REPORT WHETHER CONTINUED PARTICIPATION BY THIS STATE IN THE COMPACT IS IN THE BEST INTEREST OF THE CITIZENS AND POLICYHOLDERS OF THIS STATE, AND TO PROVIDE A SUNSET FOR PARTICIPATION IN THE COMPACT.

The General Assembly of North Carolina enacts:

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

"Article 91.

"Interstate Insurance Product Regulation Compact Act.

"**§ 58-91-1. Preamble.**

The Interstate Insurance Product Regulation Compact Act is intended to help states join together to establish an interstate compact to regulate designated insurance products.

Pursuant to terms and conditions of this Article, this State seeks to join with other states and establish the Interstate Insurance Product Regulation Compact and thus become a member of the Interstate Insurance Product Regulation Commission. The Commissioner of Insurance, or the Commissioner's designee, is hereby designated to serve as the representative of this State to the Commission.

"**§ 58-91-5. Purposes.**

The purposes of this Compact are, through means of joint and cooperative action among the compacting states:

(1) To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income, and long-term care insurance products.

(2) To develop uniform standards for insurance products covered under the Compact.
(3) To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the Compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more compacting states.
(4) To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard.
(5) To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the Compact.
(6) To create the Interstate Insurance Product Regulation Commission.
(7) To perform these and any other related function as may be consistent with the state regulation of the business of insurance.

"**§ 58-91-10. Definitions.**

For purposes of this Article and the Compact:

(1) "Advertisement" means any material designed to create public interest in a product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace, or retain a policy, as more specifically defined in the Rules and Operating Procedures of the Commission.
(2) "Bylaws" means those bylaws established by the Commission for its governance, or for directing or controlling the Commission's actions or conduct.
(3) "Compacting state" means any state which has enacted this Compact legislation and which has not withdrawn or been terminated pursuant to G.S. 58-91-70.
(4) "Commission" means the "Interstate Insurance Product Regulation Commission" established by this Compact.
(5) "Commissioner" means the chief insurance regulatory official of a state, including a commissioner, superintendent, director, or administrator.
(6) "Domiciliary state" means the state in which an insurer is incorporated or organized; or, in the case of an foreign insurer, its state of entry.
(7) "Insurer" means any entity licensed by a state to issue contracts of insurance for any of the lines of insurance covered by this Article.
(8) "Member" means the person chosen by a compacting state as its representative to the Commission, or that person's designee.
(9) "Noncompacting state" means any state which is not at the time a compacting state.
(10) "Operating procedures" means procedures promulgated by the Commission implementing a rule, uniform standard, or a provision of this Compact.

(11) "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income, or long-term care insurance product that an Insurer is authorized to issue.

(12) "Rule" means a statement of general or particular applicability and future effect promulgated by the Commission, including a uniform standard developed pursuant to G.S. 58-91-35, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the Commission, which shall have the force and effect of law in the compacting states.

(13) "State" means any state, district, or territory of the United States of America.

(14) "Third-party filer" means an entity that submits a product filing to the Commission on behalf of an insurer.

(15) "Uniform standard" means a standard adopted by the Commission for a product line, pursuant to G.S. 58-91-35, and shall include all of the product requirements in aggregate. Each uniform standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading, or ambiguous provisions in a product, and the form of the product made available to the public shall not be unfair, inequitable or against public policy as determined by the Commission.

"**§ 58-91-15. Establishment of the Commission and venue.**

(a) The compacting states hereby create and establish a joint public agency known as the "Interstate Insurance Product Regulation Commission." Pursuant to G.S. 58-91-20, the Commission shall have the power to develop uniform standards for product lines, receive, and provide prompt review of products filed with the Commission, and give approval to those product filings satisfying applicable uniform standards. It is not intended for the Commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any insurer from filing its product in any state wherein the insurer is licensed to conduct the business of insurance; and that filing shall be subject to the laws of the state where filed.

(b) The Commission is a body corporate and politic and an instrumentality of the compacting states.

(c) The Commission is solely responsible for its liabilities except as otherwise specifically provided in this Compact.

(d) Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located.

"**§ 58-91-20. Powers of the Commission.**

The Commission shall have the following powers:

(1) To promulgate rules, pursuant to G.S. 58-91-35, which shall have the force and effect of law and shall be binding in the compacting states to the extent and in the manner provided in this Compact.

(2) To exercise its rule-making authority and establish reasonable uniform standards for products covered under the Compact, and advertisement related thereto, which shall have the force and effect of law and shall be binding in the compacting states, but only for those products filed with the Commission. Notwithstanding this subdivision, a compacting state shall have the right to opt out of a uniform standard pursuant to G.S. 58-91-35, to the extent and in the manner provided in this Compact, and any uniform standard established by the Commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The Commission shall consider whether any subsequent amendments to the NAIC Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the NAIC require amending of the uniform standards established by the Commission for long-term care insurance products.

(3) To receive and review in an expeditious manner products filed with the Commission, and rate filings for disability income and long-term care insurance products, and give approval of those products and rate filings that satisfy the applicable uniform standard, where the approval shall have the force and effect of law and be binding on the compacting states to the extent and in the manner provided in the Compact.

(4) To receive and review in an expeditious manner advertisement relating to long-term care insurance products for which uniform standards have been adopted by the Commission and give approval to all advertisement that satisfies the applicable uniform standard. For any product covered under this Compact, other than long-term care insurance products, the Commission shall have the authority to require an insurer to submit all or any part of its advertisement with respect to that product for review or approval prior to use, if the Commission determines that the nature of the product is such that an advertisement of the product could have the capacity or tendency to mislead the public. The actions of the Commission as provided in this section shall have the force and effect of law and shall be binding in the compacting states to the extent and in the manner provided in the Compact.

(5) To exercise its rule-making authority and designate products and advertisement that may be subject to a self-certification process without the need for prior approval by the Commission.

(6) To promulgate operating procedures pursuant to G.S. 58-91-35 which shall be binding in the compacting states to the extent and in the manner provided in this Compact.

(7) To bring and prosecute legal proceedings or actions in its name as the Commission except that the standing of any state insurance department to sue or be sued under applicable law shall not be affected.

(8) To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence.

(9) To establish and maintain offices.

(10) To purchase and maintain insurance and bonds.

(11) To borrow, accept, and contract for services of personnel, including employees of a compacting state.

(12) To hire employees, professionals, or specialists, and elect or appoint officers, and to fix their compensation, define their duties, and give them appropriate authority to carry out the purposes of the Compact, and determine their qualifications; and to establish the Commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation, and qualifications of personnel.

(13) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services, and to receive, utilize, and dispose of the same. At all times the Commission shall strive to avoid any appearance of impropriety.

(14) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use, any property, real, personal, or mixed. At all times the Commission shall strive to avoid any appearance of impropriety.

(15) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed.

(16) To remit filing fees to compacting states as may be set forth in the bylaws, rules, or operating procedures.

(17) To enforce compliance by compacting states with rules, uniform standards, operating procedures, and bylaws.

(18) To provide for dispute resolution among compacting states.

(19) To advise compacting states on issues relating to insurers domiciled or doing business in noncompacting jurisdictions, consistent with the purposes of this Compact.

(20) To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments.

(21) To establish a budget and make expenditures.

(22) To borrow money.

(23) To appoint committees, including advisory committees comprising members, state insurance regulators, state legislators or their

representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the bylaws.

(24) To provide and receive information from, and to cooperate with, law enforcement agencies.

(25) To adopt and use a corporate seal.

(26) To perform any other functions that may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of the business of insurance.

"**§ 58-91-25. Organization of the Commission.**

(a) Membership, Voting, and Bylaws. – Each compacting state shall have and be limited to one member. Each member shall be qualified to serve in that capacity pursuant to applicable law of the compacting state. Any member may be removed or suspended from office as provided by the law of the state from which the member shall be appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the compacting state wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a compacting state determines the election or appointment and qualification of its own Commissioner.

Each member shall be entitled to one vote and shall have an opportunity to participate in the governance of the Commission in accordance with the bylaws. Notwithstanding any provision herein to the contrary, no action of the Commission with respect to the promulgation of a uniform standard shall be effective unless two-thirds of the members vote in favor of the uniform standard.

The Commission shall, by a majority of the members, prescribe bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the Compact, including:

(1) Establishing the fiscal year of the Commission.

(2) Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the Management Committee.

(3) Providing reasonable standards and procedures: (i) for the establishment and meetings of other committees, and (ii) governing any general or specific delegation of any authority or function of the Commission.

(4) Providing reasonable procedures for calling and conducting meetings of the Commission that consist of a majority of Commission members, ensuring reasonable advance notice of each meeting and providing for the right of citizens to attend each meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The Commission may meet in camera only after a majority of the entire membership votes to close a meeting in toto or in part. As soon as practicable, the Commission must make public (i) a copy of the vote to close the meeting revealing the vote of each member with no proxy votes allowed, and (ii) votes taken during the meeting.

(5) Establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the Commission.

(6) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any compacting state, the bylaws shall exclusively govern the personnel policies and programs of the Commission.

(7) Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees.

(8) Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment or reserving of all of its debts and obligations.

The Commission shall publish its bylaws in a convenient form and file a copy of the bylaws and a copy of any amendment to the bylaws with the appropriate agency or officer in each of the compacting states.

(b) Management Committee, Officers and Personnel. – A Management Committee comprising no more than 14 members shall be established as follows:

(1) One member from each of the six compacting states with the largest premium volume for individual and group annuities, life, disability income, and long-term care insurance products, determined from the records of the NAIC for the prior year.

(2) Four members from those compacting states with at least two percent (2%) of the market based on the premium volume described above, other than the six compacting states with the largest premium volume, selected on a rotating basis as provided in the bylaws.

(3) Four members from those compacting states with less than two percent (2%) of the market, based on the premium volume described above, with one selected from each of the four zone regions of the NAIC as provided in the bylaws.

(b1) The Management Committee shall have such authority and duties as may be set forth in the bylaws, including but not limited to:

(1) Managing the affairs of the Commission in a manner consistent with the bylaws and purposes of the Commission.

(2) Establishing and overseeing an organizational structure within, and appropriate procedures for, the Commission to provide for the creation of uniform standards and other rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a compacting state to opt out of a uniform standard, except that that a uniform standard shall not be submitted to the compacting states for adoption unless approved by two-thirds of the members of the Management Committee.

(3) Overseeing the offices of the Commission.

(4) Planning, implementing, and coordinating communications and activities with other state, federal, and local government organizations in order to advance the goals of the Commission.

The Commission shall elect annually officers from the Management Committee, with each having the authority and duties specified in the bylaws.

The Management Committee may, subject to the approval of the Commission, appoint or retain an executive director for a period of time, upon the terms and conditions, and for the compensation deemed appropriate by the Commission. The executive director shall serve as secretary to the Commission, but shall not be a member of the Commission. The executive director shall hire and supervise any other staff authorized by the Commission.

(c) Legislative and Advisory Committees. – A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the Commission, including the Management Committee. The manner of selection and term of any legislative committee member shall be as set forth in the bylaws. Prior to the adoption by the Commission of any uniform standard, revision to the bylaws, annual budget, or other significant matter as may be provided in the bylaws, the Management Committee shall consult with and report to the legislative committee.

The Commission shall establish two advisory committees, one of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

The Commission may establish additional advisory committees as its bylaws may provide for the carrying out of its functions.

(d) Corporate Records of the Commission. – The Commission shall maintain its corporate books and records in accordance with the bylaws.

(e) Qualified Immunity, Defense, and Indemnification. – The members, officers, executive director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities except that nothing in this subsection shall be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of that person.

The Commission shall defend any member, officer, executive director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities as long as the actual or alleged act, error, or omission did not result from that person's intentional or willful and wanton

misconduct. Nothing in this subsection shall be construed to prohibit that person from retaining his or her own counsel.

The Commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities as long as the actual or alleged act, error, or omission did not result from the intentional or willful and wanton misconduct of that person.

"**§ 58-91-30. Meetings; acts of the Commission.**

(a) The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the bylaws.

(b) Each member of the Commission shall have the right and power to cast a vote to which that compacting state is entitled and to participate in the business and affairs of the Commission. A member shall vote in person or by any means provided in the bylaws. The bylaws may provide for members' participation in meetings by telephone or other means of communication.

(c) The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

"**§ 58-91-35. Rules and operating procedures: rule-making functions of the Commission and opting out of uniform standards.**

(a) Rule-Making Authority. – The Commission shall promulgate reasonable rules, including uniform standards, and operating procedures in order to effectively and efficiently achieve the purposes of this Compact. Notwithstanding the foregoing, in the event the Commission exercises its rule-making authority in a manner that is beyond the scope of the purposes of this Article, or the powers granted in this Article, then that action by the Commission shall be invalid and have no force and effect.

(b) Rule-Making Procedure. – Rules and operating procedures shall be made pursuant to a rule-making process that conforms to the Model State Administrative Procedure Act of 1981 as amended, as may be appropriate to the operations of the Commission. Before the Commission adopts a uniform standard, the Commission shall give written notice to the relevant state legislative committee in each compacting state responsible for insurance issues of its intention to adopt the uniform standard. The Commission in adopting a uniform standard shall consider fully all submitted materials and issue a concise explanation of its decision.

(c) Effective Date and Opt Out of a Uniform Standard. – A uniform standard shall become effective 90 days after its promulgation by the Commission or such later date as the Commission may determine except that a compacting state may opt out of a uniform standard as provided in this Article. "Opt out" shall be defined as any action by a compacting state to decline to adopt or participate in a promulgated uniform standard. All other rules and operating procedures, and amendments to the rules and operating procedures, shall become effective as of the date specified in each rule, operating procedure, or amendment.

(d) Opt Out Procedure. – A compacting state may opt out of a uniform standard, either by legislation or regulation duly promulgated by the insurance department under the compacting state's administrative procedure act. If a compacting state elects to opt out of a uniform standard by regulation, it must (i) give written notice to the Commission no later than 10 business days after the uniform standard is promulgated, or at the time the state becomes a compacting state and (ii) find that the uniform standard does not provide reasonable protections to the citizens of the state, given the conditions in the state. The Commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the state that warrant a departure from the uniform standard and determining that the uniform standard would not reasonably protect the citizens of the state. The Commissioner must consider and balance the following factors and find that the conditions in the state and needs of the citizens of the state outweigh:

(1) The intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the products subject to this Article; and

(2) The presumption that a uniform standard adopted by the Commission provides reasonable protections to consumers of the relevant product.

Notwithstanding the foregoing, a compacting state may, at the time of its enactment of this Compact, prospectively opt out of all uniform standards involving long-term care insurance products by expressly providing for the opt out in the enacted Compact, and the opt out shall not be treated as a material variance in the offer or acceptance of any state to participate in this Compact. The opt out shall be effective at the time of enactment of this Compact by the compacting state and shall apply to all existing uniform standards involving long-term care insurance products and those subsequently promulgated.

(e) Effect of Opt Out. – If a compacting state elects to opt out of a uniform standard, the uniform standard shall remain applicable in the compacting state electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective. Once the opt out of a uniform standard by a compacting state becomes effective as provided under the laws of that state, the uniform standard shall have no further force and effect in that state unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the state. If a compacting state opts out of a uniform standard after the uniform standard has been made effective in that state, the opt out shall have the same prospective effect as provided under G.S. 58-9-70 for withdrawals.

(f) Stay of Uniform Standard. – If a compacting state has formally initiated the process of opting out of a uniform standard by regulation, and while the regulatory opt out is pending, the compacting state may petition the Commission, at least 15 days before the effective date of the uniform standard, to stay the effectiveness of the uniform standard in that state. The Commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the Commission, the stay or extension thereof may postpone the effective date by up to 90 days, unless affirmatively extended

by the Commission. A stay shall not be permitted to remain in effect for more than one year unless the compacting state can show extraordinary circumstances that warrant a continuance of the stay, including the existence of a legal challenge that prevents the compacting state from opting out. A stay may be terminated by the Commission upon notice that the rule-making process has been terminated.

(g) Not later than 30 days after a rule or operating procedure is promulgated, any person may file a petition for judicial review of the rule or operating procedure. The filing of a petition pursuant to this subsection shall not stay or otherwise prevent the rule or operating procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Commission consistent with applicable law and shall not find the rule or operating procedure to be unlawful if the rule or operating procedure represents a reasonable exercise of the Commission's authority.

"**§ 58-91-40. Commission records and enforcement.**

(a) The Commission shall promulgate rules establishing conditions and procedures for public inspection and copying of its information and official records, except information and records involving the privacy of individuals and insurers' trade secrets. The Commission may promulgate additional rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

(b) Except as to privileged records, data, and information, the laws of any compacting state pertaining to confidentiality or nondisclosure shall not relieve any compacting state commissioner of the duty to disclose any relevant records, data, or information to the Commission. Disclosure to the Commission shall not be deemed to waive or otherwise affect any confidentiality requirement. Except as otherwise expressly provided in this Article, the Commission shall not be subject to the compacting state's laws pertaining to confidentiality and nondisclosure with respect to records, data, and information in its possession. Confidential information of the Commission shall remain confidential after the information is provided to any commissioner.

(c) The Commission shall monitor compacting states for compliance with duly adopted bylaws, rules, including uniform standards, and operating procedures. The Commission shall notify any noncomplying compacting state in writing of its noncompliance with Commission bylaws, rules, or operating procedures. If a noncomplying compacting state fails to remedy its noncompliance within the time specified in the notice of noncompliance, the compacting state shall be deemed to be in default as set forth in G.S. 58-91-70.

(d) The commissioner of any state in which an insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise that person's authority to oversee the market regulation of the activities of the insurer in accordance with the provisions of the state's law. The commissioner's enforcement of compliance with the Compact is governed by the following provisions:

(1) With respect to the commissioner's market regulation of a product or advertisement that is approved or certified to the Commission, the content of the product or advertisement shall not constitute a violation of the provisions, standards, or requirements of the Compact except upon a final order of the Commission, issued at the request of a commissioner after prior notice to the insurer and an opportunity for hearing before the Commission.

(2) Before a commissioner may bring an action for violation of any provision, standard, or requirement of the Compact relating to the content of an advertisement not approved or certified to the Commission, the Commission, or an authorized Commission officer or employee, must authorize the action. However, authorization pursuant to this subdivision does not require notice to the insurer, opportunity for hearing, or disclosure of requests for authorization or records of the Commission's action on the requests.

"**§ 58-91-45. Dispute resolution.**

The Commission shall attempt, upon the request of a member, to resolve any disputes or other issues that are subject to this Compact and which may arise between two or more compacting states, or between compacting states and noncompacting states, and the Commission shall promulgate an operating procedure providing for resolution of those disputes.

"**§ 58-91-50. Product filing and approval.**

(a) Insurers and third-party filers seeking to have a product approved by the Commission shall file the product with, and pay applicable filing fees to, the Commission. Nothing in this Article shall be construed to restrict or otherwise prevent an insurer from filing its product with the insurance department in any state wherein the insurer is licensed to conduct the business of insurance, and the filing shall be subject to the laws of the states where filed.

(b) The Commission shall establish appropriate filing and review processes and procedures pursuant to Commission rules and operating procedures. Notwithstanding any provision in this Article to the contrary, the Commission shall promulgate rules to establish conditions and procedures under which the Commission will provide public access to product filing information. In establishing rules, the Commission shall consider the interests of the public in having access to the information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a product filing or supporting information.

(c) Any product approved by the Commission may be sold or otherwise issued in those compacting states for which the insurer is legally authorized to do business.

"**§ 58-91-55. Review of Commission decisions regarding filings.**

(a) Not later than 30 days after the Commission has given notice of a disapproved product or advertisement filed with the Commission, the insurer or third-party filer whose filing was disapproved may appeal the determination to a review panel appointed by the Commission. The Commission shall promulgate rules to establish procedures for appointing review panels and provide for notice and hearing.

An allegation that the Commission, in disapproving a product or advertisement filed with the Commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with G.S. 58-91-15(d).

(b) The Commission shall have authority to monitor, review, and reconsider products and advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant uniform standard. Where appropriate, the Commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in subsection (a) of this section.

"**§ 58-91-60. Finance.**

(a) The Commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the Commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, compacting states, and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the Commission concerning the performance of its duties shall not be compromised.

(b) The Commission shall collect a filing fee from each insurer and third-party filer filing a product with the Commission to cover the cost of the operations and activities of the Commission and its staff in a total amount sufficient to cover the Commission's annual budget.

(c) The Commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in G.S. 58-91-35.

(d) The Commission shall be exempt from all taxation in and by the compacting states.

(e) The Commission shall not pledge the credit of any compacting state, except by and with the appropriate legal authority of that compacting state.

(f) The Commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the Commission shall be subject to the accounting procedures established under its bylaws. The financial accounts and reports, including the system of internal controls and procedures of the Commission, shall be audited annually by an independent certified public accountant. Upon the determination of the Commission, but no less frequently than every three years, the review of the independent auditor shall include a management and performance audit of the Commission. The Commission shall make an annual report to the Governor and legislature of the compacting states, which shall include a report of the independent audit. The Commission's internal accounts shall not be confidential, and those materials may be shared with the commissioner of any compacting state upon request except that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

(g) No compacting state shall have any claim to or ownership of any property held by or vested in the Commission or to any Commission funds held pursuant to the provisions of this Compact.

"**§ 58-91-65. Compacting states; effective date; amendment.**

(a) Any State is eligible to become a compacting state.

(b) The Compact shall become effective and binding upon legislative enactment of the Compact into law by two compacting states except that the Commission shall become effective for purposes of adopting uniform standards for, reviewing, and giving approval or disapproval of, products filed with the Commission that satisfy applicable uniform standards only after 26 states are compacting states or, alternatively, by states representing greater than forty percent (40%) of the premium volume for life insurance, annuity, disability income, and long-term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other compacting state upon enactment of the Compact into law by that state.

(c) Amendments to the Compact may be proposed by the Commission for enactment by the compacting states. No amendment shall become effective and binding upon the Commission and the compacting states unless and until all compacting states enact the amendment into law.

"**§ 58-91-70. Withdrawal; default; termination.**

(a) Withdrawal. – Once effective, the Compact shall continue in force and remain binding upon each and every compacting state though a compacting state may withdraw from the Compact ("withdrawing state") by enacting a statute specifically repealing the statute which enacted the Compact into law.

The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the Commission and the withdrawing state unless the approval is rescinded by the withdrawing state as provided in this subsection.

The commissioner of the withdrawing state shall immediately notify the Management Committee in writing upon the introduction of legislation repealing this Compact in the withdrawing state.

The Commission shall notify the other compacting states of the introduction of such legislation within 10 days after its receipt of the notice.

The withdrawing state is responsible for all obligations, duties, and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the Commission and the withdrawing state. The Commission's approval of products and advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the withdrawing state, unless formally rescinded by the withdrawing state in the same manner as provided by the laws of the withdrawing state for the prospective disapproval of products or advertisement previously approved under state law.

Reinstatement following withdrawal of any compacting state shall occur upon the effective date of the withdrawing state reenacting the Compact.

(b) Default. – If the Commission determines that any compacting state has at any time defaulted ("defaulting state") in the performance of any of its obligations or responsibilities under this Compact, the bylaws or duly promulgated rules or operating procedures, then, after notice and hearing as set forth in the bylaws, all rights, privileges, and benefits conferred by this Compact on the defaulting state shall be suspended from the effective date of default as fixed by the Commission. The grounds for default include failure of a compacting state to perform its obligations or responsibilities, and any other grounds designated in Commission rules. The Commission shall immediately notify the defaulting state in writing of the defaulting state's suspension pending a cure of the default. The Commission shall stipulate the conditions and the time period within which the defaulting state must cure its default. If the defaulting state fails to cure the default within the time period specified by the Commission, the defaulting state shall be terminated from the Compact and all rights, privileges, and benefits conferred by this Compact shall be terminated from the effective date of termination.

Product approvals by the Commission or product self-certifications, or any advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the defaulting state in the same manner as if the defaulting state had withdrawn voluntarily pursuant to subsection (a) of this section.

Reinstatement following termination of any compacting state requires a reenactment of the Compact.

(c) Dissolution of Compact. – The Compact dissolves effective upon the date of the withdrawal or default of the compacting state which reduces membership in the Compact to one compacting state.

Upon the dissolution of this Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be wound up and any surplus funds shall be distributed in accordance with the bylaws.

"**§ 58-91-75. Severability; construction.**

(a) The provisions of this Compact shall be severable; and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

(b) The provisions of this Compact shall be liberally construed to effectuate its purposes.

"**§ 58-91-80. Binding effect of Compact; other laws.**

(a) Other Laws. – Nothing herein prevents the enforcement of any other law of a compacting state, except as provided in subsection (b) of this section.

For any product approved or certified to the Commission, the rules, uniform standards, and any other requirements of the Commission shall constitute the exclusive provisions applicable to the content, approval, and certification of such products. For advertisement that is subject to the Commission's authority, any rule, uniform standard, or other requirement of the Commission that governs the content of the advertisement shall constitute the exclusive provision that a Commissioner may apply to the content of

the advertisement. Notwithstanding the foregoing, no action taken by the Commission shall abrogate or restrict: (i) the access of any person to state courts; (ii) remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the product; (iii) state law relating to the construction of insurance contracts; or (iv) the authority of the attorney general of the state, including, but not limited to, maintaining any actions or proceedings, as authorized by law.

All insurance products filed with individual states shall be subject to the laws of those states.

(b) Binding Effect of This Compact. – All lawful actions of the Commission, including all rules and operating procedures promulgated by the Commission, are binding upon the compacting states.

All agreements between the Commission and the compacting states are binding in accordance with their terms.

Upon the request of a party to a conflict over the meaning or interpretation of Commission actions, and upon a majority vote of the compacting states, the Commission may issue advisory opinions regarding the meaning or interpretation in dispute.

In the event any provision of this Compact exceeds the constitutional limits imposed on the legislature of any compacting state, the obligations, duties, powers, or jurisdiction sought to be conferred by that provision upon the Commission shall be ineffective as to that compacting state, and those obligations, duties, powers, or jurisdiction shall remain in the compacting state and shall be exercised by the agency thereof to which those obligations, duties, powers, or jurisdiction are delegated by law in effect at the time this Compact becomes effective."

SECTION 2. The Commissioner may submit interim reports to the General Assembly as deemed appropriate by the Commissioner on the effectiveness of the State's participation in the Compact. No later than January 1, 2009, the Commissioner shall submit a final report to the General Assembly on the effectiveness of the State's participation in the Compact. The report may include consideration of any issues deemed relevant by the Commissioner to the State's participation in the Compact and may include recommended legislative proposals related to the Compact. The report shall include the Commissioner's recommendation to the General Assembly as to whether the State's continued participation in the Compact is in the best interest of the citizens of this State.

SECTION 3. This act becomes effective October 1, 2005, and expires October 1, 2009.

HOUSE BILL 673:
Interstate Insurance Product Reg. Compact.-AB

BILL ANALYSIS

Committee:	House Insurance	**Date:**	May 10, 2005
Introduced by:	Rep. Holliman	**Summary by:**	Kory Goldsmith Committee Counsel
Version:	PCS to First Edition H673-CSRC-41		

SUMMARY: ***This bill adopts the National Association of Insurance Commissioners' (NAIC) Interstate Insurance Product Regulation Compact, a multi-state agreement that creates a national authority called the Interstate Insurance Product Regulation Commission. The commission, which includes one member from each participating state, has a broad range of powers, including rule-making authority. It adopts national uniform standards for certain products and receives, reviews, and provides appropriate regulatory approval for product filings and advertisements from insurers. The commission's decisions have the force and effect of law and are binding on the participating states.***

The compact, which applies to individual and group annuity, life insurance, disability income, and long-term care insurance products, is effective after two states enact it. The commission cannot adopt uniform standards or review or approve product filings until 26 states or, alternatively, states with more than 40% of covered insurance products' premium volume enact the compact. Two-thirds of the participating states must approve a uniform standard before it takes effect.

The Proposed Committee Substitute makes technical corrections to the bill.

The act becomes effective October 1, 2005 and sunsets October 1, 2009.

CURRENT LAW: There is no current law covering this matter. Except to the extent pre-empted by federal law, North Carolina has sole regulatory authority over individual and group annuity, life insurance, disability income, and long-term care insurance products offered by insurers licensed in this State.

BILL ANALYSIS: **Section 1** of House Bill 673 enacts a new Article 91 in Chapter 58, which would establish North Carolina as a member of the Interstate Insurance Product Regulation Compact. The legislation is patterned after a model act adopted by the NAIC in 2003.

Among other things, insurers wanting a product approved would have to send the filing and applicable filing fee to the commission. Any product the commission approves may be sold or issued in any participating state in which the insurer is licensed to do business. The compact does not prohibit an insurer from instead filing the product with the Insurance Department, in which case the filing will be subject to North Carolina's laws. The Insurance Department continues to oversee market conduct activities of state-licensed insurers.

A state can opt-out of any uniform standard through legislation or regulation if it determines the standard does not provide reasonable protections for its citizens. It can also withdraw from the compact by repealing the statute that adopted it.

Section 2 directs the Commissioner of Insurance to submit interim reports to the General Assembly on the effectiveness of the State's participation in the Compact. The Commissioner must submit an final report on this matter no later than January 1, 2009, and may include recommendations on legislative related to the Compact, and must include a recommendation regarding whether the State should remain a member of the Compact.

EFFECTIVE DATE: The act would become effective October 1, 2005, but would sunset October 1, 2009.

BACKGROUND: The NAIC adopted the Interstate Insurance Product Regulation Compact in July 2003. It is a multi-state agreement to create a streamlined system of product regulation that (1) allows insurers to market certain insurance products more quickly nationally and (2) reduces the number of product variations that a company needs to meet state-specific requirements. According to information made available at the National Association of Insurance Commissioners (NAIC) website, fourteen states have adopted the compact: Colorado, Hawaii, Iowa, Idaho, Kansas, Maine, Massachusetts, Nebraska New Hampshire, Rhode Island, Utah, Virginia, Washington, and West Virginia.

The U. S. Constitution requires that "No state shall, without the consent of Congress, enter into any Agreement or Compact with another State. " However, the Supreme Court ruled that consent is required only when the compact would increase the political power and influence of the compacting states and encroach upon federal authority (*Virginia v. Tennessee* 13 S. Ct. 728 (1893)). Because the compact performs a function already reserved to the states, the NAIC holds that it neither increases the states' power and influence nor encroaches on federal authority and therefore does not need Congressional consent.

H0673e1-SMRC-CSRC-41

IV

HB 673

I. Intro. – To address issue of uniformity/speed to market particularly as it pertains to life insurance, ~~Purpose~~ annuities market which is competing w/ banks/securities firms

II. Brief History

A. Discussions begin in early 2002 ways to achieve true uniform product filing standards

need/reasons ① competition w/ banks/securities firms

② increased mobility of population and consequent need for uniformity of some product lines

March 2002 - NAIC Working group proposed development of an interstate compact whereby state regulators would jointly establish uniform product standards / single point of filing for designated insurance products

B. Throughout 2002 Interstate Compact Working Group and interested regulators developed draft language - receiving comments from industry and consumer groups - 11 draft versions, 4 public hearings 5 20 written comments

Dec. 2002 - NAIC adopted the model legislation for review by state regulators / policymakers ~~you have for presentation and review~~

C. 7/17/03 - NAIC adopted amendments to address certain concerns

In 2003, both the National Conference of State Legislatures (NCSL) and the National Conference of Insurance Legislators (NCOIL) adopted resolutions in support of the proposed compact

D. Working group is already in the process of adopting draft uniform standards

~~II~~. E. As of mid January 2005, 34 product standards had been "adopted" so far ⊛

- 4 states have enacted the Compact into law incl. VA/WV
- 9 states had introduced legislation in the 2004 sessions
- 13 other states including NC had plans to intro. in 2005

These # are significant - Compact already exists (when 1st 2 states adopted) but does not become operational until adopted by 26 states or states representing more than a 40% of the premium volume for life insurance, annuity, disability income and long-term care insurance products, based on NAIC records of previous year.

III. The Act

① Purpose - To provide a single point of filing and review ~~based on uniform~~ of insurance products, in certain lines, based on uniform standards which result in timely, multi-state approval.

② Applies to products of

- Life Insurance
- Annuity
- Disability Income
- Long-Term Care

③ How does it work

- 2 states to create the compact
- 26 or 40% to become operational

↳ ④ establishes Compact Commission - a joint public agency - a body politic/instrumentality of the states

bill enumerates powers duties and responsibilities

CR-91-20 p.3 - 6 of the bill

58-91-25 sets forth Organization of the Commission procedures

Commission made up of 1 member from each compacting states - 1 member/1 vote

2/3 votes req'd for promulgation of uniform standard create and publish bylaws w/ appropriate agency or officer in each of the compacting state

(2) structure

(1) Mgmt. Committee - 14 members
- 1 member from each of the 6 compacting states w/ the largest premium volume (6)
- 4 from compacting states w/ at least 2% of the market based on premium volu
- 4 from those w/ less than 2%

(5) Legislative Committee comprised state legislators or their designees - monitor operations of the Commission and make recommendations

(3) 2 Advisory Committees
- Consumer Advisory Committee
- Industry Advisory Committee

(4) Role of Mgmt Committee
- promulgate rules, binding on compact state
- exercise rulemaking to establish uniform standards in accordance w/ Model State APA of 1981
- exercise rulemaking to designate products and advertisements that may be subject to self-certification
- establish/maintain offices etc. hire specialists
- enforce compliance

58-91-30

(10) meetings - as set forth in the bylaws but at least 1 time a year

58-91-35 Rulemaking

Opt-Out – states are bound by the uniform Standards unless they opt out

- effective 90 days after promulgation unless exercises opt-out via statute or regs. sets forth procedure.
- 10 days notice to the Commission of ~~intention~~ election to opt out and "find that the uniform standard does not provide reasonable protections to the citizens of the state, given the conditions of the state" can seek stay of uniform standard during rulemaking for 90 days but no longer than 1 year

58-91-40 Enforcement

- DOI must present to Compact for determination of violation of standard before addressing w. the company

58-91-50 - Products filed and reviewed by Compact
- 30 days review: approve or disapprove

58-91-65- Compacting States; effective date; amendment

- amendments to the compact - not effective and binding on the Commission and the compacting states unless and until all compacting states enact the amendment into law

58-91-70 Provisions for Withdrawal

- by enacting a statute specifically repealing the statute which enacted the compact into law

effect of withdrawal
- all obligations, duties, and liabilities incurred state still responsible.
- Commission's approval of products and advertisements prior to the effective date of withdrawal shall continue to be effective unless formally rescinded by the withdrawing state

Default - terminated from the Compact for non-compliance
Dissolution - only 1 state left

58-91-80

Binding effect

(a) nothing prevents the enforcement of any other law of a compacting state
(b) if a person/entity utilizes the compact, that is the exclusive provision for that product, fully etc.
(c) all lawful actions of the Commission are binding on the compacting states
- Commission can issue advisory opinions.
(d) if Commission act exceed State's Constitutional limits, ineffective w/r/t that act

Two NC DOI safeguards:
- 10/1/09 Sunset — coupled w/ 1/1/09 report to the GA about recommending staying in — MUST HAVE

could take another 2-3 years to be up and running

Pros v. Cons

919-821-6776 Susan Hargrave Swift, Anderson
919 821-6699 Jim Dorsett

AMERICAN COUNCIL OF LIFE INSURERS (ACLI) COMMENTS

THE INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

The Interstate Insurance Product Regulation Compact would establish a system to correct the biggest problem our companies have with the state regulatory system today. Life insurance, annuities, disability income, and long-term care insurance, the products sold by ACLI members, must, for the most part, be approved by each state before they are marketed. In addition, states have differing requirements for the structure of these products, so products must be revised based on each state's particular standards before they are approved. Consequently, it is expensive and time-consuming for ACLI members to get their products to market compared with our competitors in the financial services marketplace who are federally regulated. This problem was identified by our CEOs as the element of state insurance regulation most in need of reform.

House Bill 673, sponsored by Representative Holliman, would enhance state regulation of insurance by creating a Commission governed collectively by the states that would serve as a single point of filing for our products, and that would establish uniform, national standards for those products. This system would benefit consumers and state governments, as well as insurers. Consumers will benefit from strong, uniform national product standards, which is especially important given our increasingly mobile population. The quality of product review will be enhanced, as experienced staff will review the filings, thereby enabling regulators to devote more time and resources to monitoring for problems in the marketplace. The public will have more timely access to innovative insurance products. And importantly, the General Assembly will retain oversight over the process through mechanisms for opting out of the standards, oversight over the Department of Insurance, and the ability to repeal the Compact.

ACLI commends the National Association of Insurance Commissioners for its hard work in promulgating the compact, and ACLI has assisted the NAIC in achieving endorsement of the Compact by state legislative groups, including the National Conference of State Legislatures (NCSL) and the National Conference of Insurance Legislators (NCOIL). Meanwhile, the NAIC continues to draft national standards for the products that will be governed by the Compact Commission, for use by the Commission if it so chooses. We strongly support the adoption of the Compact.

ACLI urges the house Insurance Committee to give this important piece of legislation a favorable report in recognition of the need for a streamlined and efficient regulatory process for product filings. National product standards and a single point of filing for life insurance products would benefit all interested parties -- consumers, insurers, and government alike.

William K. Hale
State Counsel
May 10, 2005

- Every state joining the compact will participate in the governance of the commission
- A Management Committee is established to address daily affairs
- No uniform standards, rules, or operating procedures will become effective unless adopted by the members of the commission

How will Uniform Standards be Developed?

- Process led by state insurance regulators
- Conducted through rulemaking process
- Requires approval of 2/3 of commission management committee and 2/3 of commission members
- States can opt-out

What if a State Disagrees with Uniform Standard Developed by the Commission?

- States may opt-out of a uniform standard
  by regulation
  by enactment of law
- For long-term care insurance, states may opt-out at time of joining compact ("front-end" opt-out)
- For opt-out by regulation
  must show that the uniform standard does not provide reasonable protections to the citizens of the state and that the needs of the state outweigh the Legislature's intent to participate in and receive the benefits of the compact

What is the Role of the State in Governing Market Conduct Activity Once the Compact is Enacted?

- Individual states will continue to regulate market activities
- Compact allows for coordination between states and commission to determine violations of uniform standards

When will the Compact Become Effective?

- Compact comes into existence when two states enact compact legislation
- Commission becomes operational (i.e. adopting uniform standards, receiving products and giving approvals/disapprovals) if 26 states or states representing 40% of the premium for life, annuities, disability income insurance and LTC join the compact

How will the Compact Be Funded?

- Operations of the commission will be financed by filing fees paid by insurers

A·C·L·I AMERICAN COUNCIL OF LIFE INSURERS
FINANCIAL SECURITY FOR LIFE

Overview of the Interstate Insurance Product Regulation Compact

What is an Interstate Compact?

- Creates the framework for cooperative solutions to multistate challenges
- Referenced in the U.S. Constitution
- Historically used to address such issues as border disputes and water rights between states
- Use expanded in recent decades – taxation, adoption laws, drivers' licenses, environmental issues, emergency management
- Over 200 already in existence, covering a variety of subjects. Every state belongs to at least 14

What is the Interstate Insurance Product Regulation Compact?

- Developed by the National Association of Insurance Commissioners (NAIC) in conjunction with the states, industry and consumers
- Provides for the single point of filing for certain insurance products with uniform national standards
- Member states develop uniform standards that apply to products filed with the compact commission
- Uniform standards take effect in all compacting states 90 days after adoption by the compact commission
- Where state does not opt-out, approval of a product by the compact is the same as approval by a member state
- Companies can still file products in the individual states through the existing form filing process

Which Insurance Products are Covered by the Compact?

- Individual and Group
  - life insurance
  - annuities
  - disability income insurance
  - long-term care insurance

How is the Compact Governed?

- Compact establishes a commission

101 CONSTITUTION AVENUE, NW, Suite 700, WASHINGTON, DC 20001-2133
Telephone: (202) 624-2387 Facsimile: (202) 572-4819

MINUTES
HOUSE COMMITTEE ON INSURANCE
May 12, 2005

The House Committee on Insurance met at 11:00 AM on Tuesday, May 12, 2005 in Room 1228. The following Representatives attended, Chairman Hugh Holliman, Vice Chairs Bill Faison, Ed Jones, and Mitchell Setzer. Members: L. Allen, C. Allred, D. Almond, W. Current, R. Grady. J. Howard, D. Ross,
D. Saunders, F. Steen, R. Sutton, W. Wainwright, and T. Wright.

Rep. Setzer chaired the meeting as Chairman Holliman was detained in a prior meeting. Rep. Moore was asked to explain HB 1185 - Fire Department Grants. See Attachment II. He reported how his district would have the opportunity for the grants and that a constituent had brought this issue to his attention. After much discussion, it was decided to place HB 1185 in a sub committee. The committee would be announced at a later time.

Rep. Setzer asked Rep. Pate to speak on HB 817 -Amend Firemen's Relief Fund Requirement. Attachment III. Rep. Pate explained the need for changing the requirement of 5 years to 2 years for a destitute member fireman who has served honorably. Kory Goldsmith, Staff Attorney read the statues that apply to active service. After much discussion, it was decided that additional information and study of this issue was needed.

Chairman Holliman adjourned the meeting at 11:50 AM.

Representative. L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **Thursday, May 12, 2005**

TIME: **11:00 AM**

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 817 -Amend Firemen's Relief Fund Requirement
Representatives Pate, Faison, LaRoque McGee and Preston

HB 1185 - Fire Department Grants – Rep. Moore

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **2:55 PM on May 10, 2005**.

___Principal Clerk
___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

HOUSE INSURANCE COMMITTEE

May 12, 2005
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

HB 817 -Amend Firemen's Relief Fund Requirement
Representatives Pate, Faison, LaRoque McGee and Preston

HB 1185 - Fire Department Grants – Rep. Moore

HOUSE COMMITTEE ON INSURANCE

May 12, 2005
11:00 AM
Room 1228 Legislative Building

Attachment 1

Pages:

Name (please print clearly)	County	Representative
Laura Ruterbories	Wake	Rep. Rick Eddins
Amber Henline	Mitchell	Rep. Frye

Sergeant-At-Arms (please print)

Martha Gadison

Willie Dixon

Charles Williams

1

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 12, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Courtney J Crowder	NCDOI
FRANK W. FOLGER	NCDOI
Tim Bradley	NCDOI
Lee Hodges	KCLH
Kari Barsness	OSBM
Tom Coley	CWA
Bill McGee	NCGA
Bill Eggold	KCLH
Paul Pulley	NCATL
Bill Wilson	NCATL
Fred Bone	Bone & Asso.
Yogi Berra	NMRS Aflac duck

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 12, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Bind	IIANC
Kathleen Edwards	UNC-CH Legis. Reporting Service

ATTACHMENT 11

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H 1

HOUSE BILL 1185

Short Title:	Fire Department Grants.	(Public)
Sponsors:	Representative Moore.	
Referred to:	Insurance.	

April 12, 2005

A BILL TO BE ENTITLED

AN ACT TO AMEND THE ELIGIBILITY REQUIREMENTS FOR GRANTS TO RURAL VOLUNTEER FIRE DEPARTMENTS TO REFLECT POPULATION GROWTH IN RAPIDLY URBANIZED AREAS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-87-1 reads as rewritten:

"**§ 58-87-1. Volunteer Fire Department Fund.**

(a) There is created the Volunteer Fire Department Fund to provide matching grants to volunteer fire departments to purchase equipment and make capital improvements. The Fund shall be set up in the Department of Insurance. The State Treasurer shall invest its assets according to law, and the earnings shall remain in the Fund. The Fund shall be distributed under the direction of the Commissioner of Insurance. Beginning January 1, 1988, an eligible fire department may apply to the Commissioner of Insurance for a grant under this section. Beginning May 1, 1988, and on each May 15, thereafter, the Commissioner shall make grants to eligible fire departments subject to the following limitations:

(1) The size of a grant may not exceed twenty thousand dollars ($20,000);
(2) The applicant shall match the grant on a dollar-for-dollar basis;
(3) The grant may be used only for equipment purchases, payment of highway use taxes on those purchases, or capital expenditures necessary to provide fire protection services; and
(4) An applicant may receive no more than one grant per fiscal year.

In awarding grants under this section, the Commissioner shall to the extent possible select applicants from all parts of the State based upon need. Up to two percent (2%) of the Fund may be used for additional staff and resources to administer the Fund in each fiscal year.

No fire department may be declared ineligible for a grant under this section solely because it is classified as a municipal fire department.

(b) A fire department is eligible for a grant under this section if it meets all of the following conditions:

(1) It serves a response area of ~~6,000~~ 9,000 or less in population.

(2) It consists entirely of volunteer members, with the exception that the unit may have paid members to fill the equivalent of three full-time paid positions.

(3) It has been certified by the Department of Insurance.

In making the population determination under subdivision (1) of this subsection, the Department shall use the most recent annual population estimates certified by the State Budget Officer.

(c) The Commissioner of Insurance shall submit a written report to the General Assembly within 60 days after the grants have been made. This report shall contain the amount of the grant and the name of the recipient."

SECTION 2. This act is effective when it becomes law.

HOUSE BILL 1185:
Fire Department Grants

BILL ANALYSIS

Committee:	House Insurance	**Date:**	May 11, 2005
Introduced by:	Rep. Moore	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: House Bill 1185 would amend the eligibility requirements for State grants to rural volunteer fire departments. Grants would be made available to fire departments serving response areas of 9,000 or less in population, an increase from the current population limit of 6,000 or less, to reflect population growth in rapidly urbanized areas.

CURRENT LAW: General Statute 58-87-1 creates a Volunteer Fire Department Fund, housed in the Department of Insurance and distributed under the direction of the Commissioner of Insurance. The Commissioner awards grants of up to $20,000 that are to be matched dollar for dollar by the applicants. The grants are awarded annually and may be used only for the purchase of equipment, payment of highway use tax for the equipment purchases, or for capital expenditures necessary to provide fire protection services.

Grants are awarded to fire departments that meet the following criteria:

- Serve a response area of 6,000 or less in population;
- Consist primarily of volunteer members, employing no more than a total of the equivalent of three full-time paid positions;
- Have been certified by the Department of Insurance.

BILL ANALYSIS: House Bill 1185 would modify the first criterion of eligibility for grant funding by raising the limit on the population of a response area served by a volunteer fire department from 6,000 to 9,000 people.

EFFECTIVE DATE: The bill would be effective when it becomes law.

BACKGROUND: House Bill 1185 is intended to adapt volunteer fire department funding criteria to reflect population growth in rapidly urbanized areas.

H1185e1-SMSS

ATTACHMENT III

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H 1

HOUSE BILL 817

Short Title:	Amend Firemen's Relief Fund Requirement.	(Public)
Sponsors:	Representatives Pate; Faison, LaRoque, McGee, and Preston.	
Referred to:	Insurance.	

March 21, 2005

A BILL TO BE ENTITLED

AN ACT TO AMEND THE REQUIREMENT THAT FIREMEN HAVE FIVE YEARS OF SERVICE IN ORDER TO BE ELIGIBLE FOR ASSISTANCE UNDER THE LOCAL FIREMEN'S RELIEF FUND.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-84-35 reads as rewritten:

"**§ 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.

(2a) 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.~~two 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 which a benefit under subsections (5) and (6) shall have been reduced."

SECTION 2. This act becomes effective July 1, 2005.

HOUSE BILL 817:
Amend Firemen's Relief Fund Requirement

BILL ANALYSIS

Committee:	House Insurance	**Date:**	May 12, 2005
Introduced by:	Rep. Pate	**Summary by:**	Kory Goldsmith
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 817 allows the board of trustees of a local fireman's relief fund to provide assistance to a member who is destitute and who served honorably as a fireman for at least two, instead of five, years. This disbursement is subject to the approval of the Secretary of the State Firemen's Association.***

The act would become effective July 1, 2005.

CURRENT LAW: G.S. 105-228.5(d)(4) provides that in addition to the general tax levied on insurers, and additional ½ of 1% is levied on the gross premiums on contracts of insurance for fire and lightening damage. Under Article 84 of Chapter 58, those funds are remitted to the Secretary of Revenue, who credits the net proceeds to the Department of Insurance. The Department of Insurance in turn pays 3% to the State Firemen's Association, keeps 2% for administrative costs, credits any amounts forfeited by nonmember fire districts to the North Carolina State Firemen's Association, and pays the remaining amounts to the treasurer's of the various fire districts on a pro rata basis to the amount of business done in the fire district.[1] The funds credited to the board of trustees of the firemen's local relief fund.

The trustee's may disburse the funds only for certain purposes. These include:

- 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.
- 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.
- 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.
- 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.
- 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.
- 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.

[1] A fire district is defined as any political subdivision that has an organized fire department under the control of the governing body of the political subdivision and that has fire department apparatus and equipment valued at least one thousand dollars ($1,000).

MINUTES
HOUSE COMMITTEE ON INSURANCE
May 19, 2005

The House Committee on Insurance met at 11:00 AM on Thursday, May 17, 2005 in Room 1228. The following Representatives in attendance were: Chairman Hugh Holliman, Vice Chairs Bill Faison, Ed Jones, E. Nye, And M. Setzer. Members: L. Allen, D. Almond, H. Brubaker, W. Current, R. Grady. J. Howard, D. Ross, D. Saunders, F. Steen, R. Sutton, W. Wainwright, and T. Wright.

Chairman Holliman welcomed visitors, House pages and Sgt-At-Arms. Attachment I.

There were no objections to accept the PCS on HB 1524 - Competitive Selection/Supplemental Insurance. Rep. Wilson, a bill sponsor was asked to speak on the bill. Rep. Wilson explained this bill would continue providing the same services that had been in place for the past 20 years. Brett Joyal, with NCDST, spoke in support of this bill and how it formalizes the program for approximately 186,000 retirees. Rep. Saunders made a motion for a favorable report to the PCS unfavorable to the original bill. Motion carried. See Attachment II

Chairman Holliman explained to the committee that a vote on HB 657 - Producer Comp. Transparency and Broker Duty. -AB would not take place, as the industry had not had time to review the new PCS. He called on Frank Folger, Counselor with the Department of Insurance to explain HB 657. Mr. Folger explained how this legislation would protect consumers by requiring insurance brokers to disclose if they are receiving compensation from insurance companies for placing business and it would also specify that brokers have a fiduciary duty to their customers. Attachment III. After much discuss from the committee, John Bodie, Lobbyist with IIANC explained the first part of this bill was important for the consumer and was supported by the industry. He then spoke against Section 2 of the bill. Joe Stewart, NFINC also shared his concern with Section 2 of the bill.

Chairman Holliman announced a tentative meeting to continue hearing this legislation would be Tuesday, May 24, at 8:00 AM in Room 1228. The meeting was adjourned at 11:50 AM

Representative L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **Thursday, May 19, 2005**

TIME: **11:00 AM**

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 657 - Producer Comp. Transparency and Broker Duty.-AB
Representative Holliman

HB 1524 - Competitive Selection/Supplemental Insurance.
Representative Wilson, Bell, and Coleman

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **3:15 PM on May 16, 2005**.

___Principal Clerk
___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

HOUSE INSURANCE COMMITTEE

May 19, 2005
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

HB 657 - Producer Comp. Transparency and Broker Duty.-AB
Representative Holliman

HB 1524 - Competitive Selection/Supplemental Insurance.
Representatives Wilson, Bell, and Coleman

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Holliman (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for
HB 1524 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR COMPETITIVE SELECTION OF SUPPLEMENTAL INSURANCE PRODUCTS FOR RETIREES.

☒ With a favorable report as to the committee substitute bill, unfavorable as to the original bill.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

ATTACHMENT I

House Pages

Name Of Committee: Jus. Date: 5-19-05

1. Name: Joseph Bender
   County: Buncombe
   Sponsor: Rep. Susan Fischer
2. Name: Ben Carr
   County: Wake
   Sponsor: Rep. Stam
3. Name: _____
   County: _____
   Sponsor: _____
4. Name: _____
   County: _____
   Sponsor: _____
5. Name: _____
   County: _____
   Sponsor: _____

Sgt-At-Arms

1. Name: Martha Gadison
2. Name: Martha Parrish
3. Name: _____
4. Name: _____
5. Name: _____

(1)

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 19, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Courtney Crowder	DOI
Mari Austin	NCAHP
Robert Pasichof	Young, Moore
Mike Causey	Causey & Associates
Jack McMillan	NFOS
[illegible]	JD, AL, PA
Barbara Carsler	BCBSNC
[illegible]	BCBSNC
Suzanne Beasley	SEANC
Ardis Watkins	"
Mark Benson	Capitol Group

4

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 19, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jim Long	NCDOT
Fred Jayne	NCAIFA
Betty Tarrh	Bank of America
Lee Hodge	KCLH
David Stoller	State Farm
Amy Fullbright	Hunton & Williams
Ed Rego	NCREGEA
Pam Deardorff	NCDST
Stephanie Coplin	NCDST
Brett Joyal	NC DST

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 19, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Bird	IIANC
Bo Walker	IIANC
Susan Valauri	Nationwide
Bill Sloggins	Kemp
Andy Ellen	NCRMA
[illegible]	IFNC
[illegible]	NC Beer & Wine Assoc
[illegible]	NERA
[illegible]	Citizen

ATTACHMENT 11

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 1

HOUSE BILL 1524

Short Title:	Competitive Selection/Supplemental Insurance.	(Public)
Sponsors:	Representatives Wilson, Bell, Coleman (Primary Sponsors); B. Allen, Jones, and Wainwright.	
Referred to:	Insurance.	

April 21, 2005

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR COMPETITIVE SELECTION OF SUPPLEMENTAL INSURANCE PRODUCTS FOR RETIREES.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 135 of the General Statutes is amended by adding a new Article to read:

"Article 7.

"Supplemental Insurance Products for Retirees.

"**§ 135-115. Competitive selection of supplemental insurance products paid for by retirees.**

(a) Duties of the Department of State Treasurer. – The Department of State Treasurer shall:

(1) Review insurance products currently offered through retirement benefit payment deduction to retirees from the Teachers' and State Employees' Retirement System, the Local Government Employees Retirement System, the Legislative Retirement System, and the Consolidated Judicial Retirement System to determine if those products meet the needs and desires of retirees.

(2) Select the types of insurance products that reflect the needs and desires of retirees.

(3) Competitively select insurance products of the types determined by the Department of State Treasurer to reflect the needs and desires of retirees.

(b) Retirement Benefit Payment Deduction Slots. – The company or companies selected by the Department of State Treasurer shall be permitted to sell through retirement benefit payment deduction only the products specifically approved by the Department of State Treasurer. The assignment by the Department of State Treasurer of a retirement benefit payment deduction slot shall be for a period of not less than two

years unless the insurance company violates the terms of the written agreement specified in this subsection. Subject to the provisions of subsection (d) of this section, the insurance company awarded a retirement benefit payment deduction slot shall, pursuant to a written agreement setting out the rights and duties of the insurance company, be afforded an adequate opportunity to solicit retirees. The selected insurance company or companies shall provide information about retirement benefit payment deduction in a format and medium as may be required by the Department of State Treasurer.

When retirement benefit payment deduction is no longer available, the insurance company may not terminate insurance products purchased under the retirement benefit payment deduction plan without the retiree's specific written consent solely because the premium is no longer deducted from retirement benefit payments. Further, when retirement benefit payment deduction is no longer available, the insurance company shall give the retirees the option to continue the insurance product or products they have selected by paying the insurance company directly.

(c) Procedure for Selection of Supplemental Insurance Product Proposals. – All supplemental insurance product proposals shall be sealed. The Department of State Treasurer shall open all proposals in public, at which time the proposals become public records open to public inspection.

After the public opening, the Department of State Treasurer shall review the proposals and examine the cost, coverage, and quality of the products, the reputation and capabilities of the insurance companies submitting the proposals, and other appropriate criteria. The Department of State Treasurer shall determine which proposal, if any, would meet the needs and desires of the retirees and shall award a retirement benefit payment deduction slot to the company submitting the proposal that best meets those needs and desires. The Department of State Treasurer may reject any or all proposals.

A company may seek to modify or withdraw a proposal only after the public opening and only on the basis that the proposal contains an unintentional clerical error as opposed to an error in judgment. A company seeking to modify or withdraw a proposal shall submit to the Department of State Treasurer a written request, with facts and evidence in support of its position, prior to the award of the retirement benefit payment deduction slot, but not later than two days after the public opening of the proposals. The Department of State Treasurer shall promptly review the request, examine the nature of the error, and determine whether to permit or deny the request.

(d) Confidentiality of Names and Addresses of Retired State and Local Employees. – The Department of State Treasurer shall provide the selected insurance company or companies with the names and addresses of retirees in order for the company or companies to provide information to retirees about purchasing their selected insurance product or products. However, the selected company or companies shall keep the names and addresses so provided strictly confidential and shall not provide them to any third party or use them to solicit retirees for insurance products other than those selected by the Department of State Treasurer. With each solicitation the insurance company shall provide the retirees with the option to elect not to receive

any future solicitations by providing a preaddressed and postage prepaid card with which to make that election and return it to the insurance company.

(e) Clerical and Professional Staff; Administrative Costs. – The Department of State Treasurer may employ clerical and professional staff and such other assistance as may be necessary to assist the Department of State Treasurer in carrying out its duties and responsibilities under this section. The administrative costs to the Department of State Treasurer of carrying out its duties and responsibilities under this section may be charged to participants or deducted from participants' accounts in accordance with nondiscriminatory procedures established by the Department of State Treasurer.

(f) Option to Continue Supplemental Insurance. – At the termination of any contract entered into pursuant to this section, the insurance company or insurance companies shall provide covered retirees the option to continue supplemental insurance on a direct billing basis."

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 1524
PROPOSED COMMITTEE SUBSTITUTE H1524-CSRC-50 [v.1]

5/18/2005 7:36:49 PM

Short Title: Competitive Selection/Supplemental Insurance. (Public)

Sponsors:

Referred to:

April 21, 2005

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR COMPETITIVE SELECTION OF SUPPLEMENTAL INSURANCE PRODUCTS FOR RETIREES.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 135 of the General Statutes is amended by adding a new Article to read:

"Article 7.

"Supplemental Insurance Products for Retirees.

"**§ 135-120. Competitive selection of supplemental insurance products paid for by retirees.**

(a) Duties of the Department of State Treasurer. – The Department of State Treasurer shall:

(1) Review insurance products currently offered through retirement benefit payment deduction to retirees from the Teachers' and State Employees' Retirement System, the Local Government Employees Retirement System, the Legislative Retirement System, and the Consolidated Judicial Retirement System to determine if those products meet the needs and desires of retirees.

(2) Select the types of insurance products that reflect the needs and desires of retirees.

(3) Competitively select insurance products of the types determined by the Department of State Treasurer to reflect the needs and desires of retirees.

(b) Retirement Benefit Payment Deduction Slots. – The company or companies selected by the Department of State Treasurer shall be permitted to sell through retirement benefit payment deduction only the products specifically approved by the Department of State Treasurer. The assignment by the Department of State Treasurer of a retirement benefit payment deduction slot shall be for a period of not less than two

years unless the insurance company violates the terms of the written agreement specified in this subsection. Subject to the provisions of subsection (d) of this section, the insurance company awarded a retirement benefit payment deduction slot shall, pursuant to a written agreement setting out the rights and duties of the insurance company, be afforded an adequate opportunity to solicit retirees. The selected insurance company shall provide information about retirement benefit payment deduction. The Department of State Treasurer shall determine the format and medium the insurance company may use to provide the information to retirees.

(c) Procedure for Selection of Supplemental Insurance Product Proposals. – The following procedures shall apply to the selection of all supplemental insurance products under this section.

(1) All supplemental insurance product proposals shall be sealed. The Department of State Treasurer shall open all proposals in public, at which time the proposals become public records open to public inspection.

(2) After the public opening, the Department of State Treasurer shall review the proposals and examine the cost, coverage, and quality of the products, the reputation and capabilities of the insurance companies submitting the proposals, and other appropriate criteria. The Department of State Treasurer shall determine which proposal, if any, would meet the needs and desires of the retirees and shall award a retirement benefit payment deduction slot to the company submitting the proposal that best meets those needs and desires. The Department of State Treasurer may reject any or all proposals.

(3) A company may seek to modify or withdraw a proposal only after the public opening and only on the basis that the proposal contains an unintentional clerical error as opposed to an error in judgment. A company seeking to modify or withdraw a proposal shall submit to the Department of State Treasurer a written request, with facts and evidence in support of its position, prior to the award of the retirement benefit payment deduction slot, but not later than two days after the public opening of the proposals. The Department of State Treasurer shall promptly review the request, examine the nature of the error, and determine whether to permit or deny the request.

(d) Confidentiality of Names and Addresses of Retired State and Local Employees. – The Department of State Treasurer shall provide the selected insurance company with the names and addresses of retirees in order for the company to provide information to retirees about purchasing their selected insurance product. The selected company shall keep the names and addresses of the retirees confidential and shall not provide the information to any third party or use the information to solicit retirees for insurance products other than those selected by the Department of State Treasurer. The insurance company shall provide retirees with the each solicitation the option to elect not to receive any future solicitations by providing a preaddressed and postage prepaid card the retiree may return it to the insurance company.

(e) Clerical and Professional Staff; Administrative Costs. – The Department of State Treasurer may employ clerical and professional staff to assist the Department of State Treasurer in carrying out its duties and responsibilities under this section. The administrative costs to the Department of State Treasurer of carrying out its duties and responsibilities under this section may be charged to participants or deducted from participants' accounts under nondiscriminatory procedures established by the Department of State Treasurer.

(f) Option to Continue Supplemental Insurance. – At the termination of any contract entered into under this section, or when retirement benefit payment deduction is no longer available for a product, the insurance company shall provide covered retirees the option to continue supplemental insurance on a direct billing basis. When retirement benefit payment deduction is no longer available, the insurance company may not terminate insurance products purchased under the retirement benefit payment deduction plan without the retiree's specific written consent solely because the premium is no longer deducted from retirement benefit payments."

SECTION 2. This act is effective when it becomes law.

HOUSE BILL 1524:
Competitive Selection/Supplemental Insurance

BILL ANALYSIS

Committee:	House Insurance	**Date:**	May 19, 2005
Introduced by:	Reps. Wilson, Bell, Coleman	**Summary by:**	Kory Goldsmith
Version:	PCS to First Edition H1524-CSRC-50		Committee Counsel

SUMMARY: ***House Bill 1524 would provide statutory authorization to the Department of State Treasurer to select supplemental insurance products that may be offered to State retirees and the premiums deducted from the retirees' pension benefit payments. While there is no current explicit statutory authorization for this practice, the Department has been providing this service to retirees for about 20 years.***

The PCS makes technical changes and removes a redundant provision.

The act would become effective when the bill becomes law.

CURRENT LAW: The is no current statutory authorization for the Department of State Treasurer to select supplemental insurance products and allow retirees to pay for the products by deductions form their retirement benefits payments. However, G.S. 58-31-60 authorizes the head of each State government employee payroll unit to offer payroll deduction for insurance products. The State also allows employs to purchase supplemental insurance through the Flex Plan.

BILL ANALYSIS: The bill creates a new Article 7 in Chapter 135. Much of the language is taken from G.S. 58-31-60. It also directs the Department of State Treasurer to review insurance products offered to retirees through retirement benefit payment deduction and determine if those products meet the needs of current retirees. It also directs the Department to select the types of insurance products that meet retiree needs and competitively select those products. The bill provides specific statutory authorization for the Department to deduct premiums for specified insurance products from retirees' retirement benefit payments.

The Department would solicit bid proposals through a sealed bid process. Once the bid period ended, the bids would be opened and would be public records. The Department would award the contract with the insurer that met the needs and desires of the retirees, but the Department would have the right to reject any or all proposals. The contract with the insurer would be for not less than 2 years, and the insurer would be allowed to solicit retiree participation from current retirees.

The Department would provide the names and addresses of the retirees to the insurer, but the insurer would be prohibited from using the information to solicit business for any products that were not eligible to be paid for with retirement benefit payment deductions. A retiree could opt to stop receiving solicitations. The premiums paid by the retirees would also support the administrative costs of the program in the Department. When a contract with an insurance company expires, the company would be required to keep any retirees who chose to remain with the company.

BACKGROUND: The Department currently has a program that implements many of the provisions of this bill. The program has been in place for over 20 years and currently allows about 25,000 retirees to purchase Dental and Vision insurance under a group policy and pay those premiums through deductions from their retirement benefit payments.

ATTACHMENT III

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H 1

HOUSE BILL 657*

Short Title:	Producer Comp. Transparency and Broker Duty.-AB	(Public)
Sponsors:	Representative Holliman.	
Referred to:	Insurance.	

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO REQUIRE INSURANCE PRODUCERS TO DISCLOSE COMPENSATION ARRANGEMENTS TO CUSTOMERS AND TO CLARIFY THAT AN INSURANCE BROKER MUST SERVE THE INTEREST OF THE CUSTOMER FIRST.

The General Assembly of North Carolina enacts:

SECTION 1. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-86. Insurance producer compensation transparency.**

(a) Where any insurance producer or any affiliate of an insurance producer receives any compensation from the customer for the placement of insurance or represents the customer with respect to that placement, neither that producer nor the affiliate shall accept or receive any compensation from an insurer or other third party for that placement of insurance unless the producer has, prior to the customer's purchase of insurance:

(1) Obtained the customer's documented acknowledgment that the compensation will be received by the producer or affiliate; and

(2) Disclosed the amount of compensation from the insurer or other third party for that placement. If the amount of compensation is not known at the time of disclosure, the producer shall disclose the specific method for calculating the compensation and, if possible, a reasonable estimate of the amount.

(b) Subsection (a) of this section shall not apply to an insurance producer who:

(1) Does not receive compensation from the customer for the placement of insurance;

(2) In connection with that placement of insurance, represents an insurer that has appointed the producer; and

(3) Discloses to the customer prior to the purchase of insurance (i) that the insurance producer will receive compensation from an insurer in

connection with that placement, or (ii) that, in connection with that placement of insurance, the insurance producer represents the insurer and that the producer may provide services to the customer for the insurer.

(c) A person shall not be considered a "customer" for purposes of this section if the person is merely either (i) a participant or beneficiary of an employee benefit plan, or (ii) covered by a group or blanket insurance policy or group annuity contract sold, solicited, or negotiated by the insurance producer or affiliate.

(d) This section does not apply to either (i) a person licensed as an insurance producer who acts only as an intermediary between an insurer and the customer's producer, for example a managing general agent, a sales manager, or a wholesale broker, or (ii) a reinsurance intermediary.

(e) For purposes of this section:

(1) "Affiliate" means a person that controls, is controlled by, or is under common control with the producer.

(2) "Compensation from an insurer or other third party" means payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration, whether or not payable pursuant to a written agreement.

(3) "Compensation from the customer" shall not include any fee or amount collected by or paid to the producer that does not exceed an amount established by the Commissioner.

(4) "Documented acknowledgment" means the customer's written consent obtained prior to the customer's purchase of insurance. In the case of a purchase over the telephone or by electronic means for which written consent cannot reasonably be obtained, consent documented by the producer shall be acceptable."

SECTION 2. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-19. Fiduciary duty of broker.**

A broker has a fiduciary duty to protect the best interests of the broker's client or customer."

SECTION 3. Section 1 of this act becomes effective January 1, 2006. The remainder of this act is effective when it becomes law.

III

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 657*
PROPOSED COMMITTEE SUBSTITUTE H657-CSRC-51 [v.2]

5/18/2005 8:33:02 PM

Short Title: Broker Comp. Transparency and Broker Duty.-AB (Public)

Sponsors:

Referred to:

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO REQUIRE INSURANCE BROKERS TO DISCLOSE COMPENSATION ARRANGEMENTS TO CUSTOMERS AND TO CLARIFY THAT AN INSURANCE BROKER MUST SERVE THE INTEREST OF THE CUSTOMER FIRST.

The General Assembly of North Carolina enacts:

SECTION 1. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-86. Broker compensation consent and disclosure.**

(a) No broker that receives compensation directly from the customer shall also accept or receive any compensation from an insurer or other third party for the initial placement of insurance for a customer unless the broker has, prior to the customer's purchase of insurance complied with all of the following:

(1) Disclosed to the customer the amount of compensation the broker will receive from the insurer or other third party for the placement. If the amount of compensation is not known and cannot be determined at the time of disclosure, the broker shall disclose the specific method for calculating the compensation and, if possible, a reasonable estimate of the amount that will be received.

(2) Obtained the customer's written consent that the compensation will be received by the broker. In the case of a purchase over the telephone or by electronic means for which written consent cannot reasonably be obtained, the broker shall document the customer's consent.

(B) This section does not apply to any of the following:

(1) A person licensed as an insurance producer who acts only as an intermediary between an insurer and the customer's producer, including a managing general agent, a sales manager, or a wholesale broker

(2) A reinsurance intermediary.
(3) An agent of a company which is a member of the North Carolina Insurance Underwriting Association placing or binding coverage with the Association for a customer.
(4) An agent of a company which is a member of the North Carolina Joint Underwriting Association placing or binding coverage with the Association for a customer.
(5) The placement of insurance in excess or surplus lines.

(d) For purposes of this section:
(1) "Affiliate" has the same meaning as in G.S. 58-19-5(1).
(2) "Broker" has the same meaning as in G.S. 58-33-10(3) and includes an affiliate of a broker.
(3) "Compensation from an insurer or other third party" means payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration, whether or not payable pursuant to a written agreement.
(4) "Customer" shall not include a person who is merely either a participant or beneficiary of an employee benefit plan, or covered by a group or blanket insurance policy or group annuity contract sold, solicited, or negotiated by the broker."

SECTION 2. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-19. Fiduciary duty of broker.**

A broker has a fiduciary duty to protect the best interests of the broker's client or customer."

SECTION 3. Section 1 of this act becomes effective January 1, 2006. The remainder of this act is effective when it becomes law.

HOUSE BILL 657:
Broker Comp. Transparency and Broker Duty.-AB

BILL ANALYSIS

Committee:	House Insurance	**Date:**	May 19, 2005
Introduced by:	Rep. Holliman	**Summary by:**	Kory Goldsmith
Version:	PCS to First Edition H657-CSRC-51		Committee Counsel

SUMMARY: House Bill 657 would require a broker who is paid by a customer to obtain insurance to disclose to the customer any compensation the broker may also receive from an insurer for the initial placement of the insurance. The broker would be required to disclose the amount of compensation the broker will receive and also obtain the customer's consent that the broker will receive the compensation. The bill also provides that a broker owes a fiduciary duty to protect the best interests of the client or customer.

The PCS narrows the scope of the disclosure requirements so they only apply to brokers. The 1st Edition applies to "insurance producers".

CURRENT LAW: There are no current requirements regarding discloses by brokers who are paid by customers and also paid by an insurer with whom the broker places the insurance.

There are a number of legal requirements regarding the duties of brokers. They include:

- G.S. 58-33-46(a)(8) which holds agents and brokers to the duty of competence, trustworthiness, and financial responsibility.
- G.S. 58-33-20(b) that provides that every broker who solicits an application for insurance in any controversy between the insured (or the beneficiary) and the insurer issuing the policy represents the insured (or the beneficiary) not the insurer.
- 11 NCAC 4.0423 that states that every agent and broker shall, when in contact with the public, "conduct himself in such a manner as to inspire confidence by fair and honorable dealings."
- Case law that holds that an insurance agent acts as a fiduciary with respect to procuring insurance for an insured. Phillips v. State Farm Mut. Auto Ins. Co., 129 N.C. App. 111, 113; 497 S.E. 2d 325, 327 (1998).

BILL ANALYSIS:

Section 1 creates G.S. 58-33-86. It would provide that a broker that receives compensation directly from a customer may not accept or receive compensation from an insurer or other third party for the initial placement of insurance for a customer unless the broker complies with certain disclosure and customer consent requirements. The requirements include disclosure of the amount the broker will be paid by the insurer or third party. If the amount cannot be determined prior to the sale, the broker must disclose how the amount will be calculated and estimate the amount that the broker will receive. The broker must also obtain the customer's written consent to the compensation the broker will receive. The broker must meet these disclosure and consent requirements before the customer purchases the insurance.

The section includes a number of definitions. A "broker" is defined as a person who is a licensed agent and procures insurance for a party other than the broker through a duly authorized agent of an insurer

that is licensed to do business in North Carolina, but for which the broker is not authorized to act as an agent. The definition includes a person who is not duly licensed but who procures insurance for a party other than himself. "Compensation from an insurer or third party" means payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration, whether or not payable under a written agreement. "Affiliate" means a person that indirectly through on or more intermediaries or directly controls, is controlled by, or isunder common control with the person specified. "Customer" would not include a person who is merely either a participant or beneficiary of an employee benefit plan, or covered by a group or blanket insurance policy or group annuity contract sold, solicited, or negotiated by the broker.

The disclosure and consent requirements would not apply to: intermediaries between an insurer and the customer's agent, reinsurance intermediaries, placement with the Beach and FAIR Plans, or placement of insurance in excess or surplus lines.

Section 2 specifies that a broker has a fiduciary duty to protect the best interests of the broker's client or customer.

EFFECTIVE DATE: Section 1 of the act would become effective January 1, 2006. The remainder of the act would become effective when the bill becomes law.

BACKGROUND: This bill draft substantially mirrors model legislation adopted by the National Association of Insurance Commissioners and the National Conference of Insurance Legislators.

H0657e1-SMRC-CSRC-51

COMPENSATION DISCLOSURE REQUIREMENTS FOR PRODUCERS

5/10/05

Number of bills/regs based on NAIC amendment: 6
Number of bills/regs based on NAIC amendment with significant changes: 10
Number of these bills/regs based on NCOIL model: 6
Number of bills/regs not based on NAIC amendment: 16

Number of states that introduced legislation and/or regulation: 17
Number of states that issued bulletins: 3

The date following each state indicates the last time information for the state was reviewed/changed.

STATE	CITATION	TO WHOM APPLICABLE	TYPE OF DISCLOSE REQUIRED	FORM OF DISCLOSURE REQUIRED	BASED ON NAIC AMENDMENT & MISCELLANEOUS
AL					
AK					
AZ					
AR (5/05)	**SB 233 (2005)** Governor signed, 4/5/05.	All insurance producers. Excludes residual market; credit life or disability; and renewals, unless previously disclosed information has substantially changed.	Disclose (1) whether the producer or its affiliate represents the customer or the insurer; and (2) the source(s) of the producer's or affiliate's compensation for placement.	Not specified.	**Based on NAIC amendment with significant changes.**
CA (5/05)	***Reg. Tit. 10 §§ 2184.1 to 2184.4 pending***	*Producer – a person possessing a license described in Chapters 5 and 7 of Part 2 of Division 1 of the Insurance Code.*	*Advise the client: (1) whether the producer is acting on behalf of the insurer or the client (producer who accepts a fee from a client is conclusively deemed to be acting on behalf of the client; and (2) amount of compensation.* *Requirement to disclose all quotes.*	*Not specified.*	***Not based on NAIC amendment.*** *If producer (1) acts on behalf of client or (2) accepts fee from client, he/she must obtain client's consent before accepting compensation from third party.*

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COMPENSATION DISCLOSURE REQUIREMENTS FOR PRODUCERS

5/10/05

STATE	CITATION	TO WHOM APPLICABLE	TYPE OF DISCLOSE REQUIRED	FORM OF DISCLOSURE REQUIRED	MISCELLANEOUS
CA (cont) (5/05)	***SB 938 pending (2005)*** *Introduced, 2/22/05. Failed passage in committee, reconsideration granted, 4/27/05.*	*Licensee acting on behalf of client.*	*Disclose certain details of all quotes received that licensee knows might meet client's express needs or desires or licensee's representations.*	*Not specified.*	***Not based on NAIC amendment.*** *Establishes licensee's duties to client.*
CO					
CT (5/05)	***SB 1180 pending (2005)*** *Introduced 2/24/05.*	*All insurance producers.* *Excludes renewals or changing coverage.*	*Disclose (1) whether acting on behalf of purchaser or insurer; (2) source of compensation; and (3) all quotes received. Additional disclosure if purchaser purchases recommended product.*	*Written.*	***Based on NAIC amendment with significant changes.*** *Establishes undivided fiduciary obligation.*
	HB 6806 pending (2005) *Introduced 2/24/05. Passed House, 4/28/05.*	*All Insurance producers.* *Excludes residual market and if sole compensation is derived from commissions or other remuneration from the insurer.*	*Type of disclosure depends on whether producer receives compensation directly from the customer. If so, disclose amount or method and estimate. If not, disclose fact of compensation from insurer and representation of insurer.*	*Documented acknowledgement of customer's consent.*	***Based on NAIC amendment with significant changes.*** ***Similar to NCOIL model.***
	HB 6689 pending (2005) *Introduced 2/10/05.*	*Insurance producer who receives compensation from or represents the customer.*	*Disclose the amount of compensation from the insurer or other third party.*	*Documented acknowledgement of customer's consent.*	***Based on NAIC amendment.*** *Adds intentional misquote of premium rate as unfair trade practice.*

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COMPENSATION DISCLOSURE REQUIREMENTS FOR PRODUCERS

5/10/05

STATE	CITATION	TO WHOM APPLICABLE	TYPE OF DISCLOSE REQUIRED	FORM OF DISCLOSURE REQUIRED	MISCELLANEOUS
CT (cont) (5/05)	***Proposed Bill 1004 pending (2005)*** *Introduced 2/3/05.*	*N/A*	*N/A*	*N/A*	***Not based on NAIC amendment.*** *Prohibits use, payment or collection of contingent commissions.*
	Proposed Bill 1006 pending (2005) *Introduced 2/3/05.*	*N/A*	*N/A*	*N/A*	***Not based on NAIC amendment.*** *Establishes fiduciary duty to protect client's best interests.*
DE					
DC					
FL (5/05)	***Amendment 241796 to SB 1912 pending (2005)*** *Filed 5/3/05. Withdrawn on 2R, 5/4/05.*				
GA (5/05)	**HB 407 (2005)** Signed by Governor, 5/2/05.	Producer licensed as counselor who receives compensation from the customer. Excludes renewals.	Disclose the amount of compensation from the insurer or other third party.	Consent is required.	**Based on NAIC amendment with significant changes.**
HI					
ID					

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COMPENSATION DISCLOSURE REQUIREMENTS FOR PRODUCERS

5/10/05

STATE	CITATION	TO WHOM APPLICABLE	TYPE OF DISCLOSE REQUIRED	FORM OF DISCLOSURE REQUIRED	MISCELLANEOUS
IL (5/05)	***HB 501 pending (2005)*** *Introduced 1/27/05.*	*Producer or business entity that receives compensation from the customer.*	*Disclose amount or extent of compensation or fee.*	*Written disclosure. If the combined compensation or fee exceeds 10% of a directly attributable premium amount, the disclosure must include the signature of the consumer or contracting party.*	***Not based on NAIC amendment.*** *Retain copy of written disclosure for 7 years.*
	HB 1425 pending (2005) *Introduced 2/10/05.*	*Producer or business entity that receives compensation from the customer.*	*Disclose amount or extent of compensation or fee*	*Written disclosure. If the combined compensation or fee exceeds 10% of a directly attributable premium amount, the disclosure must include the signature of the consumer or contracting party.*	***Not based on NAIC amendment.*** *Retain copy of written disclosure for 7 years.*
	SB 2016 pending (2005) *Introduced 2/25/05.* *Postponed 3/9/05.*	*Producer who receives compensation from or represents the customer.* *Excludes producer contracted to sell on behalf of one insurer.*	*Disclose that (1) compensation may be received from insurer or third party; (2) compensation may differ depending on product and insurer; (3) producer may receive additional compensation based on other factors; and (4) some insurers may offer more compensation than others for the same customer's business.*	*Form prescribed by the Secretary and signed by the customer*	***Based on NAIC amendment with significant changes.*** *A customer may request additional information by submitting a written request within 30 days of signing the initial disclosure. The producer or affiliate shall provide the requested information within 10 business days.*
IN					
IA					

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COMPENSATION DISCLOSURE REQUIREMENTS FOR PRODUCERS

5/10/05

STATE	CITATION	TO WHOM APPLICABLE	TYPE OF DISCLOSE REQUIRED	FORM OF DISCLOSURE REQUIRED	MISCELLANEOUS
KS					
KY					
LA	***HB 355 pending (2005)*** *Prefiled 4/13/05.*	*Producer who receives compensation from the customer.* *Excludes residual markets and if sole compensation is derived from commissions or other remuneration from the insurer.*	*Disclose that producer earns a commission and may earn other incentive compensation.*	*Standardized written disclosure.*	***Based on the NAIC amendment with significant changes.*** ***Similar to NCOIL model.***
ME					
MD					
MA					
MI					
MN (5/05)	***HF 387 pending (2005)*** *Introduced 1/24/05.*	*All insurance producers.* *Risk manager must disclose compensation from an insurer providing a quote.*	*Disclose details of all quotes received.*	*Written.*	***Not based on NAIC amendment.*** *A person performing as a producer is at all times the agent of the insurer and not the insured.* *Establishes producer's duties to client.*

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COMPENSATION DISCLOSURE REQUIREMENTS FOR PRODUCERS

5/10/05

STATE	CITATION	TO WHOM APPLICABLE	TYPE OF DISCLOSE REQUIRED	FORM OF DISCLOSURE REQUIRED	MISCELLANEOUS
MN (cont) (5/05)	***HF 2445/SF 2235 pending (2005)*** *Introduced 4/18/05.*	*Every insurance producer presenting or delivering a policy.*	*Disclose details of all quotes received.*	*Written.*	***Not based on NAIC amendment.***
MS (5/05)	**HB 1173 (2005)** Introduced and referred to Insurance, 1/17/05. **Died in Committee, 2/1/05.**	All licensed producers.	Disclose the amount of commission or other valuable consideration at or before the time of sale.	Not specified.	**Not based on NAIC amendment.** Insurer restricted from paying producer who has not made the required disclosure.
MO					
MT					
NE					

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COMPENSATION DISCLOSURE REQUIREMENTS FOR PRODUCERS

5/10/05

STATE	CITATION	TO WHOM APPLICABLE	TYPE OF DISCLOSE REQUIRED	FORM OF DISCLOSURE REQUIRED	MISCELLANEOUS
NV (5/05)	Temporary Regulation Concerning Broker's Duties to Clients Effective 2/16/05 to 11/1/05.	All insurance producers performing in the capacity of brokers as defined by statute.	Disclose: (1) broker may receive compensation from insurer or third party; (2) name and identity of source of compensation including broker's ownership interest or common control with source; (3) whether compensation is standard or non-standard; (4) that additional compensation may be based on other disclosed factors; (5) other entities reasonably known to broker that will receive compensation from insurer for assisting in the sale; and (6) sources of all quotes received.	Documented acknowledgement by the client and the broker.	**Not based on NAIC amendment** Establishes broker's duty against self-dealing.
NH					
NJ (5/05)	Bulletin No. 04-20 Dated 10/22/04.	Insurance producer who charges fee to insured or prospective insured.	Must obtain agreement containing clear statement of the amount of the fee and whether a commission will be received upon the purchase of insurance (N.J.A.C. 11:17B-3.1).	Written agreement.	Producer acts in a fiduciary capacity (N.J.A.C. 11:17a-4.10).
NM					

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COMPENSATION DISCLOSURE REQUIREMENTS FOR PRODUCERS

5/10/05

STATE	CITATION	TO WHOM APPLICABLE	TYPE OF DISCLOSE REQUIRED	FORM OF DISCLOSURE REQUIRED	MISCELLANEOUS
NY (5/05)	***A 5825 pending (2005)*** *Introduced 3/1/05.*	*Every insurance agent or broker.* *Excludes agents and brokers who earn an annual salary in lieu of a commission basis.*	*The existence and nature of all compensation, including but not limited to the source, nature, form, value, and method of calculation.*	*Form devised and distributed by the Department.*	***Not based on NAIC amendment.*** *Failure to disclose is a violation of fiduciary duty.*
	A 5826 pending (2005) *Introduced 3/1/05.*	*Every insurance agent or broker who receives compensation from the client.* *Excludes producers who are not compensated by client, who are appointed, who disclose that they receive compensation from insurer or who represent the insurer.*	*The existence and nature of all compensation, including but not limited to the source, nature, form, value, and method of calculation.*	*Form devised and distributed by the Department.*	***Not based on NAIC amendment.*** *Failure to disclose is a violation of fiduciary duty.*

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COMPENSATION DISCLOSURE REQUIREMENTS FOR PRODUCERS

5/10/05

STATE	CITATION	TO WHOM APPLICABLE	TYPE OF DISCLOSE REQUIRED	FORM OF DISCLOSURE REQUIRED	MISCELLANEOUS
NY (cont) (5/05)	***A 5827 pending (2005)*** *Introduced 3/1/05.*	*Agents and/or brokers.*	*N/A*	*N/A*	***Not based on NAIC amendment.*** *Incentive or profit-sharing compensation arrangements are permitted if based on overall performance of book of business based on a combination of profitability, volume, growth and/or retention.* *Requires all such compensation arrangements to be filed annually with the department.*
	A 5828 pending (2005 *Introduced 3/1/05.*	*Every agent or broker.*	*N/A*	*N/A*	***Not based on NAIC amendment.*** *Every agent and broker shall have a duty to exercise reasonable care in obtaining the best terms possible for such agent or broker's client. Agent or broker not responsible for client's failure to select best terms offered.*

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COMPENSATION DISCLOSURE REQUIREMENTS FOR PRODUCERS

5/10/05

STATE	CITATION	TO WHOM APPLICABLE	TYPE OF DISCLOSE REQUIRED	FORM OF DISCLOSURE REQUIRED	MISCELLANEOUS
NC (5/05)	***HB 657 pending (2005)*** *Filed 3/15/05.*	*Producer who receives compensation from or represents the customer.*	*Disclose the amount of compensation from the insurer or other third party for that placement. Different disclosure if producer does not receive compensation from customer and is appointed by the insurer.*	*Documented acknowledgement of customer's consent.*	***Based on NAIC amendment.***
	SB 576 pending (2005) *Filed 3/15/05.*	*Producer who receives compensation from or represents the customer.*	*Disclose the amount of compensation from the insurer or other third party for that placement. Different disclosure if producer does not receive compensation from customer and is appointed by the insurer.*	*Documented acknowledgement with customers written consent.*	***Based on NAIC amendment.*** *Establishes fiduciary duty to protect client's best interests.*
ND					
OH					
OK					
OR (5/05)	***Proposed Rule 836-071-0260***	*Producer who charges prospective insured a service fee or combination of service fee and commission.* *Different disclosure applies between wholesale producer and retail producer.*	*Disclose certain details of representation including statement about receipt of commission or other compensation and that customer may request certain information about the commission or other compensation.*	*Written agreement between producer and prospective insured.*	***Not based on NAIC amendment.***

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COMPENSATION DISCLOSURE REQUIREMENTS FOR PRODUCERS

5/10/05

STATE	CITATION	TO WHOM APPLICABLE	TYPE OF DISCLOSE REQUIRED	FORM OF DISCLOSURE REQUIRED	MISCELLANEOUS
PA (5/05)	***HB 470 pending (2005)*** *Referred to Insurance 2/14/05.*	*Producer who receives compensation from or represents the customer.*	*Disclose the amount of compensation from the insurer or other third party for that placement. Different disclosure if producer does not receive compensation from customer and is appointed by the insurer.*	*Documented acknowledgement of customer's consent.*	***Based on NAIC amendment.***
PR					
RI (5/05)	***SB 417/HB 5469 pending (2005)*** *Introduced 2/10/05.*	*Producer who receives compensation from or represents the customer.*	*Disclose the amount of compensation or from insurer or other third party. Different disclosure if producer: (1) exclusively markets for a single insurer; (2) does not receive compensation from the customer; and (3) is appointed by the insurer.* *Disclosure form must contain all premiums offered by each insurer and the compensation related thereto, including method of calculation.*	*Form signed by both the producer and the customer.*	***Based on NAIC amendment.*** *No compensation shall be paid in excess of amount disclosed.* *Form shall be maintained in the producer's file for a period of at least one year.* *Establishes fiduciary capacity.*

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COMPENSATION DISCLOSURE REQUIREMENTS FOR PRODUCERS

5/10/05

STATE	CITATION	TO WHOM APPLICABLE	TYPE OF DISCLOSE REQUIRED	FORM OF DISCLOSURE REQUIRED	MISCELLANEOUS
RI (cont) (5/05)	***SB 545 pending (2005)*** *Introduced 2/10/05. Committee recommended measure be held for further study, 3/29/05.*	*Producer who receives compensation from or represents the customer.*	*Disclose the amount of compensation from the insurer or other third party for that placement. Different disclosure if producer does not receive compensation from customer and is contractually authorized to act as insurer's legal agent.*	*Documented acknowledgement of customer's consent.*	***Based on NAIC amendment.***
	SB 1015 pending (2005) *Introduced 4/12/05. Passed Senate 5/10/05.*	*Producer or any affiliate of such producer who receives any compensation from the customer for the initial placement of insurance.* *Excludes residual market and if sole compensation is derived from commissions or other remuneration from the insurer.*	*Provide a description of the method and factors utilized for calculating the compensation to be received from the insurer or other third party for that placement.*	*Customer's documented acknowledgment that compensation will be received.*	***Based on NAIC amendment with significant changes.*** ***Similar to NCOIL model.*** *All producers shall, at the time of sale or no later than the delivery of the policy, disclose that they will be paid a commission by the company and may receive other performance-based compensation. This does not apply to salaried employees of an insurance company.*

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COMPENSATION DISCLOSURE REQUIREMENTS FOR PRODUCERS

5/10/05

STATE	CITATION	TO WHOM APPLICABLE	TYPE OF DISCLOSE REQUIRED	FORM OF DISCLOSURE REQUIRED	MISCELLANEOUS
RI (cont) (5/05)	*HB 6233 pending (2005)* *Introduced 3/16/05.*	*Producer or any affiliate of such producer who receives any compensation from the customer for the initial placement of insurance.* *Excludes residual market and if sole compensation is derived from commissions or other remuneration from the insurer.*	*Provide a description of the method and factors utilized for calculating the compensation to be received from the insurer or other third party for that placement.*	*Customer's documented acknowledgment that compensation will be received.*	***Based on NAIC amendment with significant changes.*** *Similar to NCOIL model.* *All producers shall, at the time of sale or no later than the delivery of the policy, disclose that they will be paid a commission by the company and may receive other performance-based compensation. This does not apply to salaried employees of an insurance company.*
SC					
SD					
TN (5/05)	***Proposed Rule 0780-1-85 Dishonest Acts By Brokers***	*Producer who represents, purports to represent or allows a client to reasonably assume he represents a client in an insurance transaction.*	*Disclose all material facts surrounding receipt of income from a third party that derives in whole or party from a transaction on behalf of a client.*	*Not specified.*	***Not based on NAIC amendment.*** *Establishes fiduciary duty.*

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COMPENSATION DISCLOSURE REQUIREMENTS FOR PRODUCERS

5/10/05

STATE	CITATION	TO WHOM APPLICABLE	TYPE OF DISCLOSE REQUIRED	FORM OF DISCLOSURE REQUIRED	MISCELLANEOUS
TX (5/05)	***HB 2947 pending (2005)***	*Agent receives any compensation from the customer for the initial placement of insurance.* *Excludes surplus lines and agent whose sole compensation is derived from commissions or other remuneration from insurer.*	*Provide a description of the method and factors utilized for calculating the compensation to be received from the insurer or other third party for that placement.*	*Customer's acknowledgement obtained prior to the customer's purchase of insurance.*	***Based on NAIC amendment with significant changes.*** ***Similar to NCOIL model.***
	HB 2941 pending (2005)	*Agent receives any compensation from the customer for the placement or renewal of insurance or services the agent agrees to perform in connection with the placement.* *Excludes surplus lines and agent whose sole compensation is derived from commissions or other remuneration from insurer.*	*Provide a description of the method and factors utilized for calculating the compensation to be received from the insurer or other third party for that placement.*	*Dated acknowledgement obtained prior to the customer's purchase of insurance.*	***Based on NAIC amendment with significant changes.*** ***Similar to NCOIL model.***
UT					
VT					
VI					
VA					

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COMPENSATION DISCLOSURE REQUIREMENTS FOR PRODUCERS

5/10/05

STATE	CITATION	TO WHOM APPLICABLE	TYPE OF DISCLOSE REQUIRED	FORM OF DISCLOSURE REQUIRED	MISCELLANEOUS
WA (5/05)	Technical Assistance Advisory T 04-05 Issued 10/21/2004	Broker/agent placing property or casualty coverage who (1) receives fee from insured, (2) deals directly with insured; and (3) receives commission from insurer.	Disclose full amount of compensation.	Written form that must be signed by the insured and the agent/broker.	Disclosure must be retained by the agent/broker for five years.
WV					
WI (5/05)	Bulletin to Insurers re: §628.32(1) Dated 2/4/05	Insurance intermediary (insurance agent or broker) who accepts compensation from insured.	Disclose (1) that intermediary will also be compensated by insurer; and (2) amount of compensation.	Written.	
WY					

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Every effort has been made to provide correct and accurate summaries to assist the reader in targeting useful information. For further details, the statutes and regulations cited should be consulted. The NAIC attempts to provide current information; however, readers should consult state law for additional adoptions.

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III

Q & A on Fiduciary Duty of Brokers

How does imposition of a statutory fiduciary duty on brokers change the current legal duty owed by a broker to the customer?

None. The Department interprets current law as provided in statute, regulation and case law as imposing that duty on brokers already. See Attachment 1.

Why is this statutory change needed?

It is needed to concisely state the law on the broker's duty and provide a solid statutory basis for the Department to suspend, revoke, or refuse to renew the license of a broker when that broker violates that duty to the customer.

What is a "fiduciary duty?"

Black's Law Dictionary defines "fiduciary duty" as "[a] duty to act for someone else's benefit, while subordinating one's personal interests to that of the other person." and describes a "fiduciary" as "[a] person having duties involving good faith, trust, special confidence, and candor towards another."

For what other relationships is "a fiduciary duty" imposed?

- Attorney and client
- Guardian and ward
- Principal and agent
- Executor and heir
- Real estate broker representing the purchaser and the purchaser client
- Any relationship "[w]here a special confidence is reposed in one who in equity and good conscience is bound to act in good faith and with due regard to the interests of the one reposing the confidence."

ATTACHMENT 1

Existing law respecting the duties and responsibilities of brokers (and agents) toward their customers:

- G.S. 58-33-46(a)(8) holds agents and brokers to the duty of competence, trustworthiness, and financial responsibility.

- G.S. 58-33-20(b) provides that every broker who solicits an application for insurance in any controversy between the insured (or the beneficiary) and the insurer issuing the policy represents the insured (or the beneficiary) not the insurer.

- 11 NCAC 4.0423 states that every agent and broker shall, when in contact with the public, "conduct himself in such a manner as to inspire confidence by fair and honorable dealings."

- "An insurance agent acts as a fiduciary with respect to procuring insurance for an insured[.]" Phillips v. State Farm Mut. Auto Ins. Co., 129 N.C. App. 111, 113; 497 S.E. 2d 325, 327 (1998).

111

Service: **Get by LEXSEE®**
Citation: **129 NCApp 111**

*129 N.C. App. 111, *; 497 S.E.2d 325, **;*
*1998 N.C. App. LEXIS 360, ***

LARRY DEAN PHILLIPS, by his Guardian Ad Litem, DAVIS A. PHILLIPS, Plaintiff, v. STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY and CATHY EDWARDS, Defendants.

NO. COA97-802

COURT OF APPEALS OF NORTH CAROLINA

129 N.C. App. 111; 497 S.E.2d 325; 1998 N.C. App. LEXIS 360

February 16, 1998, Heard in the Court of Appeals
March 17, 1998, Filed

PRIOR HISTORY: **[***1]** Appeal by plaintiff from order entered 30 May 1997 by Judge Beverly T. Beal in Gaston County Superior Court.

DISPOSITION: Affirmed.

CASE SUMMARY

PROCEDURAL POSTURE: Plaintiff insured sought review of a decision from the Gaston Superior Court (North Carolina), which dismissed plaintiff's action for negligent breach of fiduciary duty for failure to explain that the insured would be eligible for uninsured motorist coverage if he increased his coverage above the statutory minimum limits.

OVERVIEW: In an action against its insurance company and the company's agent, an insured sought review of a decision from the trial court which dismissed with prejudice his action for negligence. The court determined that although an insurance company was obligated to provide the coverage requested by an insured, they were not obligated to inform the insured that he would be eligible for uninsured motorist coverage by ordering coverage in excess of the statutory minimum. Additionally, the insured had previously rejected the coverage so there was no guarantee he would accept it if it were offered.

OUTCOME: The court affirmed the order of the trial court which dismissed the insured's complaint with prejudice.

CORE TERMS: coverage, insured, policyholder, statutory minimum, insurance agent, automobile liability insurance, liability coverage, fiduciary duty, eligible, duty, correctly, procure, annually, renewed

LexisNexis(R) Headnotes ◆ Hide Headnotes

Insurance Law > Motor Vehicle Insurance > Coverage Generally

HN1 An insurance agent acts as a fiduciary with respect to procuring insurance for an insured, correctly naming the insured in the policy, and correctly advising the insured about the nature and extent of his coverage. Thus an insurance agent has a duty to procure additional insurance for a policyholder at the request of the policyholder. The duty does not, however, obligate the insurer or its agent to procure a policy for the insured which had not been requested. More Like This Headnote

♦ Show Headnotes

SYLLABUS: The minor plaintiff was a passenger in an automobile which was involved in a collision with another vehicle on 13 April 1994. On 11 April 1997 plaintiff filed this action against defendant State Farm Mutual Automobile Insurance Company ("State Farm") and defendant Cathy Edwards, a local agent of State Farm, alleging that defendants negligently breached their fiduciary duty to him.

Plaintiff alleged that both drivers were negligent in the 13 April 1994 accident and that their joint negligence produced his injuries. Plaintiff further alleged that the maximum automobile liability coverage available from both alleged tort-feasors did not exceed $ 100,000.

On the accident date, plaintiff had an automobile insurance policy with defendant State Farm, providing statutory minimum liability coverage of $ 25,000 for bodily injury or death for each person and a maximum of $ 50,000 coverage for bodily injury **[***2]** or death to two or more persons. Plaintiff's policy had $ 1,000,000 uninsured motorist coverage, but no underinsured motorist ("UIM") coverage.

Plaintiff originally obtained his automobile liability policy on 23 July 1988 from State Farm's insurance agent, defendant Cathy Edwards. At that time, he specifically gave a written rejection of UIM. Plaintiff renewed the policy annually thereafter, always with statutory minimum liability coverage. He never re-executed the waiver of UIM coverage.

Plaintiff alleges that defendants negligently breached their fiduciary duty to him by not explaining that UIM coverage was available to him provided he increased the amount of his liability coverage; that their failure to so inform him was negligence; and that plaintiff has been damaged thereby.

The trial court granted defendants' N.C. Gen. Stat. § 1A-1, Rule 12(b)(6) (1990) motion for dismissal, and plaintiff appealed.

COUNSEL: Don H. Bumgardner for plaintiff appellant.

Stott, Hollowell, Palmer & Windham, L.L.P., by Martha Raymond Thompson for defendant appellees.

JUDGES: HORTON, Judge. Chief Judge ARNOLD and Judge EAGLES concur.

OPINIONBY: HORTON

OPINION:

[327]** **[*113]** HORTON, Judge.

The issue presented **[***3]** by this appeal is whether an insurance agent negligently breaches a fiduciary duty to a policyholder who has a minimum limits automobile liability insurance policy if she does not explain to the policyholder that he would be eligible for UIM coverage if he increased his automobile liability insurance coverage above the statutory minimum limits.

HN1 An insurance agent acts as a fiduciary with respect to procuring insurance for an insured, correctly naming the insured in the policy, and correctly advising the insured about the nature and extent of his coverage. *See* R-Anell Homes, Inc. v. Alexander & Alexander, Inc., 62 N.C. App. 653, 659, 303 S.E.2d 573, 577 (1983), and the cases cited therein. Thus an insurance agent has a duty to procure additional insurance for a policyholder at the

request of the policyholder. *Johnson v. Tenuta & Co.*, 13 N.C. App. 375, 381, 185 S.E.2d 732, 736 (1972). The duty does not, however, obligate the insurer or its agent to procure a policy for the insured which had not been requested. *Baldwin v. Lititz Mutual Ins. Co.*, 99 N.C. App. 559, 561, 393 S.E.2d 306, 308 (1990).

In this case, plaintiff does not contend that he requested the agent to obtain **[***4]** UIM coverage for him. On the contrary, when plaintiff first obtained an automobile liability policy from defendant agent in 1988, he obtained a minimum limits policy and expressly waived UIM coverage. Thereafter, plaintiff annually renewed his policy of automobile liability coverage at the statutory minimum limits of coverage.

At all times relevant herein, a policyholder could only obtain UIM coverage when the policyholder purchased a policy of automobile liability insurance in excess of the minimum statutory requirement. N.C. Gen. Stat. § 20-279.21(b)(4) (1993 & Cum. Supp. 1997); *Hollar v. Hawkins*, 119 N.C. App. 795, 797, 460 S.E.2d 337, 338 (1995). In this case, plaintiff had minimum liability coverage at all times in question. We hold that, under these circumstances, defendants had no duty to advise plaintiff that, if he increased his liability coverage limits, he would be eligible for UIM coverage. We note that even had plaintiff been so notified, it is entirely speculative whether he would have incurred the additional expense of increasing his liability limits above the statutory minimum limits in order to avail himself of the opportunity to purchase UIM coverage. That **[***5]** is especially true in light of plaintiff's earlier rejection of UIM coverage.

[*114] Defendants having breached no duty to plaintiff, the order of the trial court dismissing plaintiff's action with prejudice is Affirmed.

Chief Judge ARNOLD and Judge EAGLES concur.

Service: **Get by LEXSEE®**
Citation: **129 NCApp 111**
View: Full
Date/Time: Wednesday, May 18, 2005 - 5:49 PM EDT

* Signal Legend:
- Warning: Negative treatment is indicated
- Questioned: Validity questioned by citing refs
- Caution: Possible negative treatment
- Positive treatment is indicated
- Citing Refs. With Analysis Available
- Citation information available

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§ 58-33-10. Definitions.

(3) "Broker" means a person who, being a licensed agent, procures insurance for a party other than himself through a duly authorized agent of an insurer that is licensed to do business in this State but for which the broker is not authorized to act as agent. A person not duly licensed who procures insurance for a party other than himself is a broker within the intent of this Article, and thereby becomes liable for all the duties, requirements, liabilities and penalties to which such licensed brokers are subject.

§ 58-33-20. Representation.

(a) Every agent or limited representative who solicits or negotiates an application for insurance of any kind, in any controversy between the insured or his beneficiary and the insurer, is regarded as representing the insurer and not the insured or his beneficiary. This provision does not affect the apparent authority of an agent.

(b) Every broker who solicits an application for insurance of any kind, in any controversy between the insured or his beneficiary and the insurer issuing any policy upon such application, is regarded as representing the insured or his beneficiary and not the insurer; except any insurer that directly or through its agents delivers in this State to any insurance broker a policy of insurance pursuant to the application or request of such broker, acting for an insured other than himself, is deemed to have authorized such broker to receive on its behalf payment of any premium that is due on such policy of insurance at the time of its issuance or delivery. (1987, c. 629, s. 1.)

§ 58-33-46. Suspension, probation, revocation, or nonrenewal of licenses.

(a) The Commissioner may place on probation, suspend, revoke, or refuse to renew any license issued under this Article, in accordance with the provisions of Article 3A of Chapter 150B of the General Statutes, for any one or more of the following causes: ...

(8) Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this State or elsewhere.

11 NCAC 04 .0423 ETHICAL STANDARDS

(a) Every agent, limited representative, broker, adjuster, appraiser, or other insurer's representative shall, when in contact with the public:

(1) promptly identify himself and his occupation;

(2) carry the license issued to him by the Department of Insurance while performing his duties and display it upon request to any claimant, any repairer at which he is investigating a claim or loss, any department representative, or any other person with whom he has contact while performing his duties;

(3) conduct himself in such a manner as to inspire confidence by fair and honorable dealings.

(b) No claims management person, agent, agency employee, limited representative, broker, adjuster, appraiser, or other insurer's representative shall:

(1) accept any gratuity or other form of remuneration from any provider of services for recommending that provider to claimants;

(2) purchase salvage from a claimant;

(3) intimidate or discourage any claimant from seeking legal advice and counsel by withdrawing and reducing a settlement offer previously tendered to the claimant or threatening to do so if the claimant seeks legal advice or counsel. No adjuster shall advise a claimant of the advisability of seeking legal counsel nor recommend any legal counsel to any claimant under any circumstance;

(4) cause any undue delay in the settlement of a property damage claim on account of the claimant's choice of a motor vehicle repair service.

(c) No claims management person, agent, agency employee, limited representative, broker, or other insurer's representative shall recommend the utilization of a particular motor vehicle repair service without clearly informing the claimant that he is under no obligation to use the recommended repair service and that he may use the service of his choice.

History Note: *Authority G.S. 58-2-40; 58-33-10; 58-33-25; 58-33-30; 58-35-25; 58-63-65; 58-65-40;*
Eff. December 15, 1979;
Amended Eff. April 1, 1993; April 1, 1989; July 1, 1986.

MINUTES
HOUSE COMMITTEE ON INSURANCE
May 24, 2005

The House Committee on Insurance met at 8:00 AM on Tuesday, May 24, 2005 in Room 1228. The following Representatives in attendance were: Chairman Hugh Holliman, Vice Chairs Bill Faison, Ed Jones, and Mitchell Setzer. Members: L. Allen, D. Almond, W. Current, R. Grady, L. Johnson, D. Ross, F. Steen and R. Sutton.

Chairman Holliman welcomed visitors, House pages and Sgt-At-Arms. Attachment I.

Rep. Setzer was asked to chair today's meeting. There were no objections to accept the PCS on HB 657 Producer Comp. Transparency and Broker Duty.-AB. Frank Folger, Legal Counselor, with DOI was called on to speak on the PCS. Mr. Folger explained that section 2 of the bill had been removed. Section 1 of the bill was not changed. After some discussion, Rep. Ross made a motion for a favorable report to the PCS unfavorable to the original bill. Motion carried. See Attachment II

Rep. Setzer asked the committee be at ease as an amendment was being prepared for HB 1236 - Insurance Bd. of Governors Membership. Rep. Setzer called the meeting back to order and the amendment was adopted. Shawn Parker, Committee Staff, was asked to explain the amendment to the committee. He explained the changes in the memberships and a technical change that would change term of office from 2 years to 3 years. See Attachment III. George Teague, attorney, spoke in support of bill and explained why amendment was needed. Rep. Johnson moved for a favorable report to the PCS as amendment with a title change unfavorable to the original bill. Motion carried unanimously.

The meeting was adjourned at 8:45 AM.

Representative. L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

HOUSE INSURANCE COMMITTEE

May 24, 2005
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

HB 657 - Producer Comp. Transparency and Broker Duty.-AB
Representative Holliman

HB 1236 - Insurance Bd. of Governors Membership. –
Representative Holliman

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Holliman (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for
HB 657 A BILL TO BE ENTITLED AN ACT TO REQUIRE INSURANCE PRODUCERS TO DISCLOSE COMPENSATION ARRANGEMENTS TO CUSTOMERS AND TO CLARIFY THAT AN INSURANCE BROKER MUST SERVE THE INTEREST OF THE CUSTOMER FIRST.

☒ With a favorable report as to the committee substitute bill, which changes the title, unfavorable as to the original bill.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Holliman (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for
HB 1236 A BILL TO BE ENTITLED AN ACT TO REPLACE THE ALLIANCE OF AMERICAN INSURERS AND NATIONAL ASSOCIATION OF INDEPENDENT INSURERS WITH THE PROPERTY CASUALTY INSURERS ASSOCIATION OF AMERICA AND THE NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES AS TRADE ASSOCIATION MEMBERS WHICH MUST BE REPRESENTED ON THE BOARD OF GOVERNORS OF THE NORTH CAROLINA REINSURANCE FACILITY.

☒ With a favorable report as to the committee substitute bill, which changes the title, unfavorable as to the original bill.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

HOUSE COMMITTEE ON INSURANCE

May 24, 2005
11:00 AM
Room 1228 Legislative Building

ATTACHMENT 1

Pages:

Name (please print clearly)	County	Representative
Eden Rouse	Alamance	Alice Bordsen
Lee Mann	Carteret	Drew Saunders
Hannah Myers	Davidson	Hugh Holliman

Sergeant-At-Arms (please print)

Lind Fuller

Brad Bare Foot

James Worth

Charles Williams

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 24, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
FRANK W. FOLGER	
Bob Rucho	NCAHC
Ron Walker	NCAHC
Jim Long	NCDOT
BILL HAZE	ACLI
Susan Valauri	Nationwide
Robert Paschal	Young, Moore
Joe Stewart	NFIC
BILL SCOGGIN	KCCH
	JDAL, PA

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 24, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Marion Smith	MS & Associates
Marlowe Foster	NCAHP
Courtney Crowder	NC DOI
[illegible]	MFDS
[illegible]	SA
Barbara Canada	BCGR
[illegible]	HOMAC Insurance

Attachment 11

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 657*
PROPOSED COMMITTEE SUBSTITUTE H657-CSRC-51 [v.17]

5/23/2005 5:12:37 PM

Short Title: Broker Comp. Transparency.-AB (Public)

Sponsors:

Referred to:

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO REQUIRE INSURANCE BROKERS TO DISCLOSE COMPENSATION ARRANGEMENTS TO CUSTOMERS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-86. Broker compensation consent and disclosure.**

(a) No broker that receives compensation directly from the customer shall also accept or receive any compensation from an insurer or other third party for the initial placement of insurance for a customer unless the broker has, prior to the customer's purchase of insurance complied with all of the following:

(1) Disclosed to the customer the amount of compensation the broker will receive from the insurer or other third party for the placement. If the amount of compensation is not known and cannot be determined at the time of disclosure, the broker shall disclose the specific method for calculating the compensation and, if possible, a reasonable estimate of the amount that will be received.

(2) Obtained the customer's written consent that the compensation will be received by the broker. In the case of a purchase over the telephone or by electronic means for which written consent cannot reasonably be obtained, the broker shall document the customer's consent.

(b) This section does not apply to any of the following:

(1) A person licensed as an insurance producer who acts only as an intermediary between an insurer and the customer's producer, including a managing general agent, a sales manager, or a wholesale broker

(2) A reinsurance intermediary.

(3) An agent of a company which is a member of the North Carolina Insurance Underwriting Association placing or binding coverage with the Association for a customer.

(4) An agent of a company which is a member of the North Carolina Joint Underwriting Association placing or binding coverage with the Association for a customer.

(5) The placement of insurance in excess or surplus lines.

(c) For purposes of this section:

(1) "Affiliate" has the same meaning as in G.S. 58-19-5(1).

(2) "Broker" has the same meaning as in G.S. 58-33-10(3) and includes an affiliate of a broker.

(3) "Compensation from an insurer or other third party" means payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration, whether or not payable pursuant to a written agreement.

(4) "Customer" shall not include a person who is merely either a participant or beneficiary of an employee benefit plan, or covered by a group or blanket insurance policy or group annuity contract sold, solicited, or negotiated by the broker."

SECTION 2. This act becomes effective January 1, 2006.

HOUSE BILL 657:
Broker Comp. Transparency and Broker Duty.-AB

BILL ANALYSIS

Committee:	House Insurance	**Date:**	May 19, 2005
Introduced by:	Rep. Holliman	**Summary by:**	Kory Goldsmith
Version:	PCS to First Edition H657-CSRC-51		Committee Counsel

SUMMARY: House Bill 657 would require a broker who is paid by a customer to obtain insurance to disclose to the customer any compensation the broker may also receive from an insurer for the initial placement of the insurance. The broker would be required to disclose the amount of compensation the broker will receive and also obtain the customer's consent that the broker will receive the compensation. The bill also provides that a broker owes a fiduciary duty to protect the best interests of the client or customer.

The PCS narrows the scope of the disclosure requirements so they only apply to brokers. The 1st Edition applies to "insurance producers".

CURRENT LAW: There are no current requirements regarding discloses by brokers who are paid by customers and also paid by an insurer with whom the broker places the insurance.

There are a number of legal requirements regarding the duties of brokers. They include:

- G.S. 58-33-46(a)(8) which holds agents and brokers to the duty of competence, trustworthiness, and financial responsibility.
- G.S. 58-33-20(b) that provides that every broker who solicits an application for insurance in any controversy between the insured (or the beneficiary) and the insurer issuing the policy represents the insured (or the beneficiary) not the insurer.
- 11 NCAC 4.0423 that states that every agent and broker shall, when in contact with the public, "conduct himself in such a manner as to inspire confidence by fair and honorable dealings."
- Case law that holds that an insurance agent acts as a fiduciary with respect to procuring insurance for an insured. Phillips v. State Farm Mut. Auto Ins. Co., 129 N.C. App. 111, 113; 497 S.E. 2d 325, 327 (1998).

BILL ANALYSIS:

Section 1 creates G.S. 58-33-86. It would provide that a broker that receives compensation directly from a customer may not accept or receive compensation from an insurer or other third party for the initial placement of insurance for a customer unless the broker complies with certain disclosure and customer consent requirements. The requirements include disclosure of the amount the broker will be paid by the insurer or third party. If the amount cannot be determined prior to the sale, the broker must disclose how the amount will be calculated and estimate the amount that the broker will receive. The broker must also obtain the customer's written consent to the compensation the broker will receive. The broker must meet these disclosure and consent requirements before the customer purchases the insurance.

The section includes a number of definitions. A "broker" is defined as a person who is a licensed agent and procures insurance for a party other than the broker through a duly authorized agent of an insurer

that is licensed to do business in North Carolina, but for which the broker is not authorized to act as an agent. The definition includes a person who is not duly licensed but who procures insurance for a party other than himself. "Compensation from an insurer or third party" means payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration, whether or not payable under a written agreement. "Affiliate" means a person that indirectly through on or more intermediaries or directly controls, is controlled by, or isunder common control with the person specified. "Customer" would not include a person who is merely either a participant or beneficiary of an employee benefit plan, or covered by a group or blanket insurance policy or group annuity contract sold, solicited, or negotiated by the broker.

The disclosure and consent requirements would not apply to: intermediaries between an insurer and the customer's agent, reinsurance intermediaries, placement with the Beach and FAIR Plans, or placement of insurance in excess or surplus lines.

Section 2 specifies that a broker has a fiduciary duty to protect the best interests of the broker's client or customer.

EFFECTIVE DATE: Section 1 of the act would become effective January 1, 2006. The remainder of the act would become effective when the bill becomes law.

BACKGROUND: This bill draft substantially mirrors model legislation adopted by the National Association of Insurance Commissioners and the National Conference of Insurance Legislators.

H0657e1-SMRC-CSRC-51

ATTACHMENT III

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H 1

HOUSE BILL 1236

Short Title:	Insurance Bd. of Governors Membership.	(Public)
Sponsors:	Representative Holliman.	
Referred to:	Insurance.	

April 18, 2005

A BILL TO BE ENTITLED

AN ACT TO REPLACE THE ALLIANCE OF AMERICAN INSURERS AND NATIONAL ASSOCIATION OF INDEPENDENT INSURERS WITH THE PROPERTY CASUALTY INSURERS ASSOCIATION OF AMERICA AND THE NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES AS TRADE ASSOCIATION MEMBERS WHICH MUST BE REPRESENTED ON THE BOARD OF GOVERNORS OF THE NORTH CAROLINA REINSURANCE FACILITY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-37-35(d) reads as rewritten:

"(d) The Facility shall be administered by a Board of Governors. The Board of Governors shall consist of 12 members having one vote each from the classifications specified in this subsection and the Commissioner, who shall serve ex officio without vote. Each Facility insurance company member serving on the Board shall be represented by a senior officer of the company. Not more than one company in a group under the same ownership or management shall be represented on the Board at the same time. Five members of the Board shall be selected by the member insurers, which members shall be fairly representative of the industry. To insure representative member insurers, one each shall be selected from the following trade associations: the American Insurance Association (or its successors), ~~the Alliance of American Insurers (or its successors), the National Association of Independent Insurers (or its successors),~~ the National Association of Mutual Insurance Companies (or its successors), the Property Casualty Insurers Association of America (or its successors), all other stock insurers not affiliated with those trade associations, and all other nonstock insurers not affiliated with those trade associations. The Commissioner shall appoint two members of the Board who are Facility insurance company members domiciled in this State. The Commissioner shall appoint five members of the Board who shall be fire and casualty insurance agents licensed in this State and actively engaged in writing motor vehicle insurance in this State. The initial term of office of the Board members shall be two

years. Following completion of initial terms, successors to the members of the original Board of Governors shall be selected to serve three years. All members of the Board of Governors shall serve until their successors are selected and qualified and the Commissioner may fill any vacancy on the Board from any of the classifications specified in this subsection until the vacancies are filled in accordance with this Article. The Board of Governors of the Facility shall also have as nonvoting members two persons who are not employed by or affiliated with any insurance company or the Department and who are appointed by the Governor to serve at the Governor's pleasure."

SECTION 2. This act becomes effective October 1, 2005.

HOUSE BILL 1236:
Insurance Bd. of Governors Membership

BILL ANALYSIS

Committee:	House Insurance	**Date:**	May 23, 2005
Introduced by:	Rep. Holliman	**Summary by:**	Ben Popkin
Version:	First Edition		Committee Counsel

SUMMARY: ***House Bill 1236 would replace two insurance trade associations represented on the Board of Governors of the North Carolina Motor Vehicle Reinsurance Facility. One member representing the Property Casualty Insurers Association of America and one member representing the National Association of Mutual Insurance Companies would join the Board. They would replace the members now representing the Alliance of American Insurers and the National Association of Independent Insurers.***

CURRENT LAW: The Board of Governors of the North Carolina Motor Vehicle Reinsurance Facility consists of 12 members and the Commissioner, who serves on the Board ex officio and without vote. Five of the members of the Board are to be selected by the member insurers and are intended to be fairly representative of the industry.[1] One member is selected from each of the following trade associations:

- The American Insurance Association;
- The Alliance of American Insurers;
- The National Association of Independent Insurers;
- All other stock insurers not affiliated with those trade associations; and
- All other nonstock insurers not affiliated with those trade associations.

The Commissioner appoints the remaining members of the Board – two are Facility insurance company members domiciled in the State; and five are fire and casualty insurance agents licensed in the State and actively engaged in writing motor vehicle insurance in the State.

BILL ANALYSIS: House Bill 1236 would replace representatives of two insurance trade associations currently serving on the Board of Governors of the North Carolina Motor Vehicle Reinsurance Facility. One member representing the Property Casualty Insurers Association of America and one member representing the National Association of Mutual Insurance Companies would join the Board. They would replace the members now representing the Alliance of American Insurers and the National Association of Independent Insurers.

EFFECTIVE DATE: The act would be effective October 1, 2005.

BACKGROUND: The North Carolina Motor Vehicle Reinsurance Facility is a nonprofit unincorporated legal entity consisting of all insurers licensed to write and engaged in writing motor vehicle insurance or any component of motor vehicle insurance in the State[2]. The Board of Governors is charged with the power and administrative responsibility for operating the Facility, which is, in turn, directed to assure the availability of motor vehicle insurance to any "eligible risk"[3].

H1236e1-SMRD

[1] G.S. 58-37-35(d).
[2] G.S. 58-37-5.
[3] G.S. 58-37-35(a) and (f).

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1236

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

H1236-ASQ-4 [v.2]

Date May 24, ,2005

Comm. Sub. [NO]
Amends Title [YES]
First Edition

Representative Holliman

moves to amend the bill on page 1 lines 4-5 by rewriting the lines to read "PROPERTY CASUALTY INSURERS ASSOCIATION OF AMERICA AND ONE INSURER FROM THE INDUSTRY AT LARGE SELECTED BY THE INSURER COMPANY MEMBERS OF THE BOARD AS"

and on page 1 lines 21-25 by rewriting the lines to read "~~sucessors), the National Association of independent Insurers (or its successors),~~the Property Casualty Insurers Association of America (or its successors), one from stock insurers not affiliated with those trade associations, one from nonstock insurers not affiliated with those trade associations, and one from the industry at-large, regardless of trade affiliation. The at-large insurer shall be selected by the insurer company members of the Board. ~~All other stock insurers not affiliated with those trade associations, and all other nonstock insurers not affiliated with those trade associations.~~ The Commissioner shall appoint two members of the"

and on page 1 line 29 through page 2 line 2 by rewriting those lines to read "insurance in this State. The ~~initial~~ term of office of the Board member shall be ~~two years. Following completion of the initial terms, successors to the members of the original Board of Governors shall be selected to serve~~ three years. All members of the Board of"

and by changing the long title appropriately.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1236

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

H1236-ASQ-4 [v.2]

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

MINUTES
HOUSE COMMITTEE ON INSURANCE
May 25, 2005

The House Committee on Insurance met at 11:00 AM on Tuesday, May 25, 2005 in Room 1228. The following Representatives in attendance were: Chairman Hugh Holliman, Vice Chairs Bill Faison, Ed Jones, and Mitchell Setzer. Members: L. Allen, D. Almond, W. Current, R. Grady, L. Johnson, D. Ross, F. Steen and R. Sutton.

Chairman Holliman welcomed visitors, House pages and Sgt-At-Arms. Attachment I.

Rep. Setzer was asked to chair today's meeting. There were no objections to accept the PCS on HB 657 Producer Comp. Transparency and Broker Duty.-AB. Frank Folger, Legal Counselor, with DOI was called on to speak on the PCS. Mr. Folger explained that section 2 of the bill had been removed. Section 1 of the bill was not changed. After some discussion, Rep. Ross made a motion for a favorable report to the PCS unfavorable to the original bill. Motion carried. See Attachment II

Rep. Setzer asked the committee be at ease as an amendment was being prepared for HB 1236 - Insurance Bd. of Governors Membership. Rep. Setzer called the meeting back to order and the amendment was adopted. Shawn Parker, Committee Staff, was asked to explain the amendment to the committee. He explained the changes in the memberships and a technical change that would change term of office from 2 years to 3 years. See Attachment III. George Teague, attorney, spoke in support of bill and explained why amendment was needed. Rep. Johnson moved for a favorable report to the PCS as amendment with a title change unfavorable to the original bill. Motion carried unanimously.

The meeting was adjourned at 8:45 AM.

Representative. L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

TENTATIVE MEETING

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **Tuesday, May 24, 2005**

TIME: **8:00 AM**

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 657 - Producer Comp. Transparency and Broker Duty.-AB
Representative Holliman

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **3:00 PM on May 19, 2005.**

___Principal Clerk
___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

CORRECTED NOTICE

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **Tuesday, May 24, 2005**

TIME: **8:00 AM**

LOCATION: 1228 LB

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 657 - Producer Comp. Transparency and Broker Duty.-AB
Representative Holliman

HB 1236 - Insurance Bd. of Governors Membership. –
Rep. Holliman

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **10:00 AM on May 23, 2005.**

___Principal Clerk
___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

MINUTES
HOUSE COMMITTEE ON INSURANCE
May 26, 2005

The House Committee on Insurance met at 11:00 AM on Thursday, May 26, 2005 in Room 1228. The following Representatives in attendance were: Chairman Hugh Holliman, Vice Chairs Bill Faison, Ed Jones, and Mitchell Setzer. Members: L. Allen, C. Allred, D. Almond, H. Brubaker, W. Current, J Howard, D. Ross, D. Saunders, F. Steen and R. Sutton and W. Wainwright.

Chairman Holliman welcomed visitors, House pages and Sgt-At-Arms. Attachment I. .

Rep. Saunders was asked to chair the committee. Rep. Saunders asked for the adoption of the PCS for HB 656 - Workers' Comp/Self-Insured Guaranty Assoc.-AB and the PCS was adopted. Attachment II.

Frank Folger, Legal Counselor with DOI was called on to speak on the bill. He explained that it supports the industry and removed contradictions from the Senate bill. Rep. Faison submitted an amendment and the committee was at ease while staff prepared the amendment. Rep. Faison was called on to explain his amendment. After much discussion between committee members and the industry, Rep. Holliman requested the bill be removed from the calendar with the amendment for further review.

The meeting was adjourned at 11:45 AM.

Representative. L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

HOUSE INSURANCE COMMITTEE

May 27, 2005
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

HB 656 - Workers' Comp/Self-Insured Guaranty Assoc.-AB
Representative Holliman

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **Thursday, May 26, 2005**

TIME: **11:00 AM**

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 656 - Workers' Comp/Self-Insured Guaranty Assoc.-AB
Representative Holliman

HB 1312 - Insurance Premium Discount/Prevention Course
Representatives Wright; Coleman and Faison

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **3:00 PM on May 24, 2005**.

___Principal Clerk
___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

HOUSE COMMITTEE ON INSURANCE

May 26, 2005
11:00 AM
Room 1228 Legislative Building

ATTACHMENT I

Pages:

Name (please print clearly)	County	Representative
~~Chris Sharp~~	Cumberland	~~Rep McAllister~~
Mary Grace Owen	Gaston	Rep Current
Mark Hamblin	Beaufort	Rep Brubaker

Sergeant-At-Arms (please print)

Martha Gadison

Charles Williams

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 26, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Marlone Forster	NCAHP
Susan Valaani	Nationwide
David Stoller	State Farm
Joe Stewart	IFNC
John McMillan	MF+S
Lee Hodge	KCL+
Steve Woodson	NC FB
K Wright	BCBSNC
Barbara Canada	BCBSNC
Mike Mew	NC AFLCIO
Jim Lore	R. Jonn Lore Atty at Law
	GA

17

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 26, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David McLeod	NCDAD CF
Hannah Jernigan	BMAC Inc -
Jenna Dail	JD, AL, PA

ATTACHMENT II

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H 1

HOUSE BILL 656

Short Title:	Workers' Comp/Self-Insured Guaranty Assoc.-AB	(Public)
Sponsors:	Representative Holliman.	
Referred to:	Insurance.	

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO IMPROVE THE FUNCTIONING OF THE WORKERS' COMPENSATION SELF-INSURED GUARANTY ASSOCIATION AND THE ENFORCEMENT AUTHORITY WITH RESPECT TO WORKERS' COMPENSATION SELF-INSURERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 97-130 reads as rewritten:

"**§ 97-130. Definitions.**

As used in this Article:

(1) "Association" means the North Carolina Self-Insurance Guaranty Association established by G.S. 97-131.

(2) "Board" means the Board of Directors of the Association established by G.S. 97-132.

(3) "Commissioner" means the North Carolina Commissioner of Insurance.

(4) "Covered claim," means an unpaid claim against an insolvent self-insurer that relates to an injury that occurs while the self-insurer is a member of the Association and that is compensable under this Chapter.

(5) "Fund" means the North Carolina Self-Insurance Guaranty Fund established by G.S. 97-133.

(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 and G.S. 97-94.

(7) "Plan" means the Plan of Operation authorized by G.S. 97-134.

(8) "Self-insurer" means either: (i) an individual employer who ~~has demonstrated under G.S. 97-93 the financial ability to directly pay compensation in the amounts and manner and when due as provided in~~ retains liability under the Act and is licensed under Article 5 of this

Chapter or (ii) a group of two or more employers who have agreed to pool their liabilities under this Chapter pursuant to G.S. 97-93."

SECTION 2. G.S. 97-135 reads as rewritten:

"**§ 97-135. Insolvency.**

A member self-insurer shall be insolvent for the purposes of this Article under the following circumstances:

(1) ~~Determination~~ Upon a determination of insolvency by a court of competent jurisdiction; or

~~(2) Institution of bankruptcy proceedings by or regarding the member self-insurer; or~~

(3) ~~The Board determines~~ Upon a determination by the Board that the self-insurer's total liabilities exceed its total assets or the self-insurer is unable or ceases to pay its debts as they fall due or in the ordinary course of business."

SECTION 3. G.S. 97-165 reads as rewritten:

"**§ 97-165. Definitions.**

As used in this Article:

(1) 'Act' means the Workers' Compensation Act established in Article 1 of this Chapter.

(1a) 'Affiliate of' or 'person affiliated with' a specific person means a person that indirectly through one or more intermediaries or directly controls, is controlled by, or is under common control with the person specified.

(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,~~ self-insurer or the guarantor, in conformity with ~~generally accepted accounting principles.~~accounting principles generally accepted in the United States.

(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~~ self-insurer or the guarantor to replace the CPA with another whose relationship with the ~~individual~~ self-insurer or the guarantor is independent within the meaning of this definition.

(4) 'Commissioner' means the Commissioner of Insurance.

(4a) 'Control', 'controlling', 'controlled by', and 'under common control with' mean the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person through ownership of or through proxies for voting of greater than fifty percent (50%) of the voting securities, or in the case of a not-for-profit entity, the power to direct or cause the direction of the management and policies of the entity.

(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.~~principles generally accepted in the United States.

(6a) 'Guarantor' means a person within the same holding company system who controls the applicant, whose financial statement is used by the applicant to become a self-insurer under the Act, and who has guaranteed the payment of the self-insurer's liability under the Act.

(7) 'Hazardous financial condition' means that, based on its present or reasonably anticipated financial condition, a self-insurer or guarantor is insolvent or, although not yet financially impaired or insolvent, is unlikely to be able to meet its obligations with respect to known claims and reasonably anticipated claims or to pay other obligations in the normal course of business.

(7a) 'Holding company system' means an entity comprising two or more affiliated persons.

(8) 'Management' means those persons who are authorized to direct or control the operations of a self-insurer.

(8a) '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.

(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 an employer who retains liability under the Act and is licensed under this Article.

(11) 'Subsidiary of' a specific person means an affiliate controlled by such person indirectly through one or more intermediaries or an affiliate directly controlled by such person."

SECTION 4. G.S. 97-170 reads as rewritten:

"§ 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. This subsection does not apply to an employer authorized to self-insure its workers' compensation liabilities under the Act prior to December 1, 1997, whose authority to self-insure its workers' compensation liabilities under the Act has not terminated after that date.

(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~~ in 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 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.

(d) The license application shall ~~comprise~~ be comprised of the following information:

(1) ~~Company name,~~ Applicant name; organizational ~~structure,~~ structure of the applicant, including any controlling entity, subsidiaries, or affiliates; location of principal ~~office,~~ office; contact ~~person,~~ person; organization ~~date,~~ date; type of operations within this ~~State,~~ State; management ~~background,~~ 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~~ presentation shall facilitate application of ratio and trend analysis.
(3) Evidence of the insurance required by G.S. 97-190.
(4) Repealed by Session Laws 1999-132, s. 13.7, effective June 4, 1999.
(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~~ years and 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~~ an irrevocable letter of credit, a surety bond issued by a corporate ~~surety~~ surety, or a combination thereof, that will guarantee the applicant's compliance with this Article and the Act pursuant to G.S. 97-185."

SECTION 5. Article 5 of Chapter 97 of the General Status is amended by adding the following new section:

"**§ 97-177. License covering applicant and any subsidiary or applicant relying on a guarantor; procedure; requirements.**

(a) The Commissioner may, in the Commissioner's discretion, upon request by an applicant, issue a license to an applicant or to an applicant and one or more of its subsidiaries if all of the following requirements are satisfied:

(1) The applicant or a guarantor of the applicant executes a guaranty agreement, in a form prescribed by the Commissioner, for the payment of all workers' compensation liabilities covered under the Act. For any applicant or guarantor that is a corporation, there shall be submitted, along with the guaranty agreement, a board of directors' resolution from the respective corporation authorizing the guaranty of the liabilities of the subsidiary company or companies and granting signature authority to each person or officer executing the agreement.

(2) The applicant or guarantor files a statement with the Commissioner that lists the percentage of ownership of voting securities or proxies representing voting securities owned or held by the applicant or guarantor for each subsidiary, or in the case of a not-for-profit entity, documentation acceptable to the Commissioner evidencing control.

(3) The applicant and its guarantor or the applicant and its subsidiaries, whichever applies, satisfy the requirements of G.S. 97-170(c).

(4) All other applicable requirements for licensure under the Act are satisfied.

(b) A license issued by the Commissioner pursuant to this section shall include the name of the applicant, the name of each licensed subsidiary, and the date of issuance for each licensed subsidiary.

(c) If a self-insurer requests to add a subsidiary to its license, the Commissioner shall review the request in accordance with this section. Upon approval, the Commissioner shall issue to the self-insurer a new license that includes the newly

licensed subsidiary and the date of license issuance for the newly licensed subsidiary, and the self-insurer shall return the original license to the Commissioner.

(d) A self-insurer shall neither include nor delete a subsidiary from its license without the Commissioner's prior written approval.

(e) If a controlling relationship or guaranty agreement terminates, the self-insurer shall retain all liabilities under the Act that were incurred by the self-insurer during the period of self-insurance and shall account for all such liabilities until discharged, as evidenced by reports filed with the Commissioner. Termination of a guaranty agreement does not affect the guarantor's liability for payment of liabilities arising prior to termination of the agreement."

SECTION 6. G.S. 97-180 reads as rewritten:

"**§ 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~~ presentation shall facilitate the application of ratio and trend analysis. If the self-insurer was issued a license pursuant to G.S. 97-177, the financial statement required under this subsection shall be that of the guarantor.

(b) Every self-insurer shall submit within 120 days after the end of its fiscal year a ~~certification~~ report from a qualified actuary setting forth ~~the actuary's~~ an opinion ~~relating to~~ certifying the loss and loss adjustment expense reserves for workers' compensation obligations ~~for~~ in North Carolina. The ~~certification~~ report 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~~ and the total outstanding workers' compensation liabilities for each loss year, recorded at the close of its fiscal year for the net retained liability.

(d) Upon the request of the Commissioner, every self-insurer shall submit a report of its 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~~ name or address of the ~~businesses it self-insures or intends to self-insure, as well as~~ self-insurer or guarantor; significant changes in the financial ~~condition,~~ condition of the self-insurer, guarantor, or any affiliate, including bankruptcy ~~filings,~~ filings; and changes in its ~~business~~ organizational structure, including its

~~divisions, subsidiaries, affiliates, and internal organization.~~ subsidiaries and affiliates. Any change shall be reported in writing to the Commissioner within 10 days after the effective date of the change. Upon request by the Commissioner, a self-insurer shall provide the Commissioner copies of documents or information deemed necessary to determine whether any change has affected the privilege of the employer to self-insure."

SECTION 7. G.S. 97-185 reads as rewritten:

"**§ 97-185. Deposits; surety bonds; letters of credit.**

(a) **(Effective January 1, 2005, until January 1, 2006)** Every self-insurer shall deposit with the Commissioner an amount not less than seventy-five percent (75%) of the self-insurer's total undiscounted outstanding claim liability per the most recent ~~certification~~ report 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 greater amount as the Commissioner prescribes based on, but not limited to, the financial condition of the self-insurer or guarantor and the risk retained by the self-insurer.

(a) **(Effective January 1, 2006)** Every self-insurer shall deposit with the Commissioner an amount not less than one hundred percent (100%) of the self-insurer's total undiscounted outstanding claim liability per the most recent ~~certification~~ report 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 greater amount as the Commissioner prescribes based on, but not limited to, the financial condition of the self-insurer or guarantor and the risk retained by the self-insurer.

(b) Repealed by Session Laws 2003-115, s. 3, effective January 1, 2004.

(b1) Notwithstanding subsection (a) of this section, ~~member~~ self-insurers with a debt rating of BBB or better from Standard and Poor's Rating Service, a division of McGraw Hill, Inc., or an equivalent rating from another national rating agency shall deposit with the Commissioner an amount not less than twenty-five percent (25%) of the self-insurer's total undiscounted outstanding claim liability per the most recent ~~certification~~ report from a qualified actuary as required by G.S. 97-180(b), but not less than five hundred thousand dollars ($500,000). If a person is self-insured pursuant to G.S. 97-177, the self-insurer may utilize the debt rating of its guarantor to satisfy the requirements of this subsection. The Commissioner shall consider and may, in the Commissioner's discretion, increase or reduce the deposit to a greater or lesser percentage of the ~~member~~ self-insurer's claims liability based on the financial strength of the self-insurer or guarantor and other financial information submitted by the self-insurer.

(c) Deposits received, changes to existing deposits, or deposits exchanged after the effective date of this section, shall ~~comprise~~ be comprised of 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. A surety bond deposited pursuant to this subsection shall require that the surety reimburse the Commissioner, or his successors, assigns, or transferees, for any costs incurred in the collection of the proceeds of the surety bond, including reasonable attorneys' fees, and any costs incurred in administering the insolvent self- insurer's workers' compensation claims.

(4a) Irrevocable letters of credit in a form acceptable to the Commissioner issued by a bank acceptable to the Commissioner. An irrevocable letter of credit deposited pursuant to this subsection shall require that the bank reimburse the Commissioner, or his ~~successor,~~ successors, assigns, or transferees for any costs incurred in the collection of the proceeds of the letter of credit, including reasonable attorneys' fees.

(4b) The reimbursement of attorneys' fees and collections cost provided for in subdivisions (4) and (4a) of this subsection shall be no greater than fifteen percent (15%) of the penal amount of the bond and shall not come from the proceeds of the bond or the letter of credit but shall be in addition to the proceeds of the bond or the letter of credit.

(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 the market value is less than the 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 or guarantor'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 or guarantor 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. In the case of a letter of credit, the Commissioner may draw the full amount of a letter of credit if the letter of credit is not renewed within 90 days prior to its expiration or at any time that the bank issuing the letter of credit is no longer acceptable to the Commissioner. Interest accruing on any negotiable security deposited under this Article shall be collected and transmitted to the self-insurer if the self-insurer or guarantor 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~~ Pursuant to the provisions of this section and with the approval of the Commissioner, deposits 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.~~ acceptable forms of deposit in an amount determined by the Commissioner. Any ~~surety bond may~~ deposit to 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.~~ another form of deposit shall not be released until the approved replacement deposit is received by the Commissioner.

(h) ~~If a~~ Any self-insurer that ceases to be a ~~self-insure, self-insurer no deposits shall be released by the Commissioner~~ shall, according to the provisions of this Article, continue to secure its obligations under the Act until the self-insurer has discharged fully all of ~~the self-insurer's~~ its obligations under the Act. When a self-insurer ceases to be a self-insurer, the Commissioner may approve a reduction in the deposit amount if the remaining deposit is sufficient to cover all existing liabilities under the Act, as well as an amount determined by the Commissioner to be sufficient to cover future loss development.

(i) An endorsement to a surety bond shall be filed with the Commissioner within 90 days after the effective date of the endorsement."

SECTION 8. G.S. 97-190 reads as rewritten:

§ 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 or guarantor's financial condition.

(b) An excess insurance policy required by this section shall be issued by either ~~a licensed~~ an insurance company licensed in this State or an ~~approved~~ eligible surplus lines ~~insurance company~~insurer as defined in G.S. 58-21-10 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."

SECTION 9. G.S. 97-195 is repealed.

SECTION 10. Article 5 of Chapter 97 of the General Statutes is amended by adding the following new sections:

"**§ 97-196. Revocation, suspension, or restriction of license.**

(a) The Commission may, after notice and opportunity for a hearing, revoke, suspend, or restrict the license of a self-insurer if any of the following apply:

(1) The self-insurer fails or refuses to comply with any law, order, or rule applicable to the self-insurer.

(2) There is a determination of insolvency by a court of competent jurisdiction.

(3) The self-insurer is in a hazardous financial condition.

(4) The self-insurer has experienced a material loss or deteriorating operating trends, or has reported a deficit financial position.

(5) Any affiliate or subsidiary is insolvent, threatened with insolvency, or delinquent in payment of its monetary or any other obligation.

(6) The self-insurer has failed to pay premium taxes pursuant to Article 8B of Chapter 105 of the General Statutes.

(7) 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.

(8) 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.

(9) 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.

(10) The self-insurer has experienced, or will experience in the foreseeable future, cash flow or liquidity problems.

(11) The self-insurer has failed to make proper and timely payment of claims, as required by this Article.

(b) Any self-insurer subject to license revocation, suspension, or restriction under subsection (a) 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.

"**§ 97-197. Civil penalties or restitution for violations; administrative procedure.**

(a) Whenever the Commissioner has reason to believe that a self-insurer has violated any of the provisions of this Article, and the violation subjects the license of the self-insurer to suspension or revocation, the Commissioner may, after notice and opportunity for a hearing, proceed under the appropriate subsections of this section.

(b) If the Commissioner finds a violation of this Article, the Commissioner may, in addition to or instead of suspending or revoking the license, order the payment or a monetary penalty as provided in subsection (c) of this section or petition the Superior Court of Wake County for an order directing payment of restitution as provided in subsection (d) of this section, or both. Each day during which a violation occurs constitutes a separate violation.

(c) If the Commissioner orders the payment of a monetary penalty pursuant to subsection (b) of this section, the penalty shall not be 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 clear proceeds of the penalty shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2. 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.

(d) Upon petition of the Commissioner, the court may order the self-insurer who committed a violation specified in subsection (b) of this section to make restitution in an amount that would make whole any person harmed by the violation. The petition may be made at any time, and the petition may be made in any appeal of the Commissioner's order.

(e) 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.

(f) Nothing in this section prevents the Commissioner from negotiating a mutually acceptable agreement with any self-insurer as to the status of the self-insurer's license or as to any civil penalty or restitution.

(g) Unless otherwise specifically provided for, all administrative proceedings under this Article are governed by Chapter 150B of the General Statutes. Appeals of the Commissioner's orders under this section shall be governed by G.S. 58-2-75."

SECTION 11. This act becomes effective October 1, 2005.

11

HOUSE BILL 656 –
WORKERS' COMP/SELF-INSURED GUARANTY ASS'N

This bill would amend the workers compensations self-insurance laws in Articles 4 and 5 of Chapter 97 of the General Statutes to incorporate into statute specific regulations governing how a subsidiary or affiliate of a company can be licensed as a self-insurer in this State under the parent or affiliate company's license. In S.L. 2004-199, the General Assembly enacted an amendment that put into place statutorily a practice already permitted by the Department of licensing subsidiaries and affiliates under a parent or affiliate meeting the statutory requirements for self-insurance licensure, when certain guarantees were met This bill would formalize those procedures and requirements. The bill also makes technical grammatical changes to the affected statutes, rewrites for uniformity the license revocation provisions, and provides for enforcement authority identical to that applicable to insurance companies.

Section 1. Amends the definitional section of Article 4 governing the Self-Insured Guaranty Association to conform to the statutory allowance of subsidiary and affiliate licensing.
Section 2. Makes technical and grammatical changes.
Section 3. Adds definitions needed to conform to last year's statutory change: "affiliate", "control", "guarantor", "holding company system", "person", and "subsidiary". In addition, the section makes conforming changes by referencing "self insurer or the guarantor" and uses current terminology regarding accounting principles.
Section 4. Makes technical, grammatical and conforming changes.
Section 5. Creates a new section, G.S. 97-177, specifying the conditions under which the Commissioner may, in the Commissioner's discretion, issue a license to self-insure an affiliate or subsidiary. Those conditions include:

- Submission of a guaranty agreement executed by the guarantor in a form prescribed by the Commissioner.
- Filing of a statement with the Commissioner listing percentage of ownership and control of the subsidiary or affiliate by the applicant or guarantor.
- Satisfaction by the applicant or guarantor or applicant and its subsidiaries of the fixed asset requirements of G.S. 97-170(c) ($500,000 or more)
- Satisfaction of all other requirements for licensure.

This section also provides requirements and procedures for adding subsidiaries to or deleting subsidiaries from an existing self-insured's license, and declares that the self-insurer remains liable under the Act for all liabilities incurred by the self-insurer during the period of self-insurance even if the guaranty agreement or controlling relationship terminates.
Section 6. Clarifies that if a license to self-insure is issued under the newly proposed G.S. 97-177, the financial documents required under G.S. 97-180 must be those of the guarantor. This section makes further technical and conforming changes, and requires self-insurers to provide documents requested by the Commissioner deemed necessary to determine whether any change has affected the privilege of the employer to self-insure.

Section 7. Makes technical and conforming changes, clarifies that a person licensed to self-insure under the newly proposed G.S. 97-177 may utilize the guarantor's debt rating to be eligible for a reduction in deposit requirements under G.S. 97-185, and rewrites for clarity how deposits may be replaced and to what extent an employer ceasing to be a self-insurer can reduce its deposit amounts.

Section 8. Makes technical, clarifying and conforming changes.

Section 9. Repeals the existing provisions for revocation of a self-insurer's license (to be replaced by the provision in Section 10 of the bill).

Section 10. Rewrites the old provision for revocation, suspension or restriction of a self-insurer's license, including every former basis for such action by the Commissioner such that it more uniformly reflects the procedures applied in other license revocation procedures. Also, establishes an enforcement procedure identical to that applied to other insurers in G.S. 58-2-70.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 656
PROPOSED COMMITTEE SUBSTITUTE H656-CSSQ-19 [v.2]

5/26/2005 11:02:39 AM

Short Title: Workers' Comp Ind Self-Insured Amendments.-AB (Public)

Sponsors:

Referred to:

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE PROCEDURES BY WHICH SUBSIDIARY AND AFFILIATE COMPANIES MAY BE LICENSED AS SELF-INSURERS FOR WORKERS COMPENSATION AND TO MAKE OTHER CONFORMING AND TECHNICAL CHANGES TO THE WORKERS COMPENSATION LAWS RESPECTING INDIVIDUAL SELF-INSURERS IN ARTICLE 5 OF CHAPTER 97 OF THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 97-165 reads as rewritten:

"**§ 97-165. Definitions.**

As used in this Article:

(1) "Act" means the Workers' Compensation Act established in Article 1 of this Chapter.

(1a) 'Affiliate of' or 'person affiliated with' a specific person means a person that indirectly through one or more intermediaries or directly controls, is controlled by, or is under common control with the person specified.

(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,~~self-insurer or guarantor, in conformity with ~~generally accepted accounting principles.~~accounting principles generally accepted in the United States.

(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~~ self insurer or the guarantor to replace the CPA with another whose relationship with the ~~individual~~ self insurer or guarantor is independent within the meaning of this definition.

(4) "Commissioner" means the Commissioner of Insurance.

(4a) 'Control', 'controlling', 'controlled by', and 'under common control with' mean the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person through ownership of or through proxies for voting of greater than fifty percent (50%) of the voting securities, or in the case of a not-for- profit entity, the power to direct or cause the direction of the management and policies of the entity.

(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.~~principles generally accepted in the United States.

(6a) 'Guarantor' means a person within the same holding company system who controls the applicant, whose financial statement is used by the applicant to become a self-insurer under the Act, and who has guaranteed the payment of the self-insurer's liability under the Act.

(7) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a self-insurer or guarantor 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.

(7a) 'Holding company system' means an entity comprising two or more affiliated persons.

(8) "Management" means those persons who are authorized to direct or control the operations of a self-insurer.

(8a) '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.

(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 an employer who retains liability under the Act and is licensed under this Article.

(11) 'Subsidiary of' a specific person means an affiliate controlled by such person indirectly through one or more intermediaries or an affiliate directly controlled by such a person."

SECTION 2. G.S. 97-170(d) reads as rewritten:

"(d) The license application shall ~~comprise~~ be comprised of the following information:

(1) ~~Company name,~~Applicant name; organizational ~~structure,~~structure of the applicant, including any controlling entity, subsidiaries, or affiliates; location of principal ~~office,~~office; contact ~~person,~~person; organization ~~date,~~date; type of operations within this ~~State,~~State; management ~~background,~~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~~presentation shall facilitate application of ratio and trend analysis.

...

(6) Summary of workers' compensation benefits paid for the last three calendar ~~years, as well as~~years and 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.

...

~~(8) Book value of fixed assets located within the State.~~

..."

SECTION 3. Article 5 of Chapter 97 of the General Statutes is amended by adding the following new section:

"**§ 97-177. License covering applicant and any subsidiary or applicant relying on a guarantor; procedure; requirements.**

(a) The Commissioner may, in the Commissioner's discretion, upon request by an applicant, issue a license to an applicant or to an applicant and one or more of its subsidiaries if all of the following requirements are satisfied:

(1) The applicant or guarantor of the applicant executes a guaranty agreement, in a form prescribed by the Commissioner, for the payment of all workers' compensation liabilities covered under the Act. For any applicant or guarantor that is a corporation, there shall be submitted, along with the guaranty agreement, a board of directors' resolution from the respective corporation authorizing the guaranty of liabilities of the subsidiary company or companies and granting signature authority to each person or officer executing the agreement.

(2) The applicant or guarantor files a statement with the Commissioner that lists the percentage of ownership of voting securities or proxies representing voting securities owned or held by the applicant or guarantor for each subsidiary, or in the case of a not-for-profit entity, documentation acceptable to the Commissioner evidencing control.

(3) The applicant and its guarantor or the applicant and its subsidiaries, whichever applies, satisfy the requirements of G.S. 97-170(c).

(4) All other applicable requirements for licensure under the Act are satisfied.

(b) A license issued by the Commissioner pursuant to this section shall include the name of the applicant, the name of each licensed subsidiary, and the date of issuance for each licensed subsidiary.

(c) If a self-insurer requests to add a subsidiary to its license, the Commissioner shall review the request in accordance with this section. Upon approval, the Commissioner shall issue to the self-insurer a new license that includes the newly licensed subsidiary and the date of license issuance for the newly licensed subsidiary, and the self-insurer shall return the original license to the Commissioner.

(d) A self-insurer shall neither include nor delete a subsidiary from its license without the Commissioner's prior written approval.

(e) If a controlling relationship or guaranty agreement terminates, the self-insurer shall retain all liabilities under the Act that were incurred by the self-insurer during the period of self-insurance and shall account for all such liabilities until discharged, as evidenced by reports filed with the Commissioner. Termination of a guaranty agreement does not affect the guarantor's liability for payment of liabilities arising prior to termination of the agreement."

SECTION 4. G.S. 97-180 reads as rewritten:

"**§ 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~~ presentation shall facilitate the application of ratio and trend analysis. If the self-insurer was issued a license pursuant to G.S. 97-177, the financial statement required under this subsection shall be of the guarantor.

(b) Every self-insurer shall submit within 120 days after the end of its fiscal year a ~~certification~~report from a qualified actuary setting forth ~~the actuary's~~ an opinion ~~relating to~~ certifying the loss and loss adjustment expense reserves for workers' compensation obligations ~~for~~in North Carolina. The ~~certification~~report 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~~and

the total outstanding workers' compensation liabilities for each loss year, recorded at the close of its fiscal year for the net retained liability.

(d) Upon the request of the Commissioner, every self-insurer shall submit a report of its 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~~name or address of the ~~businesses it self-insures or intends to self-insure, as well as~~self-insurer or guarantor; significant changes in the financial ~~condition,~~condition of the self-insurer, guarantor, or any affiliate, including bankruptcy ~~filings,~~filings; and changes in its ~~business~~organizational structure, including its ~~divisions, subsidiaries, affiliates, and internal organization.~~subsidiaries and affiliates. Any change shall be reported in writing to the Commissioner within 10 days after the effective date of the change. Upon request by the Commissioner, a self-insurer shall provide the Commissioner copies of documents or information deemed necessary to determine whether any change has affected the privilege of the employer to self insure."

SECTION 5. G.S. 97-190 reads as rewritten:

"**§ 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 or guarantor's financial condition.

(b) An excess insurance policy required by this section shall be issued by either ~~a licensed~~an insurance company licensed in this State or an ~~approved~~eligible surplus lines ~~insurance company~~insurer as defined in G.S. 58-21-10 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."

SECTION 6. This act becomes effective October 1, 2005.

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 2, 2005

The House Committee on Insurance met at 9:00 AM on Thursday, June 2, 2005 in Room 1228. The following Representatives in attendance were: Chairman Hugh Holliman, Vice Chairs Bill Faison, Ed Jones, Members: L. Allen, J. Barnhart, W. Current, J. Howard, D. Ross, and D. Saunders.

Chairman Holliman welcomed visitors, House pages and Sgt-At-Arms. Attachment I.

Chairman Holliman explained why HB 653 - Credit Insurance Changes. -AB was being brought back to the committee. Rep. Faison was asked to chair. He asked for a motion to reconsider the Committee's earlier recommendation to give the bill a favorable report and moved that the Committee adopt a new PCS for consideration. Rep. Saunders made the motion and the motion carried. Frank Folger, Legal Counselor, with DOI was called on to speak on the PCS. Mr. Folger explained the changes in the language. An amendment making a technical change was discussed and adopted.

After some discussion Rep. Howard move for a favorable report as amended which changes the title and unfavorable to the original bill. Attachment II.

The meeting was adjourned at 9:15 AM.

Representative. L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

Carol Bowers (Rep. Holliman)

Subject: FW: CORRECTED NOTICE House Committee on Insurance 06-02-05

TIME CHANGE AND BILL NUMBER CORRECTION

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **THURSDAY, JUNE 2, 2005**

TIME: **9:00 AM**

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 647 - DOI Hearing/Unauth. Ins. Summary C&D Order. -AB
Representative Holliman

HB 653 - Credit Insurance Changes. -AB
Representative Holliman

HB 659 - Unauthorized Insurer Misconduct.-AB
Representative Faison and Holliman

Respectfully,
Representatives Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 12:15 PM on June 1, **2005.**

___Principal Clerk
___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

6/1/2005

HOUSE INSURANCE COMMITTEE

June 2, 2005
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

HB 653 - Credit Insurance Changes. -AB
Representative Holliman

HB 647 - DOI Hearing/Unauth. Ins. Summary C&D Order. -AB
Representative Holliman

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Holliman (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 653 A BILL TO BE ENTITLED AN ACT TO MAKE CHANGES TO THE CREDIT INSURANCE LAWS TO DEFINE "CRITICAL PERIOD COVERAGE"; CLARIFY THE APPROPRIATE REFUND OF PREMIUMS METHOD WHEN A POLICY OR GROUP CERTIFICATE IS TERMINATED PRIOR TO THE SCHEDULED MATURITY DATE OF THE SUBJECT DEBT; ALLOW CREDIT CARD COVERAGE FROM OUT-OF-STATE FINANCIAL INSTITUTIONS; PROVIDE THAT INSURERS MUST ACKNOWLEDGE TO THE CLAIMANT ANY CLAIMS NOT PAID WITHIN THIRTY DAYS; CLARIFY THAT INSURERS CAN REQUIRE REGISTRATION WITH THE STATE UNEMPLOYMENT OFFICE TO QUALIFY FOR CREDIT UNEMPLOYMENT INSURANCE BUT CANNOT IMPOSE A TIME LIMIT ON THAT REGISTRATION NOR CONDITION QUALIFICATION FOR BENEFITS UNDER A POLICY UPON QUALIFICATION FOR STATE UNEMPLOYMENT BENEFITS; CLARIFY THAT, WITH RESPECT TO CREDIT UNEMPLOYMENT INSURANCE, THE REFUND SHALL EQUAL THE PRO RATA UNEARNED GROSS PREMIUM; AND PROVIDE THE COMMISSIONER OF INSURANCE WITH THE AUTHORITY TO ENFORCE THE LAWS GOVERNING CREDIT INSURANCE CONSISTENT WITH THE COMMISSIONER'S GENERAL ENFORCEMENT AUTHORITY AS SET FORTH IN CHAPTER 58 OF THE GENERAL STATUTES. as amended

☒ With a favorable report as to the committee substitute bill, which changes the title, unfavorable as to the original bill.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

ATTACHMENT 1

House Pages

Name Of Committee: INSURANCE Date: 6-2-05

1. Name: Neltonia Atkinson
   County: Wake
   Sponsor: Speaker Pro Tem. Morgan
2. Name: Lisa Martin
   County: Wake
   Sponsor: Speaker Black
3. Name: Alexandra Leonard
   County: Wake
   Sponsor: Linda Coleman
4. Name: _____
   County: _____
   Sponsor: _____
5. Name: _____
   County: _____
   Sponsor: _____

Sgt-At-Arms

1. Name: Martha Gadison
2. Name: Jay Calloway
3. Name: Charles Williams
4. Name: _____
5. Name: _____

VISITOR REGISTRATION SHEET

17

Insurance — 6/2

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kathleen Edwards	UNC-CH Legis. Reporting Service
Robert PASchal	Young, Moore
[signature]	IFNC
Bill Mehn	NCATL
[signature]	[signature]
MaryAlice Malone	GA Intern
Kate Poetzer	Duke Public Policy Institute
Bill Scoggin	KLL 17
Lee Hodges	—
[signature]	[signature]
Steve Woodson	NCFB

VISITOR REGISTRATION SHEET

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
S Flannery	NHCPA

ATTACHMENT II

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 1

HOUSE BILL 653*

Short Title:	Credit Insurance Changes.-AB	(Public)
Sponsors:	Representative Holliman.	
Referred to:	Insurance.	

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE CREDIT INSURANCE LAWS TO DEFINE "CRITICAL PERIOD COVERAGE"; CLARIFY THE APPROPRIATE REFUND OF PREMIUMS METHOD WHEN A POLICY OR GROUP CERTIFICATE IS TERMINATED PRIOR TO THE SCHEDULED MATURITY DATE OF THE SUBJECT DEBT; ALLOW CREDIT CARD COVERAGE FROM OUT-OF-STATE FINANCIAL INSTITUTIONS; PROVIDE THAT INSURERS MUST ACKNOWLEDGE TO THE CLAIMANT ANY CLAIMS NOT PAID WITHIN THIRTY DAYS; CLARIFY THAT INSURERS CAN REQUIRE REGISTRATION WITH THE STATE UNEMPLOYMENT OFFICE TO QUALIFY FOR CREDIT UNEMPLOYMENT INSURANCE BUT CANNOT IMPOSE A TIME LIMIT ON THAT REGISTRATION NOR CONDITION QUALIFICATION FOR BENEFITS UNDER A POLICY UPON QUALIFICATION FOR STATE UNEMPLOYMENT BENEFITS; CLARIFY THAT, WITH RESPECT TO CREDIT UNEMPLOYMENT INSURANCE, THE REFUND SHALL EQUAL THE PRO RATA UNEARNED GROSS PREMIUM; AND PROVIDE THE COMMISSIONER OF INSURANCE WITH THE AUTHORITY TO ENFORCE THE LAWS GOVERNING CREDIT INSURANCE CONSISTENT WITH THE COMMISSIONER'S GENERAL ENFORCEMENT AUTHORITY AS SET FORTH IN CHAPTER 58 OF THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-57-5 is amended by adding a new subdivision to read:

"(5a) "Critical period coverage" means insurance coverage for which benefits are limited to a stated number of payments or the payments end with the expiration of the policy, whichever is less."

SECTION 2. G.S. 58-57-50(b) reads as rewritten:

"(b) The refund of premiums for decreasing term credit life insurance shall be equal to the premium that would be charged for the remaining term and amount of

coverage in the policy. The refund of premiums for ~~decreasing term credit life insurance in transactions of 60 months duration or less and the refund of premiums for~~ single interest credit property insurance and single interest physical damage insurance shall be equal to the amount computed by the sum of digits formula known as the "Rule of 78." ~~The refund of premiums for decreasing term credit life insurance in transactions of more than 60 months duration shall be equal to the premium that would be charged for the remaining term and amount of coverage in the policy.~~ The refund of premiums for level term credit life insurance and dual interest credit property insurance and dual interest physical damage insurance shall be equal to the pro rata unearned gross premiums."

SECTION 3. G.S. 58-57-55 reads as rewritten:

"**§ 58-57-55. Issuance of policies.**

All policies of credit life insurance and credit accident and health insurance shall be issued only by an insurer authorized to do business in this State and shall be issued only through holders of licenses or authorizations issued by the Commissioner. With the exception of credit insurance issued in accordance with G.S. 58-57-105, all ~~All~~ policies of credit life insurance and credit accident and health insurance shall be delivered or issued for delivery in this ~~State only by an insurer authorized to do an insurance business therein, and shall be issued only through holders of licenses or authorizations issued by the Commissioner.~~ State. The enrollment of debtors under a group policy issued to a creditor and authorized under this Article shall not constitute the issuance of a policy of insurance."

SECTION 4. G.S. 58-57-60 is amended by adding a new subsection to read:

"(d) A claim acknowledgment shall be sent to the claimant within 30 days after receiving written or electronic notice of the claim. Acknowledgment shall include the following:

(1) A statement made to the insured or the claimant advising that the claim is being investigated.

(2) Payment of the claim.

(3) A bona fide written offer of settlement.

(4) A written denial of the claim."

SECTION 5. G.S. 58-57-110 reads as rewritten:

"**§ 58-57-110. Credit unemployment insurance rate standards; policy provisions.**

(a) Each year the Commissioner shall prescribe a minimum incurred loss ratio standard requirement to develop a premium rate reasonable in relation to the benefits provided by credit unemployment insurance coverage. The following requirements must be met:

(1) Coverage is provided or offered, with or without underwriting, to all debtors regardless of age who are working for salary, wages, or other employment income for at least 30 hours per week and have done so for 12 consecutive ~~months;~~ months.

(2) Coverage sets forth a definition of involuntary unemployment as a loss of employment income that may include, but is not limited to, loss caused by layoff, general strike, termination of employment, or ~~lockout;~~ lockout.

(3) Coverage does not contain any exclusion except: debts with irregular monthly payments; voluntary forfeiture of salary, wages, or other employment income; resignation; retirement; sickness, disease, or normal pregnancy; or loss of income due to termination as a result of willful misconduct that is a violation of some established, definite rule of conduct, a forbidden act, or willful dereliction of duty, or criminal misconduct.

(4) As long as there is no required time period limitation for registration, the insured may be required to register with the State unemployment office in order to qualify for benefit payments under the credit unemployment coverage. Qualification for State unemployment benefits shall not be required in order to qualify for benefit payments under the credit unemployment coverage.

(b) The Commissioner may approve other policy provisions and coverages consistent with the purposes of unemployment coverage.

(c) Joint coverage rates for credit unemployment insurance shall be one and two-thirds (1 2/3) times the approved single rate of coverage.

(d) The refund provision for credit unemployment insurance shall be equal to the pro rata unearned gross premium."

SECTION 6. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-57-71. Enforcement and penalties.**

(a) The Commissioner may, after notice and opportunity for a hearing, impose civil penalties or petition for restitution under G.S. 58-2-70, revoke, suspend, or restrict 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 or any of the insurer's officers, directors, employees, or other representatives refuse to submit to any examination authorized by 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 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 or electronic notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgment of the claim shall be one of the following:

(1) A statement made to the claimant or to the claimant's legal representative advising that the claim is being investigated.

(2) Payment of the claim.

(3) A bona fide written offer of settlement.

(4) A written denial of the claim. With respect to a claim under an accident, health, or disability policy, if the acknowledgment sent to the claimant indicates that the claim remains under investigation, within 45 days after receipt by the insurer of the initial claim, the insurer shall send a claim status report to the insured and every 45 days thereafter until the claim is paid or denied. The report shall give details sufficient for the insured to understand why processing of the claim has not been completed and whether the insurer needs additional information to process the claim. If the claim acknowledgment includes information about why processing of the claim has not been completed and indicates whether additional information is needed, it may satisfy the requirement for the initial claim status report.

(d) If a foreign insurance company's license is suspended or revoked, the Commissioner shall cause written notification of the suspension or revocation to be given to all of the company's agents in this State. Until the Commissioner restores the company's license, 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 the insurer's policyholders or creditors."

SECTION 7. G.S. 58-57-70 and G.S. 58-57-80 are repealed.

SECTION 8. This act becomes effective January 1, 2006, and applies to policies or certificates issued or renewed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 653*
PROPOSED COMMITTEE SUBSTITUTE H653-PCS80424-RC-60

Short Title: Credit Insurance Changes.-AB (Public)

Sponsors:

Referred to:

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE CREDIT INSURANCE LAWS TO DEFINE "CRITICAL PERIOD COVERAGE"; CLARIFY THE APPROPRIATE REFUND OF PREMIUMS METHOD WHEN A POLICY OR GROUP CERTIFICATE IS TERMINATED PRIOR TO THE SCHEDULED MATURITY DATE OF THE SUBJECT DEBT; ALLOW CREDIT CARD COVERAGE FROM OUT-OF-STATE FINANCIAL INSTITUTIONS; PROVIDE THAT INSURERS MUST ACKNOWLEDGE TO THE CLAIMANT ANY CLAIMS NOT PAID WITHIN THIRTY DAYS; CLARIFY THAT INSURERS CAN REQUIRE REGISTRATION WITH THE STATE UNEMPLOYMENT OFFICE AND PROVISION OF AN OFFICIAL STATE UNEMPLOYMENT OFFICE DECISION LETTER REGARDING THE CLAIM TO QUALIFY FOR CREDIT UNEMPLOYMENT INSURANCE BENEFITS UNDER THE POLICY BUT CANNOT IMPOSE A TIME LIMIT ON THAT REGISTRATION; AND PROVIDE THE COMMISSIONER OF INSURANCE WITH THE AUTHORITY TO ENFORCE THE LAWS GOVERNING CREDIT INSURANCE CONSISTENT WITH THE COMMISSIONER'S GENERAL ENFORCEMENT AUTHORITY AS SET FORTH IN CHAPTER 58 OF THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-57-5 is amended by adding a new subdivision to read:

"(5a) "Critical period coverage" means insurance coverage for which benefits are limited to a stated number of payments or the payments end with the expiration of the policy, whichever is less."

SECTION 2. G.S. 58-57-50(b) reads as rewritten:

"(b) The refund of premiums for decreasing term credit life insurance shall be the actuarial method of calculating refunds which produces a refund equal to the original premium multiplied by the ratio of the sum of the remaining insured balances divided by the sum of the original insured balances as of the due date nearest the date of

prepayment in full. The refund of premiums for ~~decreasing term credit life insurance in transactions of 60 months duration or less and the refund of premiums for~~ single interest credit property insurance and single interest physical damage insurance shall be equal to the amount computed by the sum of digits formula known as the "Rule of 78." ~~The refund of premiums for decreasing term credit life insurance in transactions of more than 60 months duration shall be equal to the premium that would be charged for the remaining term and amount of coverage in the policy.~~ The refund of premiums for level term credit life insurance and dual interest credit property insurance and dual interest physical damage insurance shall be equal to the pro rata unearned gross premiums."

SECTION 3. G.S. 58-57-55 reads as rewritten:

"**§ 58-57-55. Issuance of policies.**

All policies of credit life insurance and credit accident and health insurance shall be issued only by an insurer authorized to do business in this State and shall be issued only through holders of licenses or authorizations issued by the Commissioner. With the exception of credit insurance issued in accordance with G.S. 58-57-105, all ~~All~~ policies of credit life insurance and credit accident and health insurance shall be delivered or issued for delivery in this ~~State only by an insurer authorized to do an insurance business therein, and shall be issued only through holders of licenses or authorizations issued by the Commissioner.~~ State. The enrollment of debtors under a group policy issued to a creditor and authorized under this Article shall not constitute the issuance of a policy of insurance."

SECTION 4. G.S. 58-57-60 is amended by adding a new subsection to read:

"(d) A claim acknowledgment shall be sent to the claimant within 30 days after receiving written or electronic notice of the claim. Acknowledgment shall include the following:

(1) A statement made to the insured or the claimant advising that the claim is being investigated.

(2) Payment of the claim.

(3) A bona fide written offer of settlement.

(4) A written denial of the claim."

SECTION 5. G.S. 58-57-110 reads as rewritten:

"**§ 58-57-110. Credit unemployment insurance rate standards; policy provisions.**

(a) Each year the Commissioner shall prescribe a minimum incurred loss ratio standard requirement to develop a premium rate reasonable in relation to the benefits provided by credit unemployment insurance coverage. The following requirements must be met:

(1) Coverage is provided or offered, with or without underwriting, to all debtors regardless of age who are working for salary, wages, or other employment income for at least 30 hours per week and have done so for 12 consecutive ~~months;~~ months.

(2) Coverage sets forth a definition of involuntary unemployment as a loss of employment income that may include, but is not limited to, loss caused by layoff, general strike, termination of employment, or ~~lockout;~~ lockout.

(3) Coverage does not contain any exclusion except: debts with irregular monthly payments; voluntary forfeiture of salary, wages, or other employment income; resignation; retirement; sickness, disease, or normal pregnancy; or loss of income due to termination as a result of willful misconduct that is a violation of some established, definite rule of conduct, a forbidden act, or willful dereliction of duty, or criminal misconduct.

(4) Eligibility for benefits may be based upon registration with the State unemployment office but shall not be limited by any provision requiring registration within a specified time. An insurer may require the insured to provide a copy of the official State unemployment office decision letter regarding the claim for State unemployment benefits in order to qualify for benefits. The official State unemployment office decision letter may only be used to deny a claim for benefits under the credit unemployment coverage if the letter cites a reason listed in G.S. 58-57-110(a)(3).

(b) The Commissioner may approve other policy provisions and coverages consistent with the purposes of unemployment coverage.

(c) Joint coverage rates for credit unemployment insurance shall be one and two-thirds (1 2/3) times the approved single rate of coverage."

SECTION 6. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-57-71. Enforcement and penalties.**

(a) The Commissioner may, after notice and opportunity for a hearing, impose civil penalties or petition for restitution under G.S. 58-2-70, revoke, suspend, or restrict 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 or any of the insurer's officers, directors, employees, or other representatives refuse to submit to any examination authorized by 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 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 or electronic notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgment of the claim shall be one of the following:

(1) A statement made to the claimant or to the claimant's legal representative advising that the claim is being investigated.

(2) Payment of the claim.

(3) A bona fide written offer of settlement.

(4) A written denial of the claim. With respect to a claim under an accident, health, or disability policy, if the acknowledgment sent to the claimant indicates that the claim remains under investigation, within 45 days after receipt by the insurer of the initial claim, the insurer shall send a claim status report to the insured and every 45 days thereafter until the claim is paid or denied. The report shall give details sufficient for the insured to understand why processing of the claim has not been completed and whether the insurer needs additional information to process the claim. If the claim acknowledgment includes information about why processing of the claim has not been completed and indicates whether additional information is needed, it may satisfy the requirement for the initial claim status report.

(d) If a foreign insurance company's license is suspended or revoked, the Commissioner shall cause written notification of the suspension or revocation to be given to all of the company's agents in this State. Until the Commissioner restores the company's license, 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 the insurer's policyholders or creditors."

SECTION 7. G.S. 58-57-70 and G.S. 58-57-80 are repealed.

SECTION 8. This act becomes effective January 1, 2006, and applies to policies or certificates issued or renewed on or after that date.

72467 SHIELDS BUSINESS FORMS, RALEIGH, NC 27605

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NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

H

EDITION No. _____

H. B. No. 653 DATE 6/2/05

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
) _____
Sen.)

1 moves to amend the bill on page 2, line 24
2 ( ) WHICH CHANGES THE TITLE
3 by rewriting the line to read as follows:
4
5 " receiving written or electronic notice of
6 the claim. Acknowledgment shall include
7 one of the ".
8
9
10
11
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13
14
15
16
17
18
19

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 653:
Credit Insurance Changes.-AB

BILL ANALYSIS

Committee:	House Insurance	**Date:**	June 1, 2005
Introduced by:	Rep. Holliman	**Summary by:**	Shawn Parker and Kory Goldsmith, Committee Staff
Version:	PCS to First Edition H653-PCS80424-RC-60		

SUMMARY: House Bill 653 amends Article 57 "Regulation of Credit Insurance" of Chapter 58 of the General Statutes by clarifying statutory requirements, codifying Departmental policy and making the Commissioner's authority to impose monetary penalties on credit insurers consistent with the Commissioner's general enforcement authority.

The bill would become effective January 1, 2006 and apply to policies or certificates issued or renewed on or after that date.

BILL ANALYSIS: House Bill 653 makes technical changes that codify Departmental policy and clarify statutory requirements. **Section 1** adds the definition of "critical period coverage" which reflects the definition presently permitted by the Department. **Section 2** sets an appropriate refund method for decreasing term credit life insurance. **Section 3** allows credit card insurance to be provided through out-of state insurance contracts to account for current market conditions. **Section 4** requires acknowledgment of credit insurance claims not paid within 30 days. Current law does not require this acknowledgment and the changes would make credit insurance uniform with other lines regarding acknowledgment of a claim. **Section 5** allows a requirement of registration with the state unemployment office for involuntary unemployment benefits under a credit unemployment policy and prohibits the placing of a deadline for that registration or qualification for state unemployment benefits to qualify for the insurance benefits. **Section 6** makes the Commissioner's authority to impose monetary penalties on credit insurers consistent with the authority regarding other insurers. Current law only allows the Commissioner to impose a penalty if the company fails to implement an order of the Commissioner. **Section 7** repeals the provision on enforcement and civil and criminal penalties relating to credit insurance (G.S. 58-57-70 and G.S. 58-57-80). These provisions now appear in G.S. 58-57-71 as it appears in Section 6 of this bill. **Section 8** makes the act effective on January 1, 2006 and applies to policies or certificates issued or renewed on or after that date.

Shawn Parker, Insurance Committee Staff, substantially contributed to this summary.

H0653e1-SMRC-PCS80424-RC-60

MINUTES
HOUSE COMMITTEE ON INSURANCE
July 5, 2005

The House Committee on Insurance met at 11:00 AM on Tuesday, July 5, 2005 in Room 1228. The following Representatives attended, Chairman Hugh Holliman, Vice Chairs: Bill Faison, Edward Jones, and Mitchell Setzer. Members: Lucy Allen, William Current, Deborah Ross, Drew Saunders, Ron Sutton, and Tom Wright.

Chairman Holliman called the meeting to order and welcomed visitors and recognized Sgt-At Arms. Attachment I.

Senator Dalton sponsor for SB 577 - Unauthorized Insurer Misconduct. -AB was called on to explain the bill. Being no opposition to the legislation, Rep. Ross asked for a favorable report. Motion carried. Attachment II.

Senator Dalton was asked to speak on SB 552 - DOI Hearing/Unauth. Ins. Summary C&D Order.-AB. He pointed out how the language clarifies procedure under existing law and called on Frank Folger, Legal Counsel with DOI, to answer questions from the committee. Rep. Sutton moved for a favorable report and the motion carried. Attachment III.

Rep. Holliman asked for a motion to accept the PCS for Senate Bill 626, HIPAA Compliance and Fairness.-AB.. The PCS was adopted. Senator Thomas was asked to explain the bill. Sen. Thomas thanked the committee and called on Kory Goldsmith, Staff Attorney to explain a technical amendment. The amendment was adopted. Frank Folger, DOI explained how this bill conforms NC HIPAA law to the Federal HIPAA law and how this will benefit the consumers. Rep. Faison motioned for a favorable report for the PCS as amended and to roll the bill with the amendment into a new PCS. Motioned carried. Attachment IV.

Senator Berger was asked to speak on SB 707 - Agent/Bail Bonds Applicant Petition Deadline. He explained this is a technical bill changing the word "may" to "shall" for the 30-day period of time for review. The PCS for the bill was adopted. Frank Folger with DOI explained the language changes. Rep. Saunders moved for a favorable report to the PCS unfavorable to the original bill. Motion carried. Attachment V.

Chairman Holliman adjourned the meeting at 11:38 AM.

Representative. L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **Tuesday July 5, 2005**

TIME: **11:00 AM**

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

SB 552 - DOI Hearing/Unauth. Ins. Summary C&D Order.-AB - Senator Dalton

SB 577 - Unauthorized Insurer Misconduct.-AB - Senator Dalton

SB 626 - HIPAA Compliance and Fairness.-AB - Senator Thomas

SB 707 - Agent/Bail Bonds Applicant Petition Deadline. – Senator Berger

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **2:30 PM on June 29, 2005**.

___Principal Clerk
___Reading Clerk - House Chamber
Carol Bowers (Committee Assistant)

HOUSE INSURANCE COMMITTEE

July 5, 2005
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

SB 552 - DOI Hearing/Unauth. Ins. Summary C&D Order.-AB - Senator Dalton

SB 577 - Unauthorized Insurer Misconduct.-AB - Senator Dalton

SB 626 - HIPAA Compliance and Fairness.-AB - Senator Thomas

SB 707 - Agent/Bail Bonds Applicant Petition Deadline. – Senator Berger

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Holliman (Chair) for the Committee on INSURANCE.

☒ Committee Substitute for
SB 552 A BILL TO BE ENTITLED AN ACT TO PROVIDE AN UNAUTHORIZED INSURER AGAINST WHICH AN EMERGENCY CEASE AND DESIST ORDER HAS BEEN ISSUED TO PETITION THE DEPARTMENT OF INSURANCE FOR A HEARING ON THE MATTER AND TO APPEAL THAT DECISION TO THE SUPERIOR COURT OF WAKE COUNTY.

☒ With a favorable report.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Holliman (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for

SB 577 A BILL TO BE ENTITLED AN ACT TO CLARIFY THAT AN UNAUTHORIZED INSURER SHALL NOT OPERATE IN THIS STATE IN ITS OWN NAME OR UNDER A "DOING BUSINESS AS" DESIGNATION AS A THIRD PARTY ADMINISTRATOR.

☒ With a favorable report.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Holliman (Chair) for the Committee on INSURANCE.

☒Committee Substitute for
SB 626 A BILL TO BE ENTITLED AN ACT TO BRING NORTH CAROLINA LAW INTO COMPLIANCE WITH THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT; TO PROVIDE SPECIAL ENROLLMENT PERIODS WITHOUT PENALTY FOR PERSONS ENROLLED UNDER A GROUP PLAN WHOSE COVERAGE IS TERMINATED WHEN AN INSURER DISCONTINUES WRITING A CERTAIN TYPE OF GROUP HEALTH INSURANCE COVERAGE THROUGHOUT THAT ENTIRE SMALL OR LARGE GROUP MARKET; AND TO PROVIDE CONTINUED GUARANTEED ISSUE RIGHTS TO A PERSON WHO IS HIPAA ELIGIBLE, WHO IS INSURED IN THE INDIVIDUAL MARKET, AND WHOSE INSURER DISCONTINUES WRITING A CERTAIN TYPE OF HEALTH INSURANCE COVERAGE THROUGHOUT THE ENTIRE INDIVIDUAL MARKET.

☒ With a favorable report as to House committee substitute bill, unfavorable as to Senate committee substitute bill -1.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House/Senate) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Holliman (Chair) for the Committee on INSURANCE.

☒Committee Substitute for
SB 707 A BILL TO BE ENTITLED AN ACT TO CLARIFY THAT THE THIRTY-DAY DEADLINES IMPOSED UPON AGENTS AND BAIL BONDSMEN SEEKING INTERNAL ADMINISTRATIVE REVIEW OF A DENIAL OF LICENSURE AND SUBSEQUENTLY SEEKING A HEARING UNDER ARTICLE 3A OF CHAPTER 150B OF THE GENERAL STATUTES ARE MANDATORY, NOT OPTIONAL.

☒ With a favorable report as to House committee substitute bill, unfavorable as to Senate committee substitute bill -1.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House/Senate) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

ATTACHMENT 1

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — July 5, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Suzanne Buckley	GA Legislative Office
Patrick Boffin	NCGA - Rep. Nye
Barbara Canaday	BCBSNC
Joe Stewart	IFNC
David Sadler	State Farm
Bill Scoggin	KCCH
Grant Ferguson	NMRS
[illegible]	JD, AIC, PA
Matt Latrick	Intern
Joey Grantham	Schering
Henry Taylor	NCAHP

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — July 5, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kathleen Edwards	UNC-CH Institute of Gov't
[signature]	S.H.

SHEET #2 OF 2

HOUSE COMMITTEE ON INSURANCE

July 5, 2005
11:00 AM
Room 1228 Legislative Building

Pages:

Name (please print clearly)	County	Representative

Sergeant-At-Arms (please print)

BILL FREEMAN

BILL SULLIVAN

FRED HINES

Attachment 11

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

S 1

SENATE BILL 577*

Short Title:	Unauthorized Insurer Misconduct.-AB	(Public)
Sponsors:	Senators Dalton; Atwater and Dorsett.	
Referred to:	Commerce.	

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THAT AN UNAUTHORIZED INSURER SHALL NOT OPERATE IN THIS STATE IN ITS OWN NAME OR UNDER A "DOING BUSINESS AS" DESIGNATION AS A THIRD PARTY ADMINISTRATOR.

The General Assembly of North Carolina enacts:

SECTION 1. Article 56 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-56-52. Prohibitions.**

(a) No insurance company shall act as a third party administrator with respect to residents of this State, or residents of another state from offices in this State, in connection with life or health insurance or annuities unless that insurance company is authorized to do the business of insurance in this State and otherwise complies with the applicable laws of this State.

(b) No insurance company shall enter into an agreement with an unauthorized insurance company to provide administrative services for residents of this State, or residents of another state from offices in this State, in connection with life or health insurance or annuities that would subject the unauthorized insurer to this section."

SECTION 2. This act becomes effective October 1, 2005.

SENATE BILL 577:
Unauthorized Insurer Misconduct.-AB

BILL ANALYSIS

Committee:	House Insurance	**Date:**	June 8, 2005
Introduced by:	Sen. Dalton	**Summary by:**	Shawn Parker
Version:	First Edition		Committee Staff

SUMMARY: Senate Bill 577 adds a new statute to Article 56 of Chapter 58 of the General Statutes, *Third Party Administrators*. G.S. 58-56-52. The bill prohibits an unauthorized insurance company from acting as a third party administrator in this State in connection with life or health insurance or annuities. The bill also prohibits an insurance company from entering into an agreement with an unauthorized insurer to provide administrative services in the State in connection with life or health insurance.

A "third party administrator" is defined in G.S. 58-56-2(5) as "a person who directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, or adjusts or settles claims on residents of this State, in connection with life or health insurance or annuities." Specific exceptions are provided in the statute which is set out below.

EFFECTIVE DATE: The bill would become effective October 1, 2005.

§ 58-56-2. Definitions.

The following definitions apply in this Article:

(1) Affiliate. Any person who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified entity or person.

(2) Control. Defined in G.S. 58-19-5(2).

(3) Insurance. Any coverage offered or provided by an insurer.

(4) Insurer. A person who undertakes to provide life or health insurance or benefits in this State that are subject to this Chapter. The term "insurer" does not include a bona fide employee benefit plan established by an employer, an employee organization, or both, for which the insurance laws of this State are preempted pursuant to the Employee Retirement Income Security Act of 1974.

(5) Third party administrator. A person who directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, or adjusts or settles claims on residents of this State, or residents of another state from offices in this State, in connection with life or health insurance or annuities, except any of the following:

a. An employer on behalf of its employees or the employees of one or more of its affiliates.

b. A union on behalf of its members.

c. An insurer that is licensed under Articles 1 through 67 of this Chapter or that is acting as an insurer with respect to a policy lawfully issued and delivered by it and pursuant to the laws of a state in which the insurer is licensed to write insurance.

d. An agent or broker who is licensed by the Commissioner to sell life or health insurance and whose activities are limited exclusively to the sale of insurance.

e. A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors.

f. A trust and its trustees, agents, and employees acting pursuant to the trust established in conformity with 29 U.S.C. § 186.

g. A trust exempt from taxation under section 501(a) of the Internal Revenue Code and its trustees and employees acting pursuant to the trust, or a custodian and the custodian's agents or employees acting pursuant to a custodian account that meets the requirements of section 401(f) of the Internal Revenue Code.

h. A financial institution subject to supervision or examination by federal or state banking authorities, or a mortgage lender, to the extent the financial institution or mortgage lender collects and remits premiums to licensed insurance agents or authorized insurers in connection with loan payments.

i. An attorney-at-law who adjusts or settles claims in the normal course of business as an attorney-at-law and who does not collect charges or premiums in connection with life or health insurance or annuities.

j. An adjuster licensed by the Commissioner whose activities are limited to adjustment of claims.

k. A person who acts solely as a TPA of one or more bona fide employee benefit plans established by an employer, an employee organization, or both, for which the insurance laws of this State are preempted pursuant to the Employee Income Security Act of 1974. The person shall comply with the requirements of G.S. 58-56-51(f).

l. A person licensed as a managing general agent in this State, whose activities are limited exclusively to the scope of activities conveyed under the license.

(6) TPA. A third party administrator.

(7) Underwriting. This term includes the acceptance of employer or individual applications for coverage of individuals in accordance with the written rules of the insurer, the planning and coordination of an insurance program, and the ability to procure bonds and excess insurance.

Tim Hovis, counsel to Senate Commerce, substantially contributed to this summary.

S0577e1-SMSQ

Attachment III 2

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

S

SENATE BILL 552*
Judiciary II Committee Substitute Adopted 4/19/05

Short Title: DOI Hearing/Unauth. Ins. Summary C&D Order.-AB (Public)

Sponsors:

Referred to:

March 15, 2005

A BILL TO BE ENTITLED

AN ACT TO PROVIDE AN UNAUTHORIZED INSURER AGAINST WHICH AN EMERGENCY CEASE AND DESIST ORDER HAS BEEN ISSUED TO PETITION THE DEPARTMENT OF INSURANCE FOR A HEARING ON THE MATTER AND TO APPEAL THAT DECISION TO THE SUPERIOR COURT OF WAKE COUNTY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-28-20 reads as rewritten:

"**§ 58-28-20. Cease and desist ~~orders.~~orders; judicial review.**

(a) Whenever the ~~Commissioner, from evidence satisfactory to him,~~ Commissioner has reasonable grounds to believe that any person is violating or is about to violate G.S. 58-28-5, ~~he~~ the Commissioner may, after notice and opportunity for hearing, ~~reduce his findings to writing~~ make written findings and issue and cause to be served upon ~~such~~ the person an order to cease and desist ~~from~~ violating G.S. 58-28-5.

(b) Until the expiration of the time allowed under ~~G.S. 58-28-25(a)~~G.S. 58-2-75 for filing a petition for review, ~~if no such petition has been duly filed within such time; or if a petition for review has been filed within such time, then until the transcript of the record in the proceeding has been filed in the Court,~~ the Commissioner may at any time, upon ~~such~~ notice and in ~~such~~ a manner ~~as he~~the Commissioner considers proper, modify or set aside in whole or in part any order issued by ~~him~~ the Commissioner under this ~~section.~~section as follows:

(1) Any time before the expiration of the time allowed for seeking judicial review, if no petition for review has been filed; or

(2) If a petition for review has been timely filed, until the transcript of the record in the proceeding has been filed with the Court.

(c) ~~After the expiration of the time allowed for filing a petition for review, if no such petition has been duly filed within such time,~~ If no petition for judicial review has been filed within the time provided under G.S. 58-2-75, the Commissioner may at any time, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in

whole or in part, any order issued by ~~him~~ the Commissioner under this section, whenever in ~~his~~ the Commissioner's opinion conditions of fact or of law have so changed as to require such action or if the public interest requires.

(d) Whenever the Commissioner has evidence that any person has or is violating G.S. 58-28-5, or has or is violating any order or requirement of the Commissioner issued ~~or promulgated~~ by the Commissioner under this Article, and that the interests of policyholders, creditors, or the public may be irreparably harmed by delay, the Commissioner may issue ~~a~~ an emergency cease and desist ~~order. Notice of the cease and desist order and notice of hearing shall be delivered by first-class mail.~~ order that shall become effective on the date specified in the order or upon service of a certified copy of the order upon the person ordered to cease and desist, whichever is later. The emergency cease and desist order shall also include a notice of hearing, which shall be conducted as provided under Article 3A of Chapter 150B of the General Statutes. However, the person ordered to cease and desist under this subsection may request and shall be granted an expedited review of the order. The emergency order shall remain in effect prior to and during the proceedings, unless modified by the Commissioner as provided under subsection (b) of this section.

(e) Any person required to cease and desist violating G.S. 58-28-5 by an order issued after notice and a hearing under subsection (a) or (d) of this section may seek judicial review of that order under G.S. 58-2-75."

SECTION 2. G.S. 58-28-25 is repealed.

SECTION 3. This act becomes effective October 1, 2005, and applies to orders issued on or after that date.

SENATE BILL 552: DOI Hearing/Unauth. Ins. Summary C&D Order.-AB

BILL ANALYSIS

Committee:	Senate Judiciary II	**Date:**	June 30, 2005
Introduced by:	Sen. Dalton	**Summary by:**	Tim Hovis, Kory Goldsmith Committee Counsels
Version:	Second Edition		

SUMMARY: ***Senate Bill 552 is an Agency bill that creates a hearing procedure in the event the Commissioner of Insurance issues an emergency cease and desist order against a person who is selling insurance without a license. The order may be issued prior to a hearing, but a hearing would have to be held according to the procedures specified under the Administrative Procedures Act (APA).***

This act would become effective October 1, 2005, and would apply to orders issued on or after that date.

[As introduced, this bill was identical to H647, as introduced by Rep. Holliman, which is currently in House Insurance.]

CURRENT LAW: G.S. 58-28-20 gives the Commissioner of Insurance the authority to issue a cease and desist order if a person is selling insurance or otherwise transacting insurance business without a license. G.S. 58-28-20(a) provides that the cease and desist order may be issued after the person has been given notice and an opportunity for a hearing. G.S. 58-28-20(d) authorizes the Commissioner to issue a cease and desist order without notice or a hearing if the Commissioner believes that the "interests of policyholders, creditors, or the public maybe irreparably harmed by delay." The statute does not provide a hearing procedure following the issuance of this type of cease and desist order, thereby making its enforceability susceptible to a due process challenge.

G.S. 58-28-25 provides a procedure for judicial review after a cease and desist order has been ordered. The procedure is identical to the one specified in G.S. 58-2-75.

BILL ANALYSIS:

Section 1 of the bill makes a number of changes to G.S. 58-28-20, although the changes in subsections (a) through (c) are primarily stylistic. Subsection (d) is the law that already authorizes the Commissioner to issue a cease and desist order without notice and a hearing. The changes to this subsection are as follows:

- Distinguishes these types of cease and desist orders by designating them as "emergency" orders.
- Makes the order effective either upon a date specified in the order, or when a certified copy of the order has been served on the person, which ever is later.
- Specifies that the emergency order must include a notice of hearing, that the Commissioner must proceed under the APA for contested cases (Article 3A of Chapter 150B of the General Statutes), and that the person ordered to cease and desist may request and shall be granted an expedited hearing.
- Specify that the emergency order remains in effect during the hearing process.

The act also creates a new subsection (e) that provides that a person who wants to seek judicial review of a cease and desist order may do so under G.S. 58-2-75.

Section 2 of the bill repeals G.S. 58-28-25 which contained the process for judicial review of a cease and desist order. The procedure in G.S. 58-28-25 is identical to that in G.S. 58-2-75 that has been substituted as the procedure in Section 1 of the bill. (See copy of G.S. 58-2-75 below)

EFFECTIVE DATE: The act would become effective October 1, 2005 and apply to orders issued on or after that date.

§ 58-2-75. Court review of orders and decisions.

(a) Any order or decision made, issued or executed by the Commissioner, except an order to make good an impairment of capital or surplus or a deficiency in the amount of admitted assets and except an order or decision that the premium rates charged or filed on all or any class of risks are excessive, inadequate, unreasonable, unfairly discriminatory or are otherwise not in the public interest or that a classification assignment is unwarranted, unreasonable, improper, unfairly discriminatory, or not in the public interest, shall be subject to review in the Superior Court of Wake County on petition by any person aggrieved filed within 30 days from the date of the delivery of a copy of the order or decision made by the Commissioner upon such person. A copy of such petition for review as filed with and certified to by the clerk of said court shall be served upon the Commissioner or in his absence upon someone in active charge of the Department within five days after the filing thereof. If such petition for review is not filed within the said 30 days, the parties aggrieved shall be deemed to have waived the right to have the merits of the order or decision reviewed and there shall be no trial of the merits thereof by any court to which application may be made by petition or otherwise, to enforce or restrain the enforcement of the same.

(b) The Commissioner shall within 30 days, unless the time be extended by order of court, after the service of the copy of the petition for review as provided in subsection (a) of this section, prepare and file with the clerk of the Superior Court of Wake County a complete transcript of the record of the hearing, if any, had before him, and a true copy of the order or decision duly certified. The order or decision of the Commissioner if supported by substantial evidence shall be presumed to be correct and proper. The court may change the place of hearing,

(1) Upon consent of the parties; or
(2) When the convenience of witnesses and the ends of justice would be promoted by the change; or
(3) When the judge has at any time been interested as a party or counsel.

The cause shall be heard by the trial judge as a civil case upon transcript of the record for review of findings of fact and errors of law only. It shall be the duty of the trial judge to hear and determine such petition with all convenient speed and to this end the cause shall be placed on the calendar for the next succeeding term for hearing ahead of all other cases except those already given priority by law. If on the hearing before the trial judge it shall appear that the record filed by the Commissioner is incomplete, he may by appropriate order direct the Commissioner to certify any or all parts of the record so omitted.

(c) The trial judge shall have jurisdiction to affirm or to set aside the order or decision of the Commissioner and to restrain the enforcement thereof.

(d) Appeals from all final orders and judgments entered by the superior court in reviewing the orders and decisions of the Commissioner may be taken to the appellate division of the General Court of Justice by any party to the action as in other civil cases.

(e) The commencement of proceedings under this section shall not operate as a stay of the Commissioner's order or decision, unless otherwise ordered by the court.

Attachment IV

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

S 2

SENATE BILL 626*
Commerce Committee Substitute Adopted 4/5/05

Short Title: HIPAA Compliance and Fairness.-AB (Public)

Sponsors:

Referred to:

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO BRING NORTH CAROLINA LAW INTO COMPLIANCE WITH THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT; TO PROVIDE SPECIAL ENROLLMENT PERIODS WITHOUT PENALTY FOR PERSONS ENROLLED UNDER A GROUP PLAN WHOSE COVERAGE IS TERMINATED WHEN AN INSURER DISCONTINUES WRITING A CERTAIN TYPE OF GROUP HEALTH INSURANCE COVERAGE THROUGHOUT THAT ENTIRE SMALL OR LARGE GROUP MARKET; AND TO PROVIDE CONTINUED GUARANTEED ISSUE RIGHTS TO A PERSON WHO IS HIPAA ELIGIBLE, WHO IS INSURED IN THE INDIVIDUAL MARKET, AND WHOSE INSURER DISCONTINUES WRITING A CERTAIN TYPE OF HEALTH INSURANCE COVERAGE THROUGHOUT THE ENTIRE INDIVIDUAL MARKET.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-68-30(c) reads as rewritten:

"(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)).
k. ~~The Health Insurance Program for Children established in Part 8 of Chapter 108A of the General Statutes, or any successor program.~~ Title XXI of the Social Security Act (State Children's Health Insurance Program).

"Creditable coverage" does not include coverage consisting solely of coverage of excepted benefits. However, short-term limited-duration health insurance coverage shall be considered creditable coverage for purposes of this section and G.S. 58-51-15(a)(2)b.

(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.
d. For an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

(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."

SECTION 2. G.S. 58-68-30(f)(1) reads as rewritten:

"(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;~~ cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, ~~or~~ reduction in the number of hours of ~~employment;~~ employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing; ~~or~~ (iii) employer contributions toward the coverage were ~~terminated.~~ terminated; (iv) was terminated by the health insurer pursuant to G.S. 58-68-45(c)(2); (v) in the case of coverage offered through an arrangement that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; (vi) in the case of a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; or (vii) a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

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."

SECTION 3. G.S. 58-68-60 is amended by adding the following new subsections to read:

"(i) Rights of Replacement Coverage Upon Termination. – Subsection (a) of this section shall apply to an eligible individual whose coverage issued pursuant to this section is terminated by a health insurer pursuant to G.S. 58-68-65(c)(2) provided the application for the replacement coverage is dated not more than 63 days following the termination date.

(j) Waiting Period. – In determining the length of any break in coverage for an individual as prescribed in G.S. 58-68-60(b)(1)(i), a significant break in coverage does not occur during the waiting period. The "waiting period" is defined as the period that begins on the date the individual submits a substantially complete application for coverage and ends on:

(1) If the application results in coverage, the date coverage begins; or

(2) If the application does not result in coverage, the date on which the application is denied by the issuer or the date on which the offer for coverage lapses."

SECTION 4. G.S. 58-68-30(b) reads as rewritten:

"(b) Definitions. – For the purposes of this Part:

(1) 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. If an individual receiving benefits under a group health insurance plan changes benefit packages, or if the plan changes health insurer, the individual's enrollment date does not change.

(2) 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.

(3) 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,~~ effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before ~~the date.~~that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a preenrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.

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.

(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.

a. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period.

b. If an individual seeks individual health insurance coverage, a waiting period begins on the date the individual submits a substantially complete application and ends on: (i) if the

application results in coverage, the date coverage begins; or (ii) if the application does not result in coverage, the date on which the application is denied by the health insurer or the date on which the offer for coverage lapses."

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 626*

Commerce Committee Substitute Adopted 4/5/05

PROPOSED HOUSE COMMITTEE SUBSTITUTE S626-CSRC-68 [v.3]

7/1/2005 10:51:43 AM

Short Title: HIPAA Compliance and Fairness.-AB (Public)

Sponsors:

Referred to:

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO BRING NORTH CAROLINA LAW INTO COMPLIANCE WITH THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT; TO PROVIDE SPECIAL ENROLLMENT PERIODS WITHOUT PENALTY FOR PERSONS ENROLLED UNDER A GROUP PLAN WHOSE COVERAGE IS TERMINATED WHEN AN INSURER DISCONTINUES WRITING A CERTAIN TYPE OF GROUP HEALTH INSURANCE COVERAGE THROUGHOUT THAT ENTIRE SMALL OR LARGE GROUP MARKET; AND TO PROVIDE CONTINUED GUARANTEED ISSUE RIGHTS TO A PERSON WHO IS HIPAA ELIGIBLE, WHO IS INSURED IN THE INDIVIDUAL MARKET, AND WHOSE INSURER DISCONTINUES WRITING A CERTAIN TYPE OF HEALTH INSURANCE COVERAGE THROUGHOUT THE ENTIRE INDIVIDUAL MARKET.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-68-30(c) reads as rewritten:

"(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)).
k. ~~The Health Insurance Program for Children established in Part 8 of Chapter 108A of the General Statutes, or any successor program.~~ Title XXI of the Social Security Act (State Children's Health Insurance Program).

"Creditable coverage" does not include coverage consisting solely of coverage of excepted benefits. However, short-term limited-duration health insurance coverage shall be considered creditable coverage for purposes of this section and G.S. 58-51-15(a)(2)b.

(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.
d. For an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period shall not be considered when determining whether a significant break in coverage has occurred.

(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."

SECTION 2. G.S. 58-68-30(f)(1) reads as rewritten:

"(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~~ With respect to the employee's or dependent's coverage under a plan described in sub-subdivision ~~a.:~~ a. of this subdivision, at least one of the following applies: (i) the coverage was under a COBRA continuation provision and the coverage under the provision was exhausted; (ii) the coverage was not under ~~that~~ a COBRA continuation provision and ~~either~~ the coverage was terminated because of loss of eligibility for the coverage, including legal separation, divorce, ~~death,~~ cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, ~~or~~ reduction in the number of hours of ~~employment;~~ employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing; ~~or~~ (iii) the employer terminated contributions toward the ~~coverage were terminated.~~ coverage; (iv) the individual lost coverage because the individual no longer resided, lived, or worked in the service area (whether or not within the choice of the individual) if the coverage was offered through an arrangement that did not provide benefits to individuals who no longer reside, live, or work in a service area, and no other benefit package is available to the individual; (v) an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; or (vi) a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

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."

SECTION 2.1. G.S. 58-68-30(f)(1), as amended by Section 2 of this bill, reads as rewritten:

"(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. With respect to the employee's or dependent's coverage described in sub-subdivision a. of this subsection: (i) the coverage was under a COBRA continuation provision and the coverage under the provision was exhausted; (ii) the coverage was not under that provision and either the coverage was terminated because of loss of eligibility for the coverage, including legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing; (iii) employer contributions toward the coverage were terminated; (iv) in the case of coverage offered through an arrangement that does not provide benefits to individuals who no longer reside, live, or work in a service area, there has been loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; (v) an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; or (vi) a plan no longer offers any benefits to the class of similarly situated individuals that includes the ~~individual.~~ individual; or (vii) the health insurer terminated coverage under G.S. 58-68-45(c)(2).

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."

SECTION 3. G.S. 58-68-60 is amended by adding the following new subsections to read:

"(i) Rights of Replacement Coverage Upon Termination. – Subsection (a) of this section shall apply to an eligible individual whose coverage issued under this section is terminated by a health insurer under G.S. 58-68-65(c)(2) the application for the replacement coverage is dated not more than 63 days following the termination date.

(j) Waiting Period. – In determining the length of any break in coverage for an individual as prescribed in G.S. 58-68-60(b)(1)(i), a significant break in coverage does not occur during the waiting period. The "waiting period" is defined as the period that begins on the date the individual submits a substantially complete application for coverage and ends on:

(1) The date coverage begins, if the application results in coverage, or

(2) The date on which the application is denied by the issuer or the date on which the offer for coverage lapses, if the application does not result in coverage."

SECTION 4. G.S. 58-68-30(b) reads as rewritten:

"(b) Definitions. – For the purposes of this Part:

(1) 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. An individual's enrollment date does not change if the individual receiving benefits under a group health insurance plan changes benefit packages or if the plan changes health insurers.

(2) 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.

(3) 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,~~ effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before ~~the date.~~ that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a preenrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.

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.

(4) Waiting period. –

a. 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.

b. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before the late or special enrollment is not a waiting period.

c. If an individual seeks individual health insurance coverage, a waiting period begins on the date the individual submits a substantially complete application and ends on: (i) the date coverage begins if the application results in coverage; or (ii) the date on which the application is denied by the health insurer or the date on which the offer for coverage lapses if the application does not result in coverage."

SECTION 5. Section 2 of this act is effective when it becomes law, applies to all health benefit plans that are delivered, issued for delivery, or renewed on and after that date. Sections 2.1 and 3 of this act become effective January 1, 2006, and apply to all health benefit plans that are delivered, issued for delivery, or renewed on and after that date. The remainder of this act is effective when it becomes law and applies to all health benefit plans that are delivered, issued for delivery, or renewed on and after that date. For the purposes of this act, renewal of a health benefit plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.

IV

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 626*

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

S626-ARC-29 [v.1]

Date _____,2005

Comm. Sub. [YES]
Amends Title [NO]
S626-CSRC-68[v.3]

Representative _____

moves to amend the bill on page 4, by rewriting lines 27 through 30 to read:

"enrollment not later than 30 days after the ~~date of exhaustion of coverage~~ applicable event described in sub-subdivision ~~c.(i) of this subdivision or termination of coverage or employer contribution described in sub-subdivision c.(ii)~~ c. of this subdivision.";

and on page 5, lines 29 through 32 to read:

"enrollment not later than 30 days after the applicable event described in sub-subdivision c. of this subdivision.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

IV

SENATE BILL 626:
HIPAA Compliance and Fairness.-AB

BILL ANALYSIS

Committee:	House Insurance	**Date:**	July 5, 2005
Introduced by:	Sen. Thomas	**Summary by:**	Kory Goldsmith Committee Counsel
Version:	PCS to Second Edition S626-CSRC-68		

SUMMARY: ***The bill makes a number of changes to conform North Carolina HIPAA law to the federal law.***

The Proposed Committee Substitute includes additional circumstances that will make an individual eligible to continue group health insurance coverage.

CURRENT LAW: HIPAA (The Health Insurance Portability and Accountability At) is a federal act that includes several provisions designed help individuals protect against the loss of health care coverage due to starting a new job, changing jobs, or losing a job. Among its specific protections, HIPAA: limits the use of pre-existing condition exclusions; prohibits group health plans from discriminating by denying coverage or charging extra for coverage based on a family member's past or present poor health; and guarantees the right to purchase health insurance for certain small employers, and certain individuals who lose job-related coverage.

BILL ANALYSIS:

Section 1 amends the definition of creditable coverage in G.S. 58-68-30 to provide that creditable coverage includes short-term limited-duration health insurance coverage. It requires that this type of coverage be included as coverage reducing the period of any preexisting condition exclusion by a group health insurer. It also excludes COBRA continuation coverage when determining whether a significant break in coverage has occurred.

Currently, limitations or exclusions on preexisting conditions are reduced by periods of creditable coverage applicable as of the enrollment date for group health insurance. The existence of creditable coverage is also used to determine the existence of guaranteed issue coverage upon termination of any existing coverage. Federal law requires that short-term limited-duration coverage be included as creditable coverage.

Section 2 amends G.S. 58-68-30 governing group special enrollment provisions under HIPAA to provide a special enrollment period for individuals to enroll in a group plan without penalty when their own insurance was terminated because of any of the following:

- The employer stopped making contributions towards the coverage.
- The person moved and the coverage was limited to a particular geographic area
- The person incurred a claim that would meet or exceed the lifetime benefits of the coverage.
- The plan no longer offers benefits to the class of similarly situated individuals.

Section 2.1 also amends G.S. 58-68-30, effective January 1, 2006. It would makes persons eligible for special enrollment if their own insurance was terminated by a health insurer under G.S. 58-68-45.

Under G.S. 58-68-45(c)(2), an insurer has the ability to terminate all health insurance coverage in this State if the insurer decides to withdraw from the group health insurance market in the State. In those

situations, a participant or beneficiary affected by the termination has no apparent statutorily mandated special enrollment rights under another group health plan for which they are eligible as a dependent and for which they previously waived off coverage because they had their own coverage through another group plan.

Section 3 amends 58-68-60 governing HIPAA eligible individuals to provide that once a person has obtained HIPAA eligible individual status, they retain the same guaranteed issue rights if their coverage is terminated by an insurer exercising termination rights under G.S. 58-68-65(c)(2) (which means they are terminating all individual coverage in this State) and the eligible individual replaces coverage within a stated time period.

Currently, when an individual insurer terminates all coverage in this State, HIPAA eligible individuals covered by the insurer are left with no options for replacement coverage if they have preexisting health concerns. This provision resolves that problem in favor of the otherwise disadvantaged individual whose coverage is terminated.

Section 4 clarifies that the enrollment date for an individual covered under a group health plan is not changed by the fact the benefit package the person receives changes or that there is a change in the insurer by the health plan. It also clarifies the term "waiting period" to not include the any period before the late or special enrollment for an employee or a dependent who enrolls as a late enrollee or a special enrollee. If a person seeks individual coverage, a waiting period begins on the date the individual submits a substantially complete application and ends on (1) the date coverage begins; or (2) the date the application is denied or the date the offer for coverage lapses.

EFFECTIVE DATE: Sections 1, 2, 4 and 5 are effective when they become law. Section 2 applies to all health benefit plans delivered, issued for delivery, or renewed on or after that date. Section 2.1 and 3 become effective January 1, 2006 and apply to all health benefit plans delivered, issued for delivery, or renewed on or after that date.

BACKGROUND: Senate Bill 626 is a recommendation of the Department of Insurance

Tim Hovis, counsel to Senate Commerce, and Frank Folger, Legislative Counsel to the Department of Insurance substantially contributed to this summary.

S0626e2-SMRC-CSRC-68

ATTACHMENT V

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

S 2

SENATE BILL 707
Judiciary I Committee Substitute Adopted 4/6/05

Short Title: Agent/Bail Bonds Applicant Petition Deadline. (Public)

Sponsors:

Referred to:

March 21, 2005

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THAT THE THIRTY-DAY DEADLINES IMPOSED UPON AGENTS AND BAIL BONDSMEN SEEKING INTERNAL ADMINISTRATIVE REVIEW OF A DENIAL OF LICENSURE AND SUBSEQUENTLY SEEKING A HEARING UNDER ARTICLE 3A OF CHAPTER 150B OF THE GENERAL STATUTES ARE MANDATORY, NOT OPTIONAL.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-33-30(g) reads as rewritten:

"(g) Denial of License. – If the Commissioner finds that the applicant has not fully met the requirements for licensing, ~~he~~ the Commissioner shall refuse to issue the license and shall notify in writing the applicant and the appointing insurer, if any, of ~~such~~ the denial, stating the grounds ~~therefor.~~ for 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. 58-33-46. ~~Within 30 days after service of the notification, the applicant may~~ In order for an applicant to be entitled to a review of the Commissioner's action to determine the reasonableness of the action, the applicant must make a written demand upon the Commissioner for a review ~~to determine the reasonableness of the Commissioner's action.~~ no later than 30 days after service of the notification upon the applicant. The review shall be completed without undue delay, and the applicant shall be notified promptly in writing ~~as to the~~ of the outcome of the review. ~~Within 30 days after service of the notification as to the outcome, the applicant may~~ In order for an applicant who disagrees with the outcome of the review to be entitled to a hearing under Article 3A of Chapter 150B of the General Statutes, the applicant must make a written demand upon the Commissioner for a hearing ~~under Article 3A of Chapter 150B of the General Statutes if the applicant disagrees with the outcome.~~ no later than 30 days after service upon the applicant of the notification of the outcome."

SECTION 2. G.S. 58-71-85(b) reads as rewritten:

"(b) Whenever the Commissioner denies an initial application for a license or an application for a reissuance of a license, ~~he~~ the Commissioner shall notify the applicant

and advise, in writing, the applicant of the reasons for the denial of the license. The application may also be denied for any reason for which a license may be suspended or revoked or not renewed under G.S. 58-71-80(a). ~~Within 30 days after service of the notification, the applicant may~~ In order for an applicant to be entitled to a review of the Commissioner's action to determine the reasonableness of the action, the applicant must make a written demand upon the Commissioner for a review ~~to determine the reasonableness of the Commissioner's action.~~ no later than 30 days after service of the notification upon the applicant. The review shall be completed without undue delay, and the applicant shall be notified promptly in writing ~~as to~~ of the outcome of the review. ~~Within 30 days after service of the notification as to the outcome, the applicant may~~ In order for an applicant who disagrees with the outcome of the review to be entitled to a hearing under Article 3A of Chapter 150B of the General Statutes, the applicant must make a written demand upon the Commissioner for a hearing ~~under Article 3A of Chapter 150B of the General Statutes if the applicant disagrees with the outcome.~~ no later than 30 days after service upon the applicant of the notification of the outcome."

SECTION 3. This act becomes effective October 1, 2005. This act applies to all notices of applications denied by the Commissioner served on or after that date and to all notices of review outcomes served on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 707
Judiciary I Committee Substitute Adopted 4/6/05
PROPOSED HOUSE COMMITTEE SUBSTITUTE S707-CSRD-29 [v.1]

7/1/2005 2:36:56 PM

Short Title: Agent/Bail Bonds Applicant Petition Deadline. (Public)

Sponsors:

Referred to:

March 21, 2005

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THAT THE THIRTY-DAY DEADLINES IMPOSED UPON AGENTS AND BAIL BONDSMEN SEEKING INTERNAL ADMINISTRATIVE REVIEW OF A DENIAL OF LICENSURE AND SUBSEQUENTLY SEEKING A HEARING UNDER ARTICLE 3A OF CHAPTER 150B OF THE GENERAL STATUTES ARE MANDATORY, NOT OPTIONAL.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-33-30(g) reads as rewritten:

"(g) Denial of License. – If the Commissioner finds that the applicant has not fully met the requirements for licensing, ~~he~~ the Commissioner shall refuse to issue the license and shall notify in writing the applicant and the appointing insurer, if any, of ~~such~~ the denial, stating the grounds ~~therefor.~~ for 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. 58-33-46. ~~Within 30 days after service of the notification, the applicant may~~ In order for an applicant to be entitled to a review of the Commissioner's action to determine the reasonableness of the action, the applicant must make a written demand upon the Commissioner for a review ~~to determine the reasonableness of the Commissioner's action.~~ no later than 30 days after service of the notification upon the applicant. The review shall be completed without undue delay, and the applicant shall be notified promptly in writing ~~as to the~~ of the outcome of the review. ~~Within 30 days after service of the notification as to the outcome, the applicant may~~ In order for an applicant who disagrees with the outcome of the review to be entitled to a hearing under Article 3A of Chapter 150B of the General Statutes, the applicant must make a written demand upon the Commissioner for a hearing ~~under Article 3A of Chapter 150B of the General Statutes if the applicant disagrees with the outcome.~~ no later than 30 days after service upon the applicant of the notification of the outcome."

SECTION 2. G.S. 58-71-85(b) reads as rewritten:

"(b) Whenever the Commissioner denies an initial application for a license or an application for a reissuance of a license, ~~he~~ the Commissioner shall notify the applicant and advise, in writing, the applicant of the reasons for the denial of the license. The application may also be denied for any reason for which a license may be suspended or revoked or not renewed under G.S. 58-71-80(a). ~~Within 30 days after service of the notification, the applicant may~~ In order for an applicant to be entitled to a review of the Commissioner's action to determine the reasonableness of the action, the applicant must make a written demand upon the Commissioner for a review ~~to determine the reasonableness of the Commissioner's action.~~ no later than 30 days after service of the notification upon the applicant. The review shall be completed without undue delay, and the applicant shall be notified promptly in writing ~~as to~~ of the outcome of the review. ~~Within 30 days after service of the notification as to the outcome, the applicant may~~ In order for an applicant who disagrees with the outcome of the review to be entitled to a hearing under Article 3A of Chapter 150B of the General Statutes, the applicant must make a written demand upon the Commissioner for a hearing ~~under Article 3A of Chapter 150B of the General Statutes if the applicant disagrees with the outcome.~~ no later than 30 days after service upon the applicant of the notification of the outcome."

SECTION 3. Article 71 of Chapter 58 is amended by adding the following new section.

"**58-71-151 Securities held in trust by Commissioner; authority to dispose of same.**

The securities deposited by a professional bondsman with the Commissioner shall be held in trust for the protection and benefit of the holder of bail bonds executed by or on behalf of the undersigned bondsman in this State. Notwithstanding any other provision of law, the Commissioner is authorized to select a bank or trust company as master trustee to hold cash securities to be pledged to the State when deposited with the Commissioner pursuant to statute. Securities may be held by the master trustee in any form that in fact perfects the security interest of the State in the securities. The Commissioner shall by rule establish the manner in which the master trust shall operate. The master trustee may charge the person making the deposit reasonable fees for services rendered in connection with the operation of the trust, and the assets of the account may be used to pay such charges.

A pro rata portion of the securities shall be returned to the bondsman when the Commissioner is satisfied that the deposit of securities is in excess of the amount required to be maintained with the Commissioner by said bondsman; and all the securities shall be returned if the Commissioner is satisfied that the bondsman has satisfied, or satisfactory arrangements have been made to satisfy, the obligations of the bondsman on all the bondsman's bail bonds written in the State.

The Commissioner may sell or transfer any and all of said securities or utilize the proceeds thereof for the purpose of satisfying the liabilities of the professional bondsman on bail bonds given in this State on which the bondsman is liable."

SECTION 4. G.S. 58-71-150 is repealed.

SECTION 5. This act becomes effective October 1, 2005. This act applies to all notices of applications denied by the Commissioner served on or after that date and to all notices of review outcomes served on or after that date.

SENATE BILL 707:
Agent/Bail Bonds Applicant Petition Deadline

BILL ANALYSIS

Committee:	House Insurance	**Date:**	July 1, 2005
Introduced by:	Sen. Berger of Rockingham	**Summary by:**	Ben Popkin
Version:	PCS to Second Edition S707-CSRD		Committee Counsel

SUMMARY: Senate Bill 707 would make clear that if a person denied a license to be an insurance agent, bail bondsman, or bail bondsman's runner wants a review of that denial, that person must demand a review within 30 days. Current law may leave the impression that making the demand within 30 days is optional. The bill would be effective October 1, 2005.

The Proposed Committee Substitute would authorize the "master trustee"[1] holding securities deposited by bondmen to take reasonable fees from the assets of the account to pay administrative costs relating to the operation of the trust.

CURRENT LAW: Currently, the Commissioner of Insurance has the job of approving or denying licenses for insurance agents and bail bondsmen and runners. If the Commissioner denies a license, the statutes say the applicant "may make a written demand on the Commissioner for a review" of the denial within 30 days of the applicant's being served with the denial. The statute then goes on to say that the review shall be completed without undue delay.

The Department of Insurance believes the intent of the statute was clearly that the applicant has a choice of whether or not to seek a review of the denial. But if the applicant does seek a review, the applicant must meet the 30-day deadline in order to be entitled to one. The problem is caused by the wording of the statutes, which compress into one verb clause, "may make a written demand," the two thoughts that seeking a review is optional, but that if you want a review demanding one within 30 days is not optional.

There is a parallel problem with ambiguous language about the applicant's 30-day deadline in demanding a hearing on the Commissioner's review with an administrative law judge under the Administrative Procedure Act.

Proposed Committee Substitute – Current law does not authorize any party to collect payment for administrative costs relating to the maintenance of trust accounts holding securities deposited by professional bondsmen. In contrast, payment for administrative costs relating to deposits held for insurance companies on behalf of the Commissioner is specifically authorized by statute (G.S. 58-5-1).

BILL ANALYSIS: The bill would reword the statutes to clarify that if a denied applicant for an agent's license or bail bondsman's license is to be entitled to a review, that applicant must demand a review within 30 days of being served with the notice of denial. The same rewording would be done for the 30-day deadline for taking the Commissioner's decision on review before an administrative law judge. Section 1 of the bill deals with insurance agents. Section 2 deals with bail bondsmen.

EFFECTIVE DATE: The bill would be effective October 1, 2005, and would apply to notices of license denials and notices of review outcomes served on or after that date.

Bill Gilkeson, counsel to Senate Judiciary I, substantially contributed to this summary. *S0707e2-SMRD-CSRD*

[1] The bank or trust company selected by the Commissioner "...to hold cash securities to be pledged to the State when deposited with the Commissioner pursuant to statute." (Proposed G.S. 58-71-151).

MINUTES
HOUSE COMMITTEE ON INSURANCE
July 26, 2005

The House Committee on Insurance met at 11:00 AM on Tuesday, July 26, 2005 in Room 1228. The following Representatives attended, Chairman Hugh Holliman, Vice Chairs: Bill Faison, Edward Jones, and Ed Nye. Members: Lucy Allen, D. Almond, J. Barnhart, H. Brubaker, W. Current, R. Grady, J. Howard, L. Johnson, D. Ross, D. Saunders, F. Steen, R. Sutton, W. Wainwright.

Chairman Holliman called the meeting to order and welcomed visitors and recognized Sgt-At Arms and House Pages. Attachment I.

SB 319 - Workers' Comp. Self-Insurance Security sponsored by Senator Clodfelter was removed from the agenda to be rescheduled at a later date.

Rep. Holliman asked the committee for a motion to accept the PCS for SB 687. Motion passed. Senator Kerr sponsor of SB 687 - Volunteer Rescue/EMS Funding was called on to explain the bill. He explained how the grant from DOI would assist volunteers and how this legislation is a small step in changing the law in protecting Rescue and EMS volunteers. Attachment II.

Gordan Joyner with NCAR&EMS, INC spoke in support of the bill. Tim Bradley, DOI spoke in support of the bill, and how the department funds this grant.

An amendment from Rep. Ross changing the effective date of the bill was adopted. Attachment III. Being no opposition to the legislation, Rep. Faison motioned for a favorable report to the PCS as amended unfavorable to the original bill. Motion carried.

Chairman Holliman adjourned the meeting at 11:15 AM.

Representative. L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: TUESDAY, JULY 26, 2005

TIME: 11:00 AM

LOCATION: 1228 LB

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

SB 687 - Volunteer Rescue/EMS Funding - Senator Kerr

SB 319 - Workers' Comp. Self-Insurance Security. - Senator Clodfelter

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 10:00 AM on July 21, 2005.

____Principal Clerk
____Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

HOUSE INSURANCE COMMITTEE

July 26, 2005
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

SB 687 - Volunteer Rescue/EMS Funding - Senator Kerr

SB 319 - Workers' Comp. Self-Insurance Security. - Senator Clodfelter

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Holliman (Chair) for the Committee on INSURANCE.

☒ ~~House Committee Substitute for~~
SB 687 A BILL TO BE ENTITLED AN ACT TO AMEND THE LAW GOVERNING THE VOLUNTEER RESCUE/EMS FUND.

☒ With a favorable report as to House committee substitute bill, unfavorable as to the original bill.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House/Senate) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

ATTACHMENT I

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — July 26, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kam Johnson	Smith Anderson
Mark Gibson	Capitol Group
John Lynn	NCS Strategies
Patricia Ramos	NCACC
Tim BRADLEY	NC DEPT INSURANCE
Gordon A Joyner	NCAREMS, INC
Lucius PULLEN	NC Mining Association
Kathleen Edwards	UNC-CH Institute of Gov't
John McMillan	NFOS
Russ Dubiskey	CCPS
Mike Miller	NCFB AFL-CIO

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — July 26, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Doug Howey	NCPMA
Lisa Martin	NC Home Builders
Bonnie Stevens	South Rowan High School 1655 Patterson St. China Grove, NC 28023
Stephanie Simpson	NC Assn of REALTORS
Harry Taylor	NCAHP
John McKay	Gov office
[illegible]	NMRS
Robert PASchal	Young, Moore
[illegible]	IFNC
Barbara Carsley	BSCGR
[illegible]	Bone + Mason

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — July 26, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Fran Percy	Duke Energy

HOUSE COMMITTEE ON INSURANCE

July 26, 2005
11:00 AM
Room 1228 Legislative Building

Pages:

Name (please print clearly)	County	Representative
LEJEANA Black	Mecklenburg	Rep Carney
Marketa Floyd	"	Rep Carney
Koneisha Macon	Forsyth	Rep Womble
Megan Toms	"	Rep Womble
Emily Harper	Vance	Rep. Wray

Sergeant-At-Arms (please print)

Martha Gadison

Charles Williams

ATTACHMENT H

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

S 1

SENATE BILL 687

Short Title: Volunteer Rescue/EMS Funding. (Public)

Sponsors: Senator Kerr.

Referred to: Appropriations/Base Budget.

March 21, 2005

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW GOVERNING THE VOLUNTEER RESCUE/EMS FUND.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-87-5 reads as rewritten:

"**§ 58-87-5. Volunteer Rescue/EMS Fund.**

(a) There is created in the Department of Insurance the Volunteer Rescue/EMS Fund to provide grants to volunteer rescue units providing rescue or rescue and emergency medical services to purchase equipment and make capital improvements. An eligible rescue or rescue/EMS unit may apply to the Department of Insurance for a grant under this section. The application form and criteria for grants shall be established by the Department. The North Carolina Association of Rescue and Emergency Medical Services, Inc., shall provide the Department with an advisory priority listing for rescue equipment eligible for funding and the ~~The~~ Department of Health and Human Services shall provide the Department with an advisory priority listing of EMS equipment eligible for funding. The State Treasurer shall invest the Fund's assets according to law, and the earnings shall remain in the Fund. On December 15 of each year, the Department shall make grants to eligible rescue or rescue/EMS units subject to all of the following limitations:

(1) A grant to an applicant who is required to match the grant with non-State funds may not exceed ~~fifteen thousand dollars ($15,000),~~ twenty-five thousand dollars ($25,000) and a grant to an applicant who is not required to match the grant with non-State funds may not exceed three thousand dollars ($3,000).

(2) An applicant whose liquid assets, when combined with the liquid assets of any corporate affiliate or subsidiary of the applicant, are more than one thousand dollars ($1,000) shall match the grant on a dollar-for-dollar basis with non-State funds.

(3) The grant may be used only for equipment ~~purchases, payment of highway use taxes on those purchases,~~purchases or capital expenditures.

(4) An applicant may receive no more than one grant per fiscal year.

In awarding grants under this section, the Department shall to the extent possible select applicants from all parts of the State based upon need. Up to two percent (2%) of the Fund may be used for additional staff and resources to administer the Fund in each fiscal year. In addition, notwithstanding G.S. 58-78-20, up to four percent (4%) of the Fund may be used for additional staff and resources for the North Carolina Fire and Rescue Commission.

(b) A rescue or rescue/EMS unit is eligible for a grant under this section if it meets all of the following conditions:

(1) Repealed by Session Laws 1989 (Regular Session, 1990), c. 1066, s. 33(a).

(2) It consists entirely of volunteer members, with the exception that the unit may have paid members to fill the equivalent of ~~three~~ 10 full-time paid positions.

(3) It has been recognized by the Department as an organization that provides rescue or rescue and emergency medical ~~services.~~ services, or emergency medical services only. A department that provides emergency medical services only will be eligible only after all those eligible rescue or rescue and emergency medical services that are approved have been funded each grant year, and then only to the level of emergency medical services that they are approved to provide by the authority having jurisdiction.

(4) It satisfies the eligibility criteria established by the Department under subsection (a) of this section.

(c) For the purpose of this section and Article 88 of this Chapter, "rescue" means the removal of individuals facing external, nonmedical, and nonpatient related peril to areas of relative safety. A "rescue unit" or "rescue squad" means a group of individuals who are not necessarily trained in emergency medical services, fire fighting, or law enforcement, but who expose themselves to an external, nonmedical, and nonpatient related peril to effect the removal of individuals facing the same type of peril to areas of relative safety. The unit or squad must comply with existing State statutes and with eligibility criteria established by the North Carolina Association of Rescue and Emergency Medical Services, Inc."

SECTION 2. This act becomes effective July 1, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 687
PROPOSED HOUSE COMMITTEE SUBSTITUTE S687-CSRC-75 [v.1]

7/6/2005 5:02:31 PM

Short Title: Volunteer Rescue/EMS Funding. (Public)

Sponsors:

Referred to:

March 21, 2005

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW GOVERNING THE VOLUNTEER RESCUE/EMS FUND.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-87-5 reads as rewritten:

"**§ 58-87-5. Volunteer Rescue/EMS Fund.**

(a) There is created in the Department of Insurance the Volunteer Rescue/EMS Fund to provide grants to volunteer rescue units providing rescue or rescue and emergency medical services to purchase equipment and make capital improvements. An eligible rescue or rescue/EMS unit may apply to the Department of Insurance for a grant under this section. The application form and criteria for grants shall be established by the Department. The North Carolina Association of Rescue and Emergency Medical Services, Inc., shall provide the Department with an advisory priority listing for rescue equipment eligible for funding and the ~~The~~ Department of Health and Human Services shall provide the Department with an advisory priority listing of EMS equipment eligible for funding. The State Treasurer shall invest the Fund's assets according to law, and the earnings shall remain in the Fund. On December 15 of each year, the Department shall make grants to eligible rescue or rescue/EMS units subject to all of the following limitations:

(1) A grant to an applicant who is required to match the grant with non-State funds may not exceed ~~fifteen thousand dollars ($15,000),~~ twenty-five thousand dollars ($25,000) and a grant to an applicant who is not required to match the grant with non-State funds may not exceed three thousand dollars ($3,000).

(2) An applicant whose liquid assets, when combined with the liquid assets of any corporate affiliate or subsidiary of the applicant, are more than one thousand dollars ($1,000) shall match the grant on a dollar-for-dollar basis with non-State funds.

(3) The grant may be used only for equipment ~~purchases, payment of highway use taxes on those purchases,~~purchases or capital expenditures.

(4) An applicant may receive no more than one grant per fiscal year.

In awarding grants under this section, the Department shall to the extent possible select applicants from all parts of the State based upon need. Up to two percent (2%) of the Fund may be used for additional staff and resources to administer the Fund in each fiscal year. In addition, notwithstanding G.S. 58-78-20, up to four percent (4%) of the Fund may be used for additional staff and resources for the North Carolina Fire and Rescue Commission.

(b) A ~~rescue~~ rescue, emergency medical services or rescue/EMS unit is eligible for a grant under this section if it meets all of the following conditions:

(1) Repealed by Session Laws 1989 (Regular Session, 1990), c. 1066, s. 33(a).

(2) It consists entirely of volunteer members, with the exception that the unit may have paid members to fill the equivalent of ~~three~~ 10 full-time paid positions.

(3) It has been recognized by the Department as an organization that provides ~~rescue~~ rescue, emergency medical services, or rescue and emergency medical services. A unit that provides emergency medical services only is eligible for grant funding only after all those eligible rescue or rescue and emergency medical services units that are approved have been funded each grant year. A unit that only provides emergency medical services may be funded up to the level of emergency medical services that the unit is approved to provide by the authority having jurisdiction.

(4) It satisfies the eligibility criteria established by the Department under subsection (a) of this section.

(c) For the purpose of this section and Article 88 of this Chapter, "rescue" means the removal of individuals facing external, nonmedical, and nonpatient related peril to areas of relative safety. A "rescue unit" or "rescue squad" means a group of individuals who are not necessarily trained in emergency medical services, fire fighting, or law enforcement, but who expose themselves to an external, nonmedical, and nonpatient related peril to effect the removal of individuals facing the same type of peril to areas of relative safety. The unit or squad must comply with existing State statutes and with eligibility criteria established by the North Carolina Association of Rescue and Emergency Medical Services, Inc."

SECTION 2. This act becomes effective ~~July~~ Oct. 1, 2005.

SENATE BILL 687:
Volunteer Rescue/EMS Funding

BILL ANALYSIS

Committee:	House Insurance	**Date:**	July 6, 2005
Introduced by:	Sen. Kerr	**Summary by:**	Kory Goldsmith
Version:	PCS to First Edition S687-CSRC-75		Committee Counsel

SUMMARY: ***Senate Bill 687 directs the North Carolina Association of Rescue and Emergency Medical Services, Inc. to provide the Department of Insurance with an advisory priority listing for rescue equipment eligible for grant funding, increases the maximum grant amount from $15,000 to $25,000 under the Volunteer Rescue/EMS Fund, deletes language that allows grant funds to be used for the payment of highway use taxes, increases from 3 to 10 the maximum number of paid positions a rescue unit may have to remain eligible for a grant, and allows a unit that provides only emergency medical services to be eligible for grants, provided the eligible rescue and rescue/EMS units have already been funded.***

The PCS makes technical changes.

The act becomes effective July 1, 2005.

CURRENT LAW: G.S. 58-87-5 creates the Volunteer Rescue/EMS Fund to provide grants to volunteer rescue units and volunteer rescue and emergency medical services units. The grants are administered by the Department of Insurance and distributed on December 15th of each year. Grants to applicants that are required to obtain matching non-State funds may not exceed $15,000. The funds may be used to purchase equipment, pay highway use taxes, or make capital expenditures. A unit is eligible for funding if it is a volunteer organization with paid members who fill no more than the equivalent of 3 full time positions, the unit is recognized by the Department as an organization that provides rescue or rescue and emergency medical services, it satisfies the funding criteria already specified.

The Volunteer Rescue/EMS Fund is funded by the proceeds for fees collected for inspection sticker for safety and safety and emissions inspections.[1] Eighteen cents is remitted to the Fund for each Safety or Safety and Emissions sticker issued.

S0687e1-SMRC-CSRC-75

[1] G.S. 20-183.7.

ATTACHMENT III

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 687 DATE 7/26/05

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE X

(Rep.) Ross
(Sen.)

1 moves to amend the bill on page 2, line 38

2 ( ) WHICH CHANGES THE TITLE

3 by deleting the word "July"

4 and substituting the word

5 "October".

6

7

8

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19

SIGNED _____

ADOPTED X FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

MINUTES
HOUSE COMMITTEE ON INSURANCE
August 2, 2005

The House Committee on Insurance met at 11:00 AM on Tuesday, August 2, 2005 in Room 1228. The following Representatives attended, Chairman Hugh Holliman, Vice Chairs: Bill Faison, Edward Jones, and Mitchell Setzer. Members: Lucy Allen, D. Almond, J. Barnhart, W. Current, R. Grady, L. Johnson, D. Ross, D. Saunders, F. Steen, R. Sutton, and T. Wright.

Chairman Holliman called the meeting to order and welcomed visitors and recognized Sgt-At Arms. Attachment I.

Senator Clodfelter, sponsor for SB 319 - Workers' Comp. Self-Insurance Security, was asked to explain the bill. He explained that this legislation was modeled after the system that California has adopted. Sen. Clodfelter spoke on how this bill provides greater insurance for claims at a lower cost and provides security for self-insurers. See Attachment II.

Rep. Ross was recognized with a motion to accept the PCS . Motion carried.

Frank Folger, Legal Counselor with DOI, spoke to the complications of this issue and explained the concerns the department has with the bill's language. DOI noted that any consultant hired by the Department to review a plan submitted under the bill by the Association would take at least 6 months. Mr. Folger explained why DOI could not support this legislation. Attachment III.

Ray Martinez with DOI spoke to a question from Rep. Saunders about the initial licensing by the Commissioner of companies for self-insurance of workers compensation coverage. Mr. Martinez responded that companies that are initially qualified to be a self-insured might at some future time have financial difficulties.

Rep. Ross inquired about other states that have adopted the system as outlined in the bill. Mr. Martinez indicated that, to his knowledge, only California had adopted this type of system.

Mr. Robert Kaylor, representing Duke Energy and Roger Tankersley with Progress Energy spoke in support of the bill.

After much committee discussion, Sen. Clodfelter agreed several concerns of DOI should be addressed, but added the concept is good for all. Due to time constraints, Rep. Holliman announced the bill would be on the agenda for Tuesday, August 9th and a vote would be taken at that time.

Chairman Holliman adjourned the meeting at 11:56 AM.

Representative. L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: TUESDAY, AUGUST 2, 2005

TIME: 11:00 AM

LOCATION: 1228 LB

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

SB 319 - Workers' Comp. Self-Insurance Security. - Senator Clodfelter

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 1:00 PM on July 28, 2005.

____Principal Clerk
____Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

HOUSE INSURANCE COMMITTEE

August 2, 2005
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

SB 319 - Workers' Comp. Self-Insurance Security. - Senator Clodfelter

ATTACHMENT 1

House Pages

Name Of Committee: INS Date: 8-2-05

1. Name: Trey Newman
   County: Guilford
   Sponsor: Adams
2. Name: Jessica Newman
   County: Guilford
   Sponsor: Adams
3. Name: Jay Brown
   County: Forsyth
   Sponsor: Folwell
4. Name: Erin Brawley
   County: Forsyth
   Sponsor: Folwell
5. Name:
   County:
   Sponsor:

Sgt-At-Arms

1. Name: MARTHA GADSON
2. Name: CHARLES WILLIAMS
3. Name: LESLI OAKLEY
4. Name: MARK CONE
5. Name:

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — August 2, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kathleen Edwards	UNC-CH Institute of Gov't
David Stoller	State Farm.
John Cyrus	NCSG
Colleen Kachurek	Holt York
Michael Standing	Holt York
Savanna Farris	76th District CONSTITUENTS
Kathi Farris	
Caleb Kittrell	
Bill McAulay	PSNC Energy
Jeffrey Trendel	NCDOI

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — August 2, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joseph R Ei	DOI
Ray Manley	DOI
Elizabeth Dahm	NCCBI
Nan Mumpfort	IIBG
Lee Holly	KCLH
James Andrews	NC State AFL-CIO
David Anders	PFPNC
Mark Seaman	Capitol Group
Kelly Danko	Capitol Group
ANN UHR	DOHS
Jim Stevens	IFNC

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — August 2, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Scarlette Gardner	NCIC
Cathy Stuart	Stuart Law Firm
Roger Tankersley	Progress Energy
John Goodman	Alley Associates
David Fox	Alley Associates
Brian Martin	NC Home Builders Assoc.
Courtney Crowder	NCDOI
Kathy Hawkins	Progress Energy
Dave Simpson	Carolinas AGC
R. Paul Wilms	NCHBA
STEVE GENNETT	NC SIGA

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — August 2, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Susan Valaani	Nationwide
John McMillan	MFAS
Cam Cave	BPMH L
Jim Long	NCDOT
Andy Ellen	NCRMA
Allyson Larmore	Carolinas Healthcare
Martha Ann McConnell	Carolinas HealthCare System
Richard O'Brien	PFPNC
Mike Chinn	NSHAL.CO

ATTACHMENT II

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 319
Judiciary I Committee Substitute Adopted 5/23/05
Third Edition Engrossed 5/25/05
PROPOSED HOUSE COMMITTEE SUBSTITUTE S319-CSRU-77 [v.9]

7/28/2005 3:14:48 PM

Short Title: Workers' Comp. Self-Insurance Security. (Public)

Sponsors:

Referred to:

March 3, 2005

A BILL TO BE ENTITLED

AN ACT ESTABLISHING THE NORTH CAROLINA SELF-INSURANCE SECURITY SYSTEM AND CLARIFYING THE PROCEDURES BY WHICH SUBSIDIARY AND AFFILIATE COMPANIES MAY BE LICENSED AS SELF-INSURERS FOR WORKERS COMPENSATION AND TO MAKE OTHER CONFORMING AND TECHNICAL CHANGES TO THE WORKERS COMPENSATION LAWS RESPECTING INDIVIDUAL SELF-INSURERS IN ARTICLE 5 OF CHAPTER 97 OF THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

SECTION 1.1 The title of Article 4 of Chapter 97 reads as rewritten:

"Article 4.

North Carolina Self-Insurance ~~Guaranty~~ Security Association."

SECTION 1.2. G.S. 97-130 reads as rewritten:

"**§ 97-130. Definitions.**

As used in this Article:

(1) "Association" means the North Carolina Self-Insurance ~~Guaranty~~ Security Association established by G.S. 97-131.

(1a) "Association Aggregate Security System" means the security system established by the Association under G.S. 97-133 whereby individual self-insurers collectively secure their aggregate self-insured workers' compensation liabilities through the North Carolina Self-Insurance Security Association.

(2) "Board" means the Board of Directors of the Association established by G.S. 97-132.

(3) "Commissioner" means the North Carolina Commissioner of Insurance.

(4) "Covered claim" means an unpaid claim against an insolvent individual self-insurer or group self-insurer that relates to an injury that occurs while the individual self-insurer or group self-insurer is a member of the Association and that is compensable under this Chapter.

(5) "Fund" means the North Carolina Self-Insurance ~~Guaranty~~ Security Fund established by G.S. 97-133.

(5a) "Group" or "Group self-insurer" means a group self-insurer licensed by the Commissioner under Part 1, Article 47 of Chapter 58 of the General Statutes.

(5b) "Individual self-insurer" means an individual employer licensed by the Commissioner under Article 5 of this Chapter.

(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 and G.S. 97-94.~~an individual self-insurer or group self-insurer that is required to be a member of the Association under this Article or Part 1, Article 47 of Chapter 58 of the General Statutes.

(7) "Plan" means the Plan of Operation authorized by G.S. 97-134.

~~(8) "Self-insurer" means either: (i) an individual employer who has demonstrated under G.S. 97-93 the financial ability to directly pay compensation in the amounts and manner and when due as provided in this Chapter or (ii) a group of two or more employers who have agreed to pool their liabilities under this Chapter pursuant to G.S. 97-93.~~

(9) "Servicing facility" means those persons to whom the Board delegates the authority to settle and compromise claims and to expend Fund assets to pay claims."

SECTION 2. G.S. 97-131 reads as rewritten:

"**§ 97-131. Creation.**

(a) There is created a nonprofit unincorporated legal entity to be known as the North Carolina Self-Insurance ~~Guaranty~~ Security Association. The Association is to provide mechanisms for the payment of covered claims ~~under self-insurance coverage,~~ against member self-insurers, to avoid excessive delay in ~~payment,~~ payment of covered claims, to avoid financial loss to claimants because of the insolvency of a member self-insurer, ~~and to assist, when called upon to do so by the Commissioner,~~ to assist the Commissioner in the detection of self-insurer ~~insolvencies.~~insolvencies, to fund the Association Aggregate Security System, and to capitalize the Fund to insure the availability of financial resources to pay covered claims and to fund the activities of the Association.

(b) All individual self-insurers and group self-insurers shall be and remain members of the Association as a condition of ~~authority~~ being licensed to self-insure in this ~~State under G.S. 97-93.~~ State. The Association shall perform its functions under a Plan of Operation established or amended, or both, by the Board and approved by the Commissioner, and shall exercise its powers through the Board.

(1) ~~A~~ An individual self-insurer or a group self-insurer shall be deemed to be a member of the Association for purposes of another ~~self-insurer's~~member's insolvency, as defined in G.S. 97-135, when:
a. The individual self-insurer or group self-insurer is a member of the Association when an insolvency occurs, or
b. The individual self-insurer or group self-insurer has been a member of the Association at some point in time during the 12-month period immediately preceding the insolvency in question.

(2) ~~A~~ An individual self-insurer or a group self-insurer shall be deemed to be a member of the Association for purposes of its own insolvency if it is a member when the compensable injury occurs.

(3) In determining the membership of the Association ~~pursuant to~~ for the purposes of subdivisions (1) and (2) of this subsection for any date after the effective date of this Article, no ~~employer~~ individual self-insurer or group ~~of employers claiming self-insurer status~~self-insurer may be deemed to be a member of the Association on any date after the effective date of this Article, unless that employer ~~or~~ is on that date licensed as an individual self-insurer by the Commissioner under Article 5 of this Chapter or a group of employers is at that time ~~authorized~~ licensed as a group self-insurer by the Commissioner ~~pursuant to G.S. 97-93 and G.S. 97-94.~~under Article 47 of Chapter 58 of the General Statutes."

SECTION 3. G.S. 97-132 reads as rewritten:

"**§ 97-132. Board of directors.**

The Board shall consist of not less than nine ~~persons~~ directors serving terms as established in the Plan. The ~~members of the Board~~ directors shall be selected by the ~~member self-insurers,~~ members of the Association, subject to the approval of the Commissioner, and shall serve for ~~terms which shall not exceed three years. If no members of the Board are selected within 60 days after the effective date of this Article, the Commissioner may appoint the initial members of the Board.~~ three-year terms and until a successor is elected and qualified. There is no limitation on the number of terms a director may serve. In approving selections to the Board, the Commissioner shall consider, among other things, whether ~~all member~~ individual self-insurers and group self-insurers are fairly represented. ~~Members of the Board~~ Directors may be reimbursed from the assets of the Association for expenses incurred by them as ~~members of the Board.~~directors."

SECTION 4. G.S. 97-133 reads as rewritten:

"**§ 97-133. Powers and duties of the Association.**

(a) The Association shall:

(1) Repealed by Session Laws 1999-219, s. 7.2, effective June 25, 1999.

(1a) Administer a fund, to be known as the North Carolina Self-Insurance Security Fund, which shall receive the assets of the North Carolina Self-Insurance Guaranty Fund previously established under

subdivision (2) of this section, the assessments required by subdivisions (2a) and (3a) of this subsection and any other sums received by the Association. In its discretion, the Board may determine that the assets of the Fund should be segregated or that a separate accounting shall be made in order to identify that portion of the Fund which represents assessments paid by individual self-insurers and that portion of the Fund which represents assessments paid by group self-insurers. If the Board segregates the Fund in this manner, the Association shall thereafter pay covered claims against individual member self-insurers from that portion of the Fund that represents assessments against individual self-insurers and shall thereafter pay covered claims against group member self-insurers from that portion of the Fund that represents assessments against group self-insurers. The costs of administering the Association shall be borne by the Fund. The Association is authorized to secure insurance, primary excess insurance, reinsurance, bonds, other insurance, financial guarantees and related financial instruments to effectuate the purposes of the Association. The Board will invest the Fund assets, and the earnings from investment of Fund assets shall be placed in or credited to the Fund.

~~(2) Assess each member of the Association as follows:~~

~~a. Each individual member self-insurer shall be annually assessed an amount equal to two percent (2%) of the annual gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that member self-insurer for workers' compensation insurance during the prior calendar year; and payment to the Association shall be made no later than May 15 following the close of that calendar year. Where any such assessment is paid based in whole or in part upon estimates of annual gross premiums for the prior calendar year, there shall be made in the next year's assessment an adjustment of the assessment of such prior year based on actual audited annual gross premiums. Each group member self-insurer shall be annually assessed an amount equal to two percent (2%) of the annual gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), of the group member self-insurer during the prior calendar year; and payment to the Association shall be made no later than May 15 following the close of that calendar year. Regardless of the size of the Fund, during its first 12 months of membership, no member self-insurer may discount or reduce this two percent (2%) assessment. For the purpose of making the assessments authorized by this subsection and subsections (c) and (d) of this section, the Secretary of Revenue shall provide to the Association the self-insurer premium and payroll~~

~~information as determined under G.S. 105-228.5(b), (b1) and (c), and the Commissioner shall provide to the Association the group self-insurer premium information reported to the Commissioner under G.S. 58-47-75 and G.S. 58-2-165.~~

~~b. Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.~~

~~c. If a self-insurer is a member of the Association for less than a full calendar year, the annual gross premiums shall be adjusted by that portion of the year the self-insurer is not a member of the Association.~~

~~d. If application of the contribution rates referenced in sub-subdivision a. of this subdivision would produce an amount in excess of the five million dollar ($5,000,000) limits of the fund, an equitable proration may be made; provided that every self-insurer that becomes a member of the Association shall pay an initial assessment, in an amount established by the Board, regardless of the size of the fund at the time the member joins the Association.~~

(2a) Establish, operate, and maintain the Association Aggregate Security System as defined in G.S. 97-130 and G.S. 97-165 as follows:

a. The Association shall annually prepare and submit to the Commissioner a written plan to provide an Association Aggregate Security System through a combination of cash on deposit in the Fund, securities, surety bonds, irrevocable letters of credit, insurance, or other financial instruments or guarantees owned or entered into by the Association and acceptable to the Commissioner. The noncash elements of the composite security may be one-year or multiple-year instruments.

b. Within 90 days following the submission of the initial plan under sub-subdivision a. of this subdivision, the Commissioner shall either approve or disapprove the initial plan and shall notify the Association in writing. If the Commissioner does not approve or disapprove the initial plan within 90 days following submission, then the initial plan shall be deemed to be approved by the Commissioner. All subsequent plans shall be either approved or disapproved within 60 days following submission.

c. The Commissioner shall also determine the total undiscounted claims liability of each individual self-insurer that will participate in the Association Aggregate Security System as well as the aggregate total undiscounted outstanding claims liabilities of all the individual self-insurers that are to participate in the Association Aggregate Security System and shall notify the Association of this determination.

d. Upon approval by the Commissioner of the Association's plan for the Association Aggregate Security System, the Association shall assess the individual self-insurers that participate in the Association Aggregate Security System pursuant to subdivision (3a) of this subsection.

e. If the Commissioner disapproves the plan for any year, every self-insurer shall deposit with the Commissioner, or continue to deposit, the amount required by G.S. 97-185(b3) in the manner prescribed by G.S. 97-185(c).

f. Group self-insurers shall not participate in the Association Aggregate Security System.

~~(3) Administer a fund, to be known as the North Carolina Self-Insurance Guaranty Fund, which shall receive the assessments required in subdivision (2) of this subsection. Once the Fund reaches five million dollars ($5,000,000), no further assessments shall be made except initial assessments of new member self-insurers that are required to be made in subdivision (2)d. of this subsection. Assessments may be subsequently made only to maintain the Fund at a level of five million dollars ($5,000,000). In its discretion, the Board may determine that the assets of the Fund should be segregated, or, that a separate accounting shall be made, in order to identify that portion of the Fund which represents assessments paid by individual self-insurers and that portion of the Fund which represents assessments paid by group self-insurers. If the Board determines to segregate the Fund in this manner, the Association shall thereafter pay covered claims against individual member self-insurers from that portion of the Fund which represents assessments against individual self-insurers and shall thereafter pay covered claims against group member self-insurers from that portion of the Fund which represents assessments against group self-insurers. The cost of administration incurred by the Association shall be borne by the Fund and the Association is authorized to secure reinsurance and bonds and to otherwise invest the assets of the Fund to effectuate the purpose of the Association, subject to the approval of the Commissioner. All earnings from investment of Fund assets shall be placed in or credited to the Fund.~~

~~The Association may purchase primary excess insurance from an insurer licensed by the Commissioner for the appropriate lines of authority to defray its exposure to loss occasioned by the default of one of its members. The terms of any excess insurance so purchased shall be limited to providing coverage of liabilities which exceed the Fund's assets after the payment by member self-insurers of the maximum post-insolvency assessment provided in subdivision (c)(1) of this section herein and the Association shall fund any such purchase by levying a special assessment on its members for this purpose or by~~

~~application of any unencumbered earnings of the Fund or any other available funds. The Association may obtain from each member any information the Association may reasonably require in order to facilitate the securing of this primary excess insurance. The Association shall establish reasonable safeguards designed to insure that information so received is used only for this purpose and is not otherwise disclosed;~~

(3a) Assess members of the Association as follows:

a. Association Aggregate Security System assessments. – The Association shall assess each individual self-insurer participating in the Association Aggregate Security System a security system assessment. The amount of the security system assessment charged to each individual self-insurer participating in the Association Aggregate Security System shall be based on the Association's reasonable consideration of all of the following factors:

1. The total amount of assessments necessary to provide aggregate security for all participating individual self-insurers.
2. The individual self-insurer's total workers' compensation liabilities under the Act.
3. The financial strength and creditworthiness of the participating individual self-insurer.
4. Any other relevant factors.

b. Special assessment. – In the event that there are covered claims against an insolvent member or members and the assets of the Fund are not sufficient to pay the obligations of the Association, then the Association may collect a special assessment from the members in an amount sufficient to pay the aggregate value of such covered claims. Each member's special assessment shall be determined by the Board and shall be based on the proportion of the member's total obligations under the Act to the aggregate total of all members' obligations under the Act.

c. Initial assessments. –An individual self-insurer that becomes a member and does not initially participate in the Association Aggregate Security System shall pay an initial assessment to the Association in an amount determined by the Board. A group self-insurer, upon receiving its initial license from the Commissioner, shall pay an initial assessment to the Association in an amount determined by the Board.

d. Each member shall be notified of assessments no later than 30 days before the assessment is due.

e. Delinquent assessments, except as otherwise provided, shall bear interest at a rate to be established by the Board.

(4) Be obligated to ~~the extent of covered claims occurring prior to the determination of the member self-insurer's insolvency, or occurring after such determination but prior to the obtaining by the self-insurer of workers' compensation insurance as otherwise required under this Chapter.~~pay covered claims.

(5) After paying any ~~claim resulting from a self-insurer's insolvency,~~ covered claim, be subrogated to the rights of the injured employee and dependents and be entitled to enforce liability against the self-insurer or any third party by any appropriate action brought in its own name or in the name of the injured employee and ~~dependents;~~dependents.

(6) ~~Assess the Fund in an amount necessary to pay only:~~Expend Fund assets in amounts necessary to pay all of the following:

a. The obligations ~~for~~ of the Association under this Article subsequent to an ~~insolvency;~~insolvency.

b. The expenses of handling covered claims subsequent to an ~~insolvency;~~insolvency.

c. The cost of examinations under ~~G.S. 97-137; and~~G.S. 97-137.

d. The costs of implementing and operating the Association Aggregate Security System.

e. ~~Other~~ All other expenses authorized by this ~~Article;~~Article.

(7) Investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation; and deny all other claims. The Association may review settlements to which the insolvent ~~self-insurer~~member was a party to determine the extent to which such settlements may be properly ~~contested;~~contested.

(8) Notify such persons as the Commissioner directs under ~~G.S. 97-136;~~G.S. 97-136.

(9) Handle claims through its ~~employees~~ directors, its employees, or through one or more ~~self-insurers~~members or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Commissioner, but designation of a member ~~self-insurer~~ as a servicing facility may be declined by such ~~self-insurer;~~member.

(10) Reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the ~~Association;~~Association.

(11) Pay ~~the~~ any other expenses of the Association authorized by this ~~section; and~~section.

~~(12) Establish in the Plan a mechanism to calculate the assessments required by subdivisions (2) and (3) of this subsection by a simple and equitable means to convert from policy or fund years that are different from a calendar year.~~

(b) The Association may:

(1) Employ or retain such ~~persons~~ persons, including but not limited to adjustors, brokers, accountants, attorneys, financial advisors, investment bankers, placement agents, and consultants, as the Board may determine are necessary to handle ~~claims~~ claims, ~~and~~ perform other duties ~~of~~ of, provide services to and consult with the ~~Association;~~Association.

(2) Borrow funds necessary to effect the purposes of this Article in accord with the ~~Plan;~~Plan, including entering into standby lines of credit.

(3) Sue or be ~~sued;~~sued.

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this ~~section; and~~section.

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this section.

(6) Reimburse the Department of Insurance up to twenty thousand dollars ($20,000) for consultants retained by the Department to review the initial plan submitted pursuant to G.S. 97-133(a)(2a).

~~(c) In the event that the assets of the Fund are not sufficient to pay the obligations of the Association, then the Association shall impose an additional assessment upon its members, which shall be known as a post insolvency assessment which shall be imposed as follows:~~

~~(1) Each individual member self-insurer shall be assessed in an amount not to exceed two percent (2%) each year of the annual gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that member self-insurer during the prior calendar year. The assessments of each individual member self-insurer shall be in the proportion that the annual gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), of the individual member self-insurer for the premium calendar year bears to the annual gross premiums of all individual member self-insurers for the preceding calendar year. For group member self-insurers, the assessment shall not exceed two percent (2%) each year the annual premium collected by that group member self-insurer during the prior calendar year. The assessments of each group member self-insurer shall be in the proportion that the annual gross premiums of the group member self-insurer for the premium calendar year bears to the annual gross premiums of all group member self-insurers for the preceding calendar year.~~

~~(2) Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.~~

~~(3) The Association may exempt or defer, in whole or in part, the assessment of any member self-insurer, if the assessment would cause that member's financial statement to reflect liabilities in excess of assets.~~

~~(4) Delinquent assessments, except as provided in subdivision (3) of this subsection, shall bear interest at the rate to be established by the Board, but not to exceed the discount rate of the Federal Reserve Bank, Richmond, Virginia, on the due date of the assessment, plus four percent (4%) annually, computed from the due date of the assessment.~~

~~(5) The Association shall establish in the Plan a mechanism to calculate the assessments required by subdivision (1) of this subsection by a simple and equitable means to convert from policy or fund years that are different from a calendar year.~~

~~(d) No individual member self-insurer may be assessed in any calendar year an amount greater than two and one-half percent (2.5%) of the annual gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that individual member self-insurer during the prior calendar year. No group member self-insurer may be assessed in any calendar year an amount greater than two and one-half percent (2.5%) of the annual gross premiums of that group member self-insurer during the prior calendar year. If the maximum assessment does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. There shall be established in the Plan a mechanism to calculate the assessments required by this section by a simple and equitable means to convert from policy or fund years that are different from a calendar year.~~"

SECTION 5. G.S. 97-134 reads as rewritten:

"**§ 97-134. Plan of Operation.**

The Plan is as follows:

(1) The Association shall submit to the Commissioner a Plan and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. The Plan and any amendments become effective upon approval in writing by the Commissioner. If the Association at any time fails to submit a suitable Plan or suitable amendment to the Plan the Commissioner shall, after notice and hearing, adopt such reasonable rules as are necessary or advisable to effectuate this Article. ~~Such~~ The rules shall continue in force until modified by the Commissioner or superseded by a Plan submitted by the Association and approved by the Commissioner.

(2) All member self-insurers shall comply with the Plan.

(3) The Plan shall:

a. Establish the procedures whereby all the powers and duties of the Association under G.S. 97-133 will be ~~performed;~~performed.

b. Establish procedures for ~~handling assets of the Association;~~investing and managing Fund assets.

c. Adopt a reasonable mechanism and procedure to achieve equity in assessing ~~the funds required in G.S. 97-133. Consideration shall be given to adjustments for audited payroll, differential~~

~~effects caused by rate changes, and other relevant factors;~~members under G.S. 97-133.

d. Establish the amount and method of reimbursing members of the Board under ~~G.S. 97-132;~~G.S. 97-132.

e. Establish procedures by which claims may be filed with the Association and establish acceptable forms of proof of covered claims. ~~A list of such claims shall be periodically submitted to the Association;~~

f. Establish regular places and times for meetings of the ~~Board;~~Board.

g. Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the ~~Board;~~Board.

h. Provide that any member self-insurer aggrieved by any final action or decision of the Association may appeal to the Commissioner within 30 days after the action or ~~decision;~~decision.

i. Establish the procedures whereby selections for the Board shall be submitted to the ~~Commissioner; and~~Commissioner.

j. Contain additional provisions necessary or proper for the execution of the powers and duties of the Association."

SECTION 6. G.S. 97-135 reads as rewritten:

"**§ 97-135. Insolvency.**

A member self-insurer shall be insolvent for the purposes of this Article under any of the following circumstances:

(1) Determination of insolvency by a court of competent ~~jurisdiction; or~~jurisdiction.

(2) Institution of bankruptcy proceedings by or regarding the member ~~self-insurer; or~~self-insurer.

(3) The Board determines that the member self-insurer's total liabilities exceed its total assets or the member self-insurer is unable or ceases to pay its debts as they fall due or in the ordinary course of business.

(4) A member self-insurer is deemed to be insolvent, bankrupt, or in default as defined by the terms of any security instrument created pursuant to the Association Aggregate Security System."

SECTION 6.1. G.S. 97-136 reads as rewritten:

"**§ 97-136. Powers and duties of the Commissioner.**

(a) The Commissioner ~~shall notify~~ shall:

(1) Notify the Association of the existence of an insolvent member self-insurer not later than 30 days after he receives notice of an insolvency pursuant to the standards set forth in G.S. 97-135.

(2) Approve or disapprove the plan for an Association Aggregate Security System as required under G.S. 97-133(a)(2a)b. and notify the Association of the information required under G.S. 97-133(a)(2a)c.

(b) The Commissioner may:

(1) Require that the Association notify the insureds of the insolvent member self-insurer and any other interested parties of the insolvency and of their rights under this Article. ~~Such~~ The notifications shall be by mail at their last known addresses, where available; but if required information for notification is not available, notice by publication in a newspaper of general circulation in this State shall be sufficient; and

(2) Revoke the designation of any servicing facility if ~~he~~ the Commissioner finds claims are being handled unsatisfactorily."

SECTION 7. G.S. 97-140 reads as rewritten:

"**§ 97-140. Nonduplication of recovery.**

Any person having a covered claim that may be recovered under more than one insurance or self-insurance guaranty or security association or its equivalent shall seek recovery first from the association of the place or residence of the claimant. Any recovery under this Article shall be reduced by the amount of recovery from any other insurance guaranty or security association or its equivalent."

SECTION 8. 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~~ any deposit made by the insolvent member 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 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. For insolvent individual member self-insurers that participate in the Association Aggregate Security System, the Association is authorized to pursue recovery under every instrument, contract, and form of security comprising the composite security. 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 9. G.S. 97-165 reads as rewritten:

"**§ 97-165. Definitions.**

As used in this Article:

(1) 'Act' means the Workers' Compensation Act established in Article 1 of this Chapter.

(1a) 'Affiliate of' or 'person affiliated with' a specific person means a person that indirectly through one or more intermediaries or directly controls, is controlled by, or is under common control with the person specified.

(1b) "Association Aggregate Security System" means the security system established pursuant to G.S. 97-133 whereby individual self-insurers collectively secure their aggregate self-insured workers' compensation liabilities under the Act through the North Carolina Self-Insurance Security Association.

(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,~~ self-insurer or the guarantor, in conformity with ~~generally accepted accounting principles.~~accounting principles generally accepted in the United States.

(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~~ self-insurer or the guarantor to replace the CPA with another whose relationship with the ~~individual~~ self-insurer or the guarantor is independent within the meaning of this definition.

(4) 'Commissioner' means the Commissioner of Insurance.

(4a) 'Control', 'controlling', 'controlled by', and 'under common control with' mean the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person through ownership of or through proxies for voting of greater than fifty percent (50%) of the voting securities, or in the case of a not-for-profit entity, the power to direct or cause the direction of the management and policies of the entity.

(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.~~principles generally accepted in the United States.

(6a) 'Guarantor' means a person within the same holding company system who controls the applicant, whose financial statement is used by the applicant to become a self-insurer under the Act, and who has guaranteed the payment of the self-insurer's liability under the Act.

(7) 'Hazardous financial condition' means that, based on its present or reasonably anticipated financial condition, a self-insurer or guarantor is insolvent or, although not yet financially impaired or insolvent, is unlikely to be able to meet its obligations with respect to known claims and reasonably anticipated claims or to pay other obligations in the normal course of business.

(7a) 'Holding company system' means an entity comprising two or more affiliated persons.

(8) 'Management' means those persons who are authorized to direct or control the operations of a self-insurer.

(8a) '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.

(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 an ~~employer who retains liability under the Act and is licensed under this Article.~~ individual self-insurer as defined by G.S. 97-130(5b).

(11) 'Subsidiary of' a specific person means an affiliate controlled by such person indirectly through one or more intermediaries or an affiliate directly controlled by such person."

SECTION 10. G.S. 97-170 reads as rewritten:

"**§ 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. This subsection does not apply to an employer authorized to self-insure its workers' compensation liabilities under the Act prior to December 1, 1997, whose authority to self-insure its workers' compensation liabilities under the Act has not terminated after that date.

(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. A copy of the application must also be filed with the North Carolina Self-Insurance Security Association at least 90 days before the proposed licensing date.

(c) Only an applicant 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 all of the following relative to the ~~applicant's:~~applicant:

(1) Organizational structure and ~~management;~~management.

(2) Financial ~~strength;~~strength.

(3) Source and reliability of financial ~~information;~~information.

(4) Risks to be ~~retained;~~retained.

(5) Workers' compensation loss ~~history;~~history.

(6) Number of ~~employees;~~employees.

(7) Claims ~~administration;~~administration.

(8) Excess ~~insurance; and~~insurance.

(9) Access to excess insurance.

(d) The license application shall ~~comprise~~ be comprised of the following information:

(1) ~~Company name,~~ Applicant name; organizational ~~structure,~~ structure of the applicant, including any controlling entity, subsidiaries, or affiliates; location of principal ~~office,~~ office; contact ~~person,~~ person; organization ~~date,~~ date; type of operations within this ~~State,~~ State; management ~~background,~~ 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~~ presentation shall facilitate application of ratio and trend analysis.

...

(6) Summary of workers' compensation benefits paid for the last three calendar ~~years, as well as~~ years and 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.

...

~~(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~~ approval for membership by the North Carolina Self-Insurance ~~Guaranty Association under Article 4 of this Chapter.~~Security Association.

(e) Every applicant shall execute and file with the Commissioner an agreement, as part of the application, in which the applicant agrees to participate in the Association Aggregate Security System, or if excluded from the Association Aggregate Security System, to deposit with the Commissioner pursuant to G.S. 97-185, cash, acceptable securities, an irrevocable letter of credit in a form acceptable to the Commissioner issued by a bank acceptable to the Commissioner, or a surety bond issued by a corporate ~~surety~~ surety, or a combination thereof, that will guarantee the applicant's compliance with this Article and the ~~Act pursuant to G.S. 97-185.~~Act."

SECTION 11. Article 5 of Chapter 97 of the General Status is amended by adding the following new section:

"**§ 97-177. License covering applicant and any subsidiary or applicant relying on a guarantor; procedure; requirements.**

(a) The Commissioner may, in the Commissioner's discretion, upon request by an applicant, issue a license to an applicant or to an applicant and one or more of its subsidiaries if all of the following requirements are satisfied:

(1) The applicant or a guarantor of the applicant executes a guaranty agreement, in a form prescribed by the Commissioner, for the payment of all workers' compensation liabilities covered under the Act. For any applicant or guarantor that is a corporation, there shall be submitted,

along with the guaranty agreement, a board of directors' resolution from the respective corporation authorizing the guaranty of the liabilities of the subsidiary company or companies and granting signature authority to each person or officer executing the agreement.

(2) The applicant or guarantor files a statement with the Commissioner that lists the percentage of ownership of voting securities or proxies representing voting securities owned or held by the applicant or guarantor for each subsidiary, or in the case of a not-for-profit entity, documentation acceptable to the Commissioner evidencing control.

(3) The applicant and its guarantor or the applicant and its subsidiaries, whichever applies, satisfy the requirements of G.S. 97-170(c).

(4) All other applicable requirements for licensure under the Act are satisfied.

(b) A license issued by the Commissioner pursuant to this section shall include the name of the applicant, the name of each licensed subsidiary, and the date of issuance for each licensed subsidiary.

(c) If a self-insurer requests to add a subsidiary to its license, the Commissioner shall review the request in accordance with this section. Upon approval, the Commissioner shall issue to the self-insurer a new license that includes the newly licensed subsidiary and the date of license issuance for the newly licensed subsidiary, and the self-insurer shall return the original license to the Commissioner.

(d) A self-insurer shall neither include nor delete a subsidiary from its license without the Commissioner's prior written approval.

(e) If a controlling relationship or guaranty agreement terminates, the self-insurer shall retain all liabilities under the Act that were incurred by the self-insurer during the period of self-insurance and shall account for all such liabilities until discharged, as evidenced by reports filed with the Commissioner. Termination of a guaranty agreement does not affect the guarantor's liability for payment of liabilities arising prior to termination of the agreement."

SECTION 12. G.S. 97-180 reads as rewritten:

"**§ 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~~ presentation shall facilitate the application of ratio and trend analysis. If the self-insurer was issued a license pursuant to G.S. 97-177, the financial statement required under this subsection shall be that of the guarantor.

(b) Every self-insurer shall submit within 120 days after the end of its fiscal year a ~~certification~~ report from a qualified actuary setting forth ~~the actuary's~~ an opinion ~~relating to~~ certifying the loss and loss adjustment expense reserves for workers' compensation obligations ~~for~~ in North Carolina. The ~~certification~~ report 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~~ and the total outstanding workers' compensation liabilities for each loss year, recorded at the close of its fiscal year for the net retained liability.

(d) Upon the request of the Commissioner, every self-insurer shall submit a report of its 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~~ name or address of the ~~businesses it self-insures or intends to self-insure, as well as~~ self-insurer or guarantor; significant changes in the financial ~~condition,~~ condition of the self-insurer, guarantor, or any affiliate, including bankruptcy ~~filings,~~ filings; and changes in its ~~business~~ organizational structure, including its ~~divisions, subsidiaries, affiliates, and internal organization.~~ subsidiaries and affiliates. Any change shall be reported in writing to the Commissioner within 10 days after the effective date of the change. Upon request by the Commissioner, a self-insurer shall provide the Commissioner copies of documents or information deemed necessary to determine whether any change has affected the privilege of the employer to self-insure."

SECTION 13. G.S. 97-185 reads as rewritten:

"**§ 97-185. Deposits; surety bonds; letters of credit.**

~~(a) (Effective January 1, 2005, until January 1, 2006) Every self-insurer shall deposit with the Commissioner an amount not less than seventy-five percent (75%) 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 greater 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.~~

~~(a) (Effective January 1, 2006) Every self-insurer shall deposit with the Commissioner an amount not less than one hundred percent (100%) 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 greater 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.~~

(a1) All individual self-insurers as defined in G.S. 97-130(5b) shall participate in the Association Aggregate Security System established under G.S. 97-131 unless excluded by the Board of Directors of the North Carolina Self-Insurance Security

Association. The Board of Directors of the North Carolina Self-Insurance Security Association shall exclude all of the following from the Association Aggregate Security System:

(1) Individual self-insurers whose licenses have previously been revoked by the Commissioner.

(2) Individual self-insurers with a debt rating as established by Standard & Poor's Rating Service or by Moody's Investor Service, below the minimum Standard & Poor's and Moody's ratings established in the written plan for the Association Aggregate Security System submitted by the Association and approved by the Commissioner under G.S. 97-133(a)(2a).

(3) Individual self-insurers that have defaulted on the payment of its self-insured workers' compensation liabilities from participation in the Association Aggregate Security System.

The Board of Directors of the North Carolina Self-Insurance Security Association shall notify the Commissioner of the individual self-insurers that are excluded from participating in the Association Aggregate Security System.

(b) Repealed by Session Laws 2003-115, s. 3, effective January 1, 2004.

~~(b1) Notwithstanding subsection (a) of this section, member self insurers with a debt rating of BBB or better from Standard and Poor's Rating Service, a division of McGraw Hill, Inc., or an equivalent rating from another national rating agency shall deposit with the Commissioner an amount not less than 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). The Commissioner shall consider and may, in the Commissioner's discretion, increase or reduce the deposit to a greater or lesser percentage of the member self insurer's claims liability based on the financial strength of the self insurer and other financial information submitted by the self insurer.~~

(b2) An individual self-insurer that is excluded from participation in the Association Aggregate Security System, including individual self-insurers that are granted a license to self-insure after the North Carolina Self-Insurance Security Association annually implements the Association Aggregate Security System, shall deposit with the Commissioner an amount not less than one hundred percent (100%) of the individual self-insurer's total undiscounted outstanding claims liability per the most recent report from a qualified actuary as required by G.S. 97-180(b), but not less than five hundred thousand dollars ($500,000), or such greater amount as the Commissioner prescribes based on, but not limited to, the financial condition of the individual self-insurer and the risk retained by the individual self-insurer.

(b3) During any period of time that no Association Alternative Security System is in effect, individual self-insurers with a debt rating of BBB or better from Standard and Poor's Rating Service, a division of McGraw Hill, Inc., or an equivalent rating from another national rating agency shall deposit with the Commissioner an amount not less than twenty five percent (25%) of the individual self-insurer's total undiscounted outstanding claims liability per the most recent report from a qualified actuary as

required by G.S. 97 180(b), but not less than five hundred thousand dollars ($500,000). An individual self-insurer licensed pursuant to G.S. 97-177 may utilize the debt rating of its guarantor for the purpose of establishing the application of this subsection. The Commissioner shall consider and may, in the Commissioner's discretion, increase or reduce the deposit to a greater or lesser percentage of the individual self-insurer's claims liability based on the financial strength of the individual self -insurer and other financial information submitted by the individual self-insurer. All other individual self-insurers shall deposit with the Commissioner an amount not less than one hundred percent (100%) of the individual self-insurer's total undiscounted outstanding claims liability per the most recent report from a qualified actuary as required by G.S. 97-180(b), but not less than five hundred thousand dollars ($500,000), or such greater amount as the Commissioner prescribes based on, but not limited to, the financial condition of the individual self-insurer and the risk retained by the individual self-insurer.

(c) Deposits received, changes to existing deposits, or deposits exchanged after the effective date of this section, shall ~~comprise~~ be comprised of 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. A surety bond deposited pursuant to this subsection shall require that the surety reimburse the Commissioner, or his successors, assigns, or transferees, for any costs incurred in the collection of the proceeds of the surety bond, including reasonable attorneys' fees, and any costs incurred in administering the insolvent self- insurer's workers' compensation claims.

(4a) Irrevocable letters of credit in a form acceptable to the Commissioner issued by a bank acceptable to the Commissioner. An irrevocable letter of credit deposited pursuant to this subsection shall require that the bank reimburse the Commissioner, or his ~~successor,~~ successors, assigns, or transferees for any costs incurred in the collection of the proceeds of the letter of credit, including reasonable attorneys' fees.

(4b) The reimbursement of attorneys' fees and collections cost provided for in subdivisions (4) and (4a) of this subsection shall be no greater than fifteen percent (15%) of the penal amount of the bond and shall not come from the proceeds of the bond or the letter of credit but shall be in addition to the proceeds of the bond or the letter of credit.

(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 the market value is less than the 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 or guarantor'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 or guarantor 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. In the case of a letter of credit, the Commissioner may draw the full amount of a letter of credit if the letter of credit is not renewed within 90 days prior to its expiration or at any time that the bank issuing the letter of credit is no longer acceptable to the Commissioner. Interest accruing on any negotiable security deposited under this Article shall be collected and transmitted to the self-insurer if the self-insurer or guarantor 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~~ Pursuant to the provisions of this section and with the approval of the Commissioner, deposits 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.~~ acceptable forms of deposit in amount determined by the Commissioner. Any ~~surety bond may~~ deposit to 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.~~ another form of deposit shall not be released until the approved replacement deposit is received by the Commissioner.

(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.~~ Any self-insurer that ceases to self-insure, whether by voluntary termination or by revocation of license, shall continue to secure and be liable for its obligations under the Act and shall continue to report to the Commissioner pursuant to G.S. 97-180. Upon the request of the Commissioner, a self-insurer that ceases to self-insure shall submit filings, as prescribed in G.S. 97-180, to determine whether the deposit is sufficient to satisfy those workers' compensation obligations incurred during the period that the self-insurer was licensed as a self-insurer. The Commissioner may require an increase in the deposit amount, or may grant a reduction

in the deposit amount to ensure that the deposit is sufficient to cover all existing and future obligations incurred by the self-insurer while subject to the provisions of 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."

SECTION 14. G.S. 97-190 reads as rewritten:

§ 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 or guarantor's financial condition.

(b) An excess insurance policy required by this section shall be issued by either ~~a licensed~~ an insurance company licensed in this State or an ~~approved~~ eligible surplus lines ~~insurance company~~insurer as defined in G.S. 58-21-10 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."

SECTION 15. G.S. 97-195 reads as rewritten:

"**§ 97-195. ~~Revocation of license.~~ Revocation, suspension or restriction 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.~~

(a1) The Commissioner may, upon at least 45 days notice and opportunity for a hearing, revoke, suspend, or restrict the license of a self-insurer if any of the following apply:

(1) The self-insurer fails or refuses to comply with any law, order, or rule applicable to the self-insurer.

(2) There is a determination of insolvency by a court of competent jurisdiction.

(3) The self-insurer is in a hazardous financial condition.

(4) The self-insurer has experienced a material loss or deteriorating operating trends, or has reported a deficit financial position.

(5) Any affiliate or subsidiary is insolvent, threatened with insolvency, or delinquent in payment of its monetary or any other obligation.

(6) The self-insurer has failed to pay premium taxes pursuant to Article 8B of Chapter 105 of the General Statutes.

(7) 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.

(8) 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.

(9) 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.

(10) The self-insurer has experienced, or will experience in the foreseeable future, cash flow or liquidity problems.

(11) The self-insurer has failed to make proper and timely payment of claims, as required by this Article.

(12) Failure to pay any North Carolina Self-Insurance Security Association assessments made pursuant to G.S. 97-133.

(13) Failure to participate in the Association Aggregate Security System or, if excluded from participation in the Association Aggregate Security System, failure to provide and maintain the deposit required by G.S. 97-185.

~~(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) Repealed by Session Laws 2003-221, s. 15, effective June 19, 2003.~~

~~(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~~ revocation, suspension, or restriction under subsection ~~(a) or (b)~~ (a1) 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."

SECTION 16. Article 5 of Chapter 97 of the General Statutes is amended by adding the following new section:

"**§ 97-196. Civil penalties or restitution for violations; administrative procedure.**

(a) Whenever the Commissioner has reason to believe that a self-insurer has violated any of the provisions of this Article, and the violation subjects the license of the self-insurer to suspension or revocation, the Commissioner may, after notice and opportunity for a hearing, proceed under the appropriate subsections of this section.

(b) If the Commissioner finds a violation of this Article, the Commissioner may, in addition to or instead of suspending or revoking the license, order the payment or a monetary penalty as provided in subsection (c) of this section or petition the Superior Court of Wake County for an order directing payment of restitution as provided in subsection (d) of this section, or both. Each day during which a violation occurs constitutes a separate violation.

(c) If the Commissioner orders the payment of a monetary penalty pursuant to subsection (b) of this section, the penalty shall not be 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 clear proceeds of the penalty shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2. 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.

(d) Upon petition of the Commissioner, the court may order the self-insurer who committed a violation specified in subsection (b) of this section to make restitution in an amount that would make whole any person harmed by the violation. The petition may be made at any time, and the petition may be made in any appeal of the Commissioner's order.

(e) 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.

(f) Nothing in this section prevents the Commissioner from negotiating a mutually acceptable agreement with any self-insurer as to the status of the self-insurer's license or as to any civil penalty or restitution.

(g) Unless otherwise specifically provided for, all administrative proceedings under this Article are governed by Chapter 150B of the General Statutes. Appeals of the Commissioner's orders under this section shall be governed by G.S. 58-2-75."

SECTION 17. G.S. 58-2-161(a)(1)p. reads as rewritten:

"**§ 58-2-161. False statement to procure or deny benefit of insurance policy or certificate.**

(a) For the purposes of this section:

(1) "Insurer" has the same meaning as in G.S. 58-1-5(3) and also includes:

...

p. The North Carolina Self-Insurance ~~Guaranty~~ Security Association under Article 4 of Chapter 97 of the General Statutes.

..."

SECTION 18. G.S. 58-30-10(7) reads as rewritten:

"**§ 58-30-10. Definitions.**

As used in this Article, unless the context clearly indicates otherwise:

...

(7) "Domestic guaranty association" means the Postassessment Insurance Guaranty Association in Article 48 of this Chapter, as amended; the North Carolina Self-Insurance ~~Guaranty~~ Security Association in Article 4 of Chapter 97 of the General Statutes; the Life and Accident and Health Insurance Guaranty Association in Article 62 of this Chapter, as amended; or any other similar entity hereafter created by the General Assembly for the payment of claims of insolvent insurers.

..."

SECTION 19. G.S. 58-47-65(f)(14) reads as rewritten:

"(f) The license application shall comprise the following information:

...

(14) A letter stipulating the applicant's acceptance of membership in the North Carolina Self-Insurance ~~Guaranty~~ Security Association under Article 4 of Chapter 97 of the General Statutes.

..."

SECTION 20. G.S. 105-259(b)(16a) reads as rewritten:

"(b) Disclosure Prohibited. – An officer, an employee, or an agent of the State who has access to tax information in the course of service to or employment by the State may not disclose the information to any other person unless the disclosure is made for one of the following purposes:

...

(16a) To provide the North Carolina Self-Insurance ~~Guaranty~~ Security Association information on self-insurers' premiums as determined under G.S. 105-228.5(b), (b1), and (c) for the purpose of collecting the assessments authorized in G.S. 97-133(a).

..."

SECTION 21. This act becomes effective January 1, 2006.

SENATE BILL 319:
Workers' Comp. Self-Insurance Security

BILL ANALYSIS

Committee:	House Insurance	**Date:**	August 1, 2005
Introduced by:	Sen. Clodfelter	**Summary by:**	Tim Hovis
Version:	Proposed Committee Substitute		Committee Counsel

SUMMARY: The Proposed Committee Substitute for Senate Bill 319 would amend the Workers' Compensation self-insurance laws by repealing the North Carolina Self-Insurance Guaranty Fund and replacing it with the North Carolina Self-Insurance Security Fund.

CURRENT LAW: Current law allows an employer to be licensed as a self-insurer for workers' compensation purposes when the employer meets certain conditions, including having at least $500,000 of total fix assets and demonstrating that the employer is sufficiently financially sound to cover its workers' compensation claims. Employers who are licensed as self-insurers are not required to purchase workers' compensation insurance coverage. All self-insurers must also participate in the NC Self-Insurance Guaranty Fund. This Fund is to guarantee workers' compensation payments in the event the employer becomes insolvent and is unable to meet its workers' compensation obligations. The Fund is funded by an assessment of all self-insurers of 2% of the annual premiums the employer would have had to pay for workers' compensation insurance coverage. If the assets of the Fund are insufficient to cover all claims of insolvent employers, additional assessments may be made.

BILL ANALYSIS: Senate Bill 319 would amend the workers' compensation self-insurance laws by eliminating the statutory assessment limits and replacing it with a system where the amount of the annual assessments for a member is determined by the NC Self-Insurance Security Association. Members of the Association may be divided into group self-insurers and individual self-insurers as defined in the bill and would pay assessments to the Association.

In addition, individual self-insurers would participate in the "Association Aggregate Security System" which the bill defines as a system allowing individual self-insurers to aggregate their workers compensation liabilities and pay assessments to the NC Self-Insurance Security Association Fund based on the following:

- The total amount of assessments necessary to provide aggregate security for all participating members.
- The member's total workers' compensation liabilities under the workers' compensation law.
- The financial strength and creditworthiness of the member.
- Any other relevant factors.

The bill also gives the Association the authority to exclude from the Association Aggregate Security System those individual self-insurers whose debt ratings by Moody's and Standard & Poor's fall below the minimum rating established by the Association upon the approval of the Commissioner of Insurance. A self-insurer excluded from the Association Aggregate Security System would have to deposit 100% of the employer's total undiscounted outstanding claims liability, but not less than $500,000, to continue as a self-insured employer.

Other provisions include the following:

- Adds definitions of affiliate, control, guarantor, holding company system, and subsidiary

- Creates a new section, G.S. 97-177, specifying the conditions under which the Commissioner may issue a license to self-insure for a company and its affiliates or subsidiaries
- Clarifies that if a license to a self-insurer is issued under the newly proposed G.S. 97-177, the financial documents required under G.S. 97-180 must be those of the guarantor
- Rewrites the old provision for revocation, suspension or restriction of a self-insurer's license, including every former basis for such action by the Commissioner such that it more uniformly reflects the procedures applied in other license revocation procedures.

EFFECTIVE DATE: This act becomes effective January 1, 2006.

S0319e3-SMRG

This summary was contributed to by O. Walker Reagan, Staff Attorney, Research Division.

ATTACHMENT III

The N.C. Self-Insurance Guaranty Association (for Workers Compensation)

Primary Purpose:
"provide for the payment of covered claims under self-insurance coverage" (G.S. 97-131(a))

[Other purposes:

1. "avoid excessive delay in payment"
2. "avoid financial loss to claimants because of the insolvency of a self-insurer"
3. "assist, when called upon to do so by the Commissioner, in the detection of self-insurer insolvencies"]

Our regulatory charge: Ensure that covered claims under self-insurance are paid and done so in the most cost-effective manner.

4 Key Problems with Senate Bill 319

- Lack of Information on the Impact of the Collateral Replacement Program ("Association Aggregate Security System" (AASS) in N.C.
  - We cannot tell you **how** Association Aggregate Security System (AASS) will work out, **if** it will work out, or **whether it will harm or benefit** claimants and/or self-insurers and/or the self-insurance marketplace as a whole.
    - AASS will completely replace the time-tested $5 million funding mechanism currently in place
    - Despite requests, we have received no feasibility study containing technical analysis regarding the cost to individual self-insurers. Individual self-insured employers did not

receive information on the cost of the new program.

- *DOI Proposed Solution: Delay action at least until 2006 Session and require submission of quantifiable feasibility study to DOI by proponents of this legislation*

- Lack of Specifics in Statute or Rule Respecting Operation of AASS within the Association/Structural and Operational Problems
  - Ex:
    - 3 categories of entities "created" by AASS –
      - participating individual self-insurers
      - non-participating individual self-insurers
      - group self-insurers (by default or definition non-participating)

- Creates a new Security Fund with monies from all 3 but proponents have refused to accept a mandate of statutorily segregation of funds and have refused to provide for restricted and unrestricted funds – would provide for greater accountability – discretion lies with the Board
- The Board decides which individual self-insurers participate in the AASS and which are excluded – there are certain criteria set out which require exclusion but other than that the Board decides
- There are no limits on the special assessments and initial assessments that can be made against self-insurers and non-

participating self-insurers respectively – in the Board's discretion

- Bill requires a copy of a self-insurer's application for licensure to be filed also with the Association – huge problem of disclosure of trade secrets – would allow companies or anyone else access to that information – what legitimate purpose – who is the regulator?
- Internal statutory inconsistencies – for example:
  - 97-131(b)(1)b. is negated by (b)(3)

➢ Problem of Increased Potential for Conflict of Interest and Leading to Potential Cost Inefficiencies

- Ongoing dispute over the claims handling process –
  - Reason: LAE is nearly double of that for private insurers in the market
    - Goes to our regulatory charge of cost-efficient payment of Claims
  - Ex: 97-133 (b)(1) – authority to hire anyone to handle claims – law currently requires claims adjustors – Commissioner needs more oversight not less as history indicates

➢ Significant Problems with Implementation and Unaddressed Logistical Concerns

- Ex: 90 day approval or deemer insufficient for extremely

complex plan – need 30 days just to hire a consultant

- $20K to hire a consultant – totally insufficient for review of a plan that costs $1 million
- No plan to "disgorge" $330 million in deposits – Jan. 1, 2006 totally unrealistic

With all 4 unresolved, we cannot support.

MINUTES
HOUSE COMMITTEE ON INSURANCE
August 23, 2005

The House Committee on Insurance met at 11:00 AM on Tuesday, August 23, 2005 in Room 1228. The following Representatives attended, Chairman Hugh Holliman, Vice Chairs: Bill Faison, Edward Jones, and Edd Nye. Members: Lucy Allen, D. Almond, J. Barnhart, H. Brubaker, W. Current, R. Grady, J. Howard, L. Johnson, D. Ross, D. Saunders, F. Steen, R. Sutton, W. Wainwright and T. Wright.

Chairman Holliman called the meeting to order and welcomed visitors and recognized Sgt-At Arms. Attachment I.

Rep. Saunders made a motion to accept the PCS and motion carried.

Frank Folger Legal Counselor with DOI explained the department's concerns with SB 319-Workers' Comp. Self-Insurance Security. He stated the bill has potential that they support the idea in principle, but does not support the execution of the bill. The department favors a study commission for the bill. Attachment II.

Jim Stewart with the Stuart Law Firm, a firm that provides counsel to the current Self-Insurance Guaranty Fund, spoke in support of the bill stating a study has already been concluded.

An amendment from Rep. Faison was submitted, discussed and approved. Attachment III.

An amendment from Rep. Ross was submitted, discussed and approved. Attachment IV

An amendment from Rep. Holliman was submitted, discussed and approved.

Attachment V

Senator Clodfelter, sponsor for SB 319 - Workers' Comp. Self-Insurance Security, was asked to address the amendments and stated that he had not seen the amendments prior to the meeting. After some discussion, he agreed with the amendments that were approved by the Committee.

Rep. Sutton stated he felt the legislation was too important to rush through and suggested it be put in a study commission.

Rep. Saunders stating that the committee needed to move forward with the legislation, made a motion for a favorable report as amended unfavorable to the original bill and that the amendments be placed into a new committee substitute. The motion carried.

Chairman Holliman adjourned the meeting at 11:40 AM.

Representative. L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

Carol Bowers (Rep. Holliman)

From: Carol Bowers (Rep. Holliman)
Sent: Thursday, August 04, 2005 10:59 AM
Subject: House Insurance Meeting - August 9, 2005

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE:	**TUESDAY, AUGUST 23, 2005**
TIME:	**11:00 AM**
LOCATION:	**1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

SB 319 - Workers' Comp. Self-Insurance Security. - Senator Clodfelter

	Respectfully,
	Representative Holliman
	Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 4:00 PM on August 11, 2005.

	___Principal Clerk
	___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

HOUSE INSURANCE COMMITTEE

August 23, 2005
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

SB 319 - Workers' Comp. Self-Insurance Security. - Senator Clodfelter

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Holliman (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for
SB 319 A BILL TO BE ENTITLED AN ACT ESTABLISHING THE NORTH CAROLINA SELF-INSURANCE SECURITY SYSTEM AND MAKING CONFORMING CHANGES TO THE WORKERS' COMPENSATION LAWS.

☒ With a favorable report as to House committee substitute bill, which changes the title, unfavorable as to the original bill..

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House/Senate) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

ATTACHMENT I

HOUSE COMMITTEE ON INSURANCE

August 23, 2005
11:00 AM
Room 1228 Legislative Building

Pages:

Name (please print clearly)	County	Representative
Joseph Jones	Sampson	Black
JohnTe' Rankins	Sampson	Black
Aaron Leake	Sampson	Black

Sergeant-At-Arms (please print)

Martha Gadison

Toussaint Avent

Charles Williams

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — August 23, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John McMillan	MFTS
Ron Taylor	Kaylor Lawfirm
FRANK W. FOLGER	NC DOT
John McAlister	Duke Energy
Michelle Bank	State Gov't Radio
ANN COLE	DVHS
Lora Pierce	Duke Energy
Evelyn Lawsome	CHCR
Elizabeth Dalton	NCCIB)
Paul Coglianese	Troutman Sanders

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — August 23, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robert Glazer	NC Auto Dealers Assn.
Bill Hurley	
Kathy Hawkins	Progress Energy
[illegible]	[illegible]
[illegible]	L.A.I.A.
David Sadler	State Farm
DAVE Simpson	Carolinas AGC
Robert Paschal	Young, Moore
Susan Valaika	National
Ray Marshburn	NC 80 1
Jeff Trendel	NCDOI

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VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — August 23, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joseph Ennis	DOI
Monte Cagno	NMRS
John Cyrus	NCS Grange
James Andrews	NC State AFL-CIO
Jim LORE	R. James Lore Atty
Courtney Crowder	DOI
David Anders	~~NC AFPI-PNC~~
Leanetta Gaudet	NCDOJ
CP Medlin	NAIL
David Crawford	AIA NC
Carl Yustanski	NCBRB

ATTACHMENT II

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

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SENATE BILL 319
Judiciary I Committee Substitute Adopted 5/23/05
Third Edition Engrossed 5/25/05
PROPOSED HOUSE COMMITTEE SUBSTITUTE S319-CSRU-77 [v.10]

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Short Title: Workers' Comp. Self-Insurance Security. (Public)

Sponsors:

Referred to:

March 3, 2005

A BILL TO BE ENTITLED

AN ACT ESTABLISHING THE NORTH CAROLINA SELF-INSURANCE SECURITY SYSTEM AND CLARIFYING THE PROCEDURES BY WHICH SUBSIDIARY AND AFFILIATE COMPANIES MAY BE LICENSED AS SELF-INSURERS FOR WORKERS COMPENSATION AND TO MAKE OTHER CONFORMING AND TECHNICAL CHANGES TO THE WORKERS COMPENSATION LAWS RESPECTING INDIVIDUAL SELF-INSURERS IN ARTICLE 5 OF CHAPTER 97 OF THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

SECTION 1.1 The title of Article 4 of Chapter 97 reads as rewritten:

"Article 4.

North Carolina Self-Insurance ~~Guaranty~~ Security Association."

SECTION 1.2. G.S. 97-130 reads as rewritten:

"**§ 97-130. Definitions.**

As used in this Article:

(1) "Association" means the North Carolina Self-Insurance ~~Guaranty~~ Security Association established by G.S. 97-131.

(1a) "Association Aggregate Security System" means the security system established by the Association under G.S. 97-133 whereby individual self-insurers collectively secure their aggregate self-insured workers' compensation liabilities through the North Carolina Self-Insurance Security Association.

(2) "Board" means the Board of Directors of the Association established by G.S. 97-132.

(3) "Commissioner" means the North Carolina Commissioner of Insurance.

(4) "Covered claim" means an unpaid claim against an insolvent individual self-insurer or group self-insurer that relates to an injury that occurs while the individual self-insurer or group self-insurer is a member of the Association and that is compensable under this Chapter.

(5) "Fund" means the North Carolina Self-Insurance ~~Guaranty~~ Security Fund established by G.S. 97-133.

(5a) "Group" or "Group self-insurer" means a group self-insurer licensed by the Commissioner under Part 1, Article 47 of Chapter 58 of the General Statutes.

(5b) "Individual self-insurer" means an individual employer licensed by the Commissioner under Article 5 of this Chapter.

(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 and G.S. 97-94.~~an individual self-insurer or group self-insurer that is required to be a member of the Association under this Article or Part 1, Article 47 of Chapter 58 of the General Statutes.

(7) "Plan" means the Plan of Operation authorized by G.S. 97-134.

~~(8) "Self-insurer" means either: (i) an individual employer who has demonstrated under G.S. 97-93 the financial ability to directly pay compensation in the amounts and manner and when due as provided in this Chapter or (ii) a group of two or more employers who have agreed to pool their liabilities under this Chapter pursuant to G.S. 97-93.~~

(9) "Servicing facility" means those persons to whom the Board delegates the authority to settle and compromise claims and to expend Fund assets to pay claims."

SECTION 2. G.S. 97-131 reads as rewritten:

"**§ 97-131. Creation.**

(a) There is created a nonprofit unincorporated legal entity to be known as the North Carolina Self-Insurance ~~Guaranty~~ Security Association. The Association is to provide mechanisms for the payment of covered claims ~~under self-insurance coverage,~~ against member self-insurers, to avoid excessive delay in ~~payment,~~ payment of covered claims, to avoid financial loss to claimants because of the insolvency of a member self-insurer, ~~and to assist, when called upon to do so by the Commissioner,~~ to assist the Commissioner in the detection of self-insurer ~~insolvencies.~~insolvencies, to fund the Association Aggregate Security System, and to capitalize the Fund to insure the availability of financial resources to pay covered claims and to fund the activities of the Association.

(b) All individual self-insurers and group self-insurers shall be and remain members of the Association as a condition of ~~authority~~ being licensed to self-insure in this ~~State under G.S. 97-93.~~ State. The Association shall perform its functions under a Plan of Operation established or amended, or both, by the Board and approved by the Commissioner, and shall exercise its powers through the Board.

(1) ~~A~~ An individual self-insurer or a group self-insurer shall be deemed to be a member of the Association for purposes of another ~~self-insurer's~~member's insolvency, as defined in G.S. 97-135, when:
a. The individual self-insurer or group self-insurer is a member of the Association when an insolvency occurs, or
b. The individual self-insurer or group self-insurer has been a member of the Association at some point in time during the 12-month period immediately preceding the insolvency in question.

(2) ~~A~~ An individual self-insurer or a group self-insurer shall be deemed to be a member of the Association for purposes of its own insolvency if it is a member when the compensable injury occurs.

(3) In determining the membership of the Association ~~pursuant to~~ for the purposes of subdivisions (1) and (2) of this subsection for any date after the effective date of this Article, no ~~employer~~ individual self-insurer or group ~~of employers claiming self-insurer status~~self-insurer may be deemed to be a member of the Association on any date after the effective date of this Article, unless that employer ~~or~~ is on that date licensed as an individual self-insurer by the Commissioner under Article 5 of this Chapter or a group of employers is at that time ~~authorized~~ licensed as a group self-insurer by the Commissioner ~~pursuant to G.S. 97-93 and G.S. 97-94.~~under Article 47 of Chapter 58 of the General Statutes."

SECTION 3. G.S. 97-132 reads as rewritten:

"**§ 97-132. Board of directors.**

The Board shall consist of not less than nine ~~persons~~ directors serving terms as established in the Plan. The ~~members of the Board~~ directors shall be selected by the ~~member self-insurers,~~ members of the Association, subject to the approval of the Commissioner, and shall serve for ~~terms which shall not exceed three years. If no members of the Board are selected within 60 days after the effective date of this Article, the Commissioner may appoint the initial members of the Board.~~ three-year terms and until a successor is elected and qualified. There is no limitation on the number of terms a director may serve. In approving selections to the Board, the Commissioner shall consider, among other things, whether ~~all member~~ individual self-insurers and group self-insurers are fairly represented. ~~Members of the Board~~ Directors may be reimbursed from the assets of the Association for expenses incurred by them as ~~members of the Board.~~directors."

SECTION 4. G.S. 97-133 reads as rewritten:

"**§ 97-133. Powers and duties of the Association.**

(a) The Association shall:

(1) Repealed by Session Laws 1999-219, s. 7.2, effective June 25, 1999.

(1a) Administer a fund, to be known as the North Carolina Self-Insurance Security Fund, which shall receive the assets of the North Carolina Self-Insurance Guaranty Fund previously established under

subdivision (2) of this section, the assessments required by subdivisions (2a) and (3a) of this subsection and any other sums received by the Association. In its discretion, the Board may determine that the assets of the Fund should be segregated or that a separate accounting shall be made in order to identify that portion of the Fund which represents assessments paid by individual self-insurers and that portion of the Fund which represents assessments paid by group self-insurers. If the Board segregates the Fund in this manner, the Association shall thereafter pay covered claims against individual member self-insurers from that portion of the Fund that represents assessments against individual self-insurers and shall thereafter pay covered claims against group member self-insurers from that portion of the Fund that represents assessments against group self-insurers. The costs of administering the Association shall be borne by the Fund. The Association is authorized to secure insurance, primary excess insurance, reinsurance, bonds, other insurance, financial guarantees and related financial instruments to effectuate the purposes of the Association. The Board will invest the Fund assets, and the earnings from investment of Fund assets shall be placed in or credited to the Fund.

~~(2) Assess each member of the Association as follows:~~

~~a. Each individual member self-insurer shall be annually assessed an amount equal to two percent (2%) of the annual gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that member self-insurer for workers' compensation insurance during the prior calendar year; and payment to the Association shall be made no later than May 15 following the close of that calendar year. Where any such assessment is paid based in whole or in part upon estimates of annual gross premiums for the prior calendar year, there shall be made in the next year's assessment an adjustment of the assessment of such prior year based on actual audited annual gross premiums. Each group member self-insurer shall be annually assessed an amount equal to two percent (2%) of the annual gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), of the group member self-insurer during the prior calendar year; and payment to the Association shall be made no later than May 15 following the close of that calendar year. Regardless of the size of the Fund, during its first 12 months of membership, no member self-insurer may discount or reduce this two percent (2%) assessment. For the purpose of making the assessments authorized by this subsection and subsections (c) and (d) of this section, the Secretary of Revenue shall provide to the Association the self-insurer premium and payroll~~

~~information as determined under G.S. 105-228.5(b), (b1) and (c), and the Commissioner shall provide to the Association the group self-insurer premium information reported to the Commissioner under G.S. 58-47-75 and G.S. 58-2-165.~~

~~b. Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.~~

~~c. If a self-insurer is a member of the Association for less than a full calendar year, the annual gross premiums shall be adjusted by that portion of the year the self-insurer is not a member of the Association.~~

~~d. If application of the contribution rates referenced in sub-subdivision a. of this subdivision would produce an amount in excess of the five million dollar ($5,000,000) limits of the fund, an equitable proration may be made; provided that every self-insurer that becomes a member of the Association shall pay an initial assessment, in an amount established by the Board, regardless of the size of the fund at the time the member joins the Association.~~

(2a) Establish, operate, and maintain the Association Aggregate Security System as defined in G.S. 97-130 and G.S. 97-165 as follows:

a. The Association shall annually prepare and submit to the Commissioner a written plan to provide an Association Aggregate Security System through a combination of cash on deposit in the Fund, securities, surety bonds, irrevocable letters of credit, insurance, or other financial instruments or guarantees owned or entered into by the Association and acceptable to the Commissioner. The noncash elements of the composite security may be one-year or multiple-year instruments.

b. Within 90 days following the submission of the initial plan under sub-subdivision a. of this subdivision, the Commissioner shall either approve or disapprove the initial plan and shall notify the Association in writing. If the Commissioner does not approve or disapprove the initial plan within 90 days following submission, then the initial plan shall be deemed to be approved by the Commissioner. All subsequent plans shall be either approved or disapproved within 60 days following submission.

c. The Commissioner shall also determine the total undiscounted claims liability of each individual self-insurer that will participate in the Association Aggregate Security System as well as the aggregate total undiscounted outstanding claims liabilities of all the individual self-insurers that are to participate in the Association Aggregate Security System and shall notify the Association of this determination.

d. Upon approval by the Commissioner of the Association's plan for the Association Aggregate Security System, the Association shall assess the individual self-insurers that participate in the Association Aggregate Security System pursuant to subdivision (3a) of this subsection.

e. If the Commissioner disapproves the plan for any year, every self-insurer shall deposit with the Commissioner, or continue to deposit, the amount required by G.S. 97-185(b3) in the manner prescribed by G.S. 97-185(c).

f. Group self-insurers shall not participate in the Association Aggregate Security System.

~~(3) Administer a fund, to be known as the North Carolina Self-Insurance Guaranty Fund, which shall receive the assessments required in subdivision (2) of this subsection. Once the Fund reaches five million dollars ($5,000,000), no further assessments shall be made except initial assessments of new member self-insurers that are required to be made in subdivision (2)d. of this subsection. Assessments may be subsequently made only to maintain the Fund at a level of five million dollars ($5,000,000). In its discretion, the Board may determine that the assets of the Fund should be segregated, or, that a separate accounting shall be made, in order to identify that portion of the Fund which represents assessments paid by individual self-insurers and that portion of the Fund which represents assessments paid by group self-insurers. If the Board determines to segregate the Fund in this manner, the Association shall thereafter pay covered claims against individual member self-insurers from that portion of the Fund which represents assessments against individual self-insurers and shall thereafter pay covered claims against group member self-insurers from that portion of the Fund which represents assessments against group self-insurers. The cost of administration incurred by the Association shall be borne by the Fund and the Association is authorized to secure reinsurance and bonds and to otherwise invest the assets of the Fund to effectuate the purpose of the Association, subject to the approval of the Commissioner. All earnings from investment of Fund assets shall be placed in or credited to the Fund.~~

~~The Association may purchase primary excess insurance from an insurer licensed by the Commissioner for the appropriate lines of authority to defray its exposure to loss occasioned by the default of one of its members. The terms of any excess insurance so purchased shall be limited to providing coverage of liabilities which exceed the Fund's assets after the payment by member self-insurers of the maximum post-insolvency assessment provided in subdivision (c)(1) of this section herein and the Association shall fund any such purchase by levying a special assessment on its members for this purpose or by~~

~~application of any unencumbered earnings of the Fund or any other available funds. The Association may obtain from each member any information the Association may reasonably require in order to facilitate the securing of this primary excess insurance. The Association shall establish reasonable safeguards designed to insure that information so received is used only for this purpose and is not otherwise disclosed;~~

(3a) Assess members of the Association as follows:

a. Association Aggregate Security System assessments. – The Association shall assess each individual self-insurer participating in the Association Aggregate Security System a security system assessment. The amount of the security system assessment charged to each individual self-insurer participating in the Association Aggregate Security System shall be based on the Association's reasonable consideration of all of the following factors:

1. The total amount of assessments necessary to provide aggregate security for all participating individual self-insurers.
2. The individual self-insurer's total workers' compensation liabilities under the Act.
3. The financial strength and creditworthiness of the participating individual self-insurer.
4. Any other relevant factors.

b. Special assessment. – In the event that there are covered claims against an insolvent member or members and the assets of the Fund are not sufficient to pay the obligations of the Association, then the Association may collect a special assessment from the members in an amount sufficient to pay the aggregate value of such covered claims. Each member's special assessment shall be determined by the Board and shall be based on the proportion of the member's total obligations under the Act to the aggregate total of all members' obligations under the Act.

c. Initial assessments. –An individual self-insurer that becomes a member and does not initially participate in the Association Aggregate Security System shall pay an initial assessment to the Association in an amount determined by the Board. A group self-insurer, upon receiving its initial license from the Commissioner, shall pay an initial assessment to the Association in an amount determined by the Board.

d. Each member shall be notified of assessments no later than 30 days before the assessment is due.

e. Delinquent assessments, except as otherwise provided, shall bear interest at a rate to be established by the Board.

(4) Be obligated to ~~the extent of covered claims occurring prior to the determination of the member self-insurer's insolvency, or occurring after such determination but prior to the obtaining by the self-insurer of workers' compensation insurance as otherwise required under this Chapter.~~pay covered claims.

(5) After paying any ~~claim resulting from a self-insurer's insolvency,~~ covered claim, be subrogated to the rights of the injured employee and dependents and be entitled to enforce liability against the self-insurer or any third party by any appropriate action brought in its own name or in the name of the injured employee and ~~dependents;~~dependents.

(6) ~~Assess the Fund in an amount necessary to pay only:~~Expend Fund assets in amounts necessary to pay all of the following:

a. The obligations ~~for~~ of the Association under this Article subsequent to an ~~insolvency;~~insolvency.

b. The expenses of handling covered claims subsequent to an ~~insolvency;~~insolvency.

c. The cost of examinations under ~~G.S. 97-137; and~~G.S. 97-137.

d. The costs of implementing and operating the Association Aggregate Security System.

e. ~~Other~~ All other expenses authorized by this ~~Article;~~Article.

(7) Investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation; and deny all other claims. The Association may review settlements to which the insolvent ~~self-insurer~~member was a party to determine the extent to which such settlements may be properly ~~contested;~~contested.

(8) Notify such persons as the Commissioner directs under ~~G.S. 97-136;~~G.S. 97-136.

(9) Handle claims through its ~~employees~~ directors, its employees, or through one or more ~~self-insurers~~members or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Commissioner, but designation of a member ~~self-insurer~~ as a servicing facility may be declined by such ~~self-insurer;~~member.

(10) Reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the ~~Association;~~Association.

(11) Pay ~~the~~ any other expenses of the Association authorized by this ~~section; and~~section.

~~(12) Establish in the Plan a mechanism to calculate the assessments required by subdivisions (2) and (3) of this subsection by a simple and equitable means to convert from policy or fund years that are different from a calendar year.~~

(b) The Association may:

(1) Employ or retain such ~~persons~~ persons, including but not limited to adjustors, brokers, accountants, attorneys, financial advisors, investment bankers, placement agents, and consultants, as the Board may determine are necessary to handle ~~claims~~ claims, ~~and~~ perform other duties ~~of~~ of, provide services to and consult with the ~~Association;~~Association.

(2) Borrow funds necessary to effect the purposes of this Article in accord with the ~~Plan;~~Plan, including entering into standby lines of credit.

(3) Sue or be ~~sued;~~sued.

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this ~~section; and~~section.

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this section.

(6) Reimburse the Department of Insurance up to twenty thousand dollars ($20,000) for consultants retained by the Department to review the initial plan submitted pursuant to G.S. 97-133(a)(2a).

~~(c) In the event that the assets of the Fund are not sufficient to pay the obligations of the Association, then the Association shall impose an additional assessment upon its members, which shall be known as a post-insolvency assessment which shall be imposed as follows:~~

~~(1) Each individual member self-insurer shall be assessed in an amount not to exceed two percent (2%) each year of the annual gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that member self-insurer during the prior calendar year. The assessments of each individual member self-insurer shall be in the proportion that the annual gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), of the individual member self-insurer for the premium calendar year bears to the annual gross premiums of all individual member self-insurers for the preceding calendar year. For group member self-insurers, the assessment shall not exceed two percent (2%) each year the annual premium collected by that group member self-insurer during the prior calendar year. The assessments of each group member self-insurer shall be in the proportion that the annual gross premiums of the group member self-insurer for the premium calendar year bears to the annual gross premiums of all group member self-insurers for the preceding calendar year.~~

~~(2) Each member self-insurer shall be notified of the assessment no later than 30 days before it is due.~~

~~(3) The Association may exempt or defer, in whole or in part, the assessment of any member self-insurer, if the assessment would cause that member's financial statement to reflect liabilities in excess of assets.~~

~~(4) Delinquent assessments, except as provided in subdivision (3) of this subsection, shall bear interest at the rate to be established by the Board, but not to exceed the discount rate of the Federal Reserve Bank, Richmond, Virginia, on the due date of the assessment, plus four percent (4%) annually, computed from the due date of the assessment.~~

~~(5) The Association shall establish in the Plan a mechanism to calculate the assessments required by subdivision (1) of this subsection by a simple and equitable means to convert from policy or fund years that are different from a calendar year.~~

~~(d) No individual member self-insurer may be assessed in any calendar year an amount greater than two and one-half percent (2.5%) of the annual gross premiums, as determined under G.S. 105-228.5(b), (b1), and (c), that would have been paid by that individual member self-insurer during the prior calendar year. No group member self-insurer may be assessed in any calendar year an amount greater than two and one-half percent (2.5%) of the annual gross premiums of that group member self-insurer during the prior calendar year. If the maximum assessment does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. There shall be established in the Plan a mechanism to calculate the assessments required by this section by a simple and equitable means to convert from policy or fund years that are different from a calendar year.~~"

SECTION 5. G.S. 97-134 reads as rewritten:

"**§ 97-134. Plan of Operation.**

The Plan is as follows:

(1) The Association shall submit to the Commissioner a Plan and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. The Plan and any amendments become effective upon approval in writing by the Commissioner. If the Association at any time fails to submit a suitable Plan or suitable amendment to the Plan the Commissioner shall, after notice and hearing, adopt such reasonable rules as are necessary or advisable to effectuate this Article. ~~Such~~ The rules shall continue in force until modified by the Commissioner or superseded by a Plan submitted by the Association and approved by the Commissioner.

(2) All member self-insurers shall comply with the Plan.

(3) The Plan shall:

a. Establish the procedures whereby all the powers and duties of the Association under G.S. 97-133 will be ~~performed;~~performed.

b. Establish procedures for ~~handling assets of the Association;~~investing and managing Fund assets.

c. Adopt a reasonable mechanism and procedure to achieve equity in assessing ~~the funds required in G.S. 97-133. Consideration shall be given to adjustments for audited payroll, differential~~

~~effects caused by rate changes, and other relevant factors;~~members under G.S. 97-133.

d. Establish the amount and method of reimbursing members of the Board under ~~G.S. 97-132;~~G.S. 97-132.

e. Establish procedures by which claims may be filed with the Association and establish acceptable forms of proof of covered claims. ~~A list of such claims shall be periodically submitted to the Association;~~

f. Establish regular places and times for meetings of the ~~Board;~~Board.

g. Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the ~~Board;~~Board.

h. Provide that any member self-insurer aggrieved by any final action or decision of the Association may appeal to the Commissioner within 30 days after the action or ~~decision;~~decision.

i. Establish the procedures whereby selections for the Board shall be submitted to the ~~Commissioner; and~~Commissioner.

j. Contain additional provisions necessary or proper for the execution of the powers and duties of the Association."

SECTION 6. G.S. 97-135 reads as rewritten:

"**§ 97-135. Insolvency.**

A member self-insurer shall be insolvent for the purposes of this Article under any of the following circumstances:

(1) Determination of insolvency by a court of competent ~~jurisdiction; or~~jurisdiction.

(2) Institution of bankruptcy proceedings by or regarding the member ~~self-insurer; or~~self-insurer.

(3) The Board determines that the member self-insurer's total liabilities exceed its total assets or the member self-insurer is unable or ceases to pay its debts as they fall due or in the ordinary course of business.

(4) A member self-insurer is deemed to be insolvent, bankrupt, or in default as defined by the terms of any security instrument created pursuant to the Association Aggregate Security System."

SECTION 6.1. G.S. 97-136 reads as rewritten:

"**§ 97-136. Powers and duties of the Commissioner.**

(a) The Commissioner ~~shall notify~~ shall:

(1) Notify the Association of the existence of an insolvent member self-insurer not later than 30 days after he receives notice of an insolvency pursuant to the standards set forth in G.S. 97-135.

(2) Approve or disapprove the plan for an Association Aggregate Security System as required under G.S. 97-133(a)(2a)b. and notify the Association of the information required under G.S. 97-133(a)(2a)c.

(b) The Commissioner may:

(1) Require that the Association notify the insureds of the insolvent member self-insurer and any other interested parties of the insolvency and of their rights under this Article. ~~Such~~ The notifications shall be by mail at their last known addresses, where available; but if required information for notification is not available, notice by publication in a newspaper of general circulation in this State shall be sufficient; and

(2) Revoke the designation of any servicing facility if ~~he~~ the Commissioner finds claims are being handled unsatisfactorily."

SECTION 7. G.S. 97-140 reads as rewritten:

"**§ 97-140. Nonduplication of recovery.**

Any person having a covered claim that may be recovered under more than one insurance or self-insurance guaranty or security association or its equivalent shall seek recovery first from the association of the place or residence of the claimant. Any recovery under this Article shall be reduced by the amount of recovery from any other insurance guaranty or security association or its equivalent."

SECTION 8. 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~~ any deposit made by the insolvent member 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 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. For insolvent individual member self-insurers that participate in the Association Aggregate Security System, the Association is authorized to pursue recovery under every instrument, contract, and form of security comprising the composite security. 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 9. G.S. 97-165 reads as rewritten:

"**§ 97-165. Definitions.**

As used in this Article:

(1) 'Act' means the Workers' Compensation Act established in Article 1 of this Chapter.

(1a) 'Affiliate of' or 'person affiliated with' a specific person means a person that indirectly through one or more intermediaries or directly controls, is controlled by, or is under common control with the person specified.

(1b) "Association Aggregate Security System" means the security system established pursuant to G.S. 97-133 whereby individual self-insurers collectively secure their aggregate self-insured workers' compensation liabilities under the Act through the North Carolina Self-Insurance Security Association.

(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,~~ self-insurer or the guarantor, in conformity with ~~generally accepted accounting principles.~~accounting principles generally accepted in the United States.

(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~~ self-insurer or the guarantor to replace the CPA with another whose relationship with the ~~individual~~ self-insurer or the guarantor is independent within the meaning of this definition.

(4) 'Commissioner' means the Commissioner of Insurance.

(4a) 'Control', 'controlling', 'controlled by', and 'under common control with' mean the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person through ownership of or through proxies for voting of greater than fifty percent (50%) of the voting securities, or in the case of a not-for-profit entity, the power to direct or cause the direction of the management and policies of the entity.

(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.~~principles generally accepted in the United States.

(6a) 'Guarantor' means a person within the same holding company system who controls the applicant, whose financial statement is used by the applicant to become a self-insurer under the Act, and who has guaranteed the payment of the self-insurer's liability under the Act.

(7) 'Hazardous financial condition' means that, based on its present or reasonably anticipated financial condition, a self-insurer or guarantor is insolvent or, although not yet financially impaired or insolvent, is unlikely to be able to meet its obligations with respect to known claims and reasonably anticipated claims or to pay other obligations in the normal course of business.

(7a) 'Holding company system' means an entity comprising two or more affiliated persons.

(8) 'Management' means those persons who are authorized to direct or control the operations of a self-insurer.

(8a) '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.

(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 an ~~employer who retains liability under the Act and is licensed under this Article.~~ individual self-insurer as defined by G.S. 97-130(5b).

(11) 'Subsidiary of' a specific person means an affiliate controlled by such person indirectly through one or more intermediaries or an affiliate directly controlled by such person."

SECTION 10. G.S. 97-170 reads as rewritten:

"**§ 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. This subsection does not apply to an employer authorized to self-insure its workers' compensation liabilities under the Act prior to December 1, 1997, whose authority to self-insure its workers' compensation liabilities under the Act has not terminated after that date.

(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. A copy of the application must also be filed with the North Carolina Self-Insurance Security Association at least 90 days before the proposed licensing date.

(c) Only an applicant 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 all of the following relative to the ~~applicant's:~~applicant:

(1) Organizational structure and ~~management;~~management.

(2) Financial ~~strength;~~strength.

(3) Source and reliability of financial ~~information;~~information.

(4) Risks to be ~~retained;~~retained.

(5) Workers' compensation loss ~~history;~~history.

(6) Number of ~~employees;~~employees.

(7) Claims ~~administration;~~administration.

(8) Excess ~~insurance; and~~insurance.

(9) Access to excess insurance.

(d) The license application shall ~~comprise~~ be comprised of the following information:

(1) ~~Company name,~~ Applicant name; organizational ~~structure,~~ structure of the applicant, including any controlling entity, subsidiaries, or affiliates; location of principal ~~office,~~ office; contact ~~person,~~ person; organization ~~date,~~ date; type of operations within this ~~State,~~ State; management ~~background,~~ 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~~ presentation shall facilitate application of ratio and trend analysis.

...

(6) Summary of workers' compensation benefits paid for the last three calendar ~~years, as well as~~ years and 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.

...

~~(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~~ approval for membership by the North Carolina Self-Insurance ~~Guaranty Association under Article 4 of this Chapter.~~Security Association.

(e) Every applicant shall execute and file with the Commissioner an agreement, as part of the application, in which the applicant agrees to participate in the Association Aggregate Security System, or if excluded from the Association Aggregate Security System, to deposit with the Commissioner pursuant to G.S. 97-185, cash, acceptable securities, an irrevocable letter of credit in a form acceptable to the Commissioner issued by a bank acceptable to the Commissioner, or a surety bond issued by a corporate ~~surety~~ surety, or a combination thereof, that will guarantee the applicant's compliance with this Article and the ~~Act pursuant to G.S. 97-185.~~Act."

SECTION 11. Article 5 of Chapter 97 of the General Status is amended by adding the following new section:

"**§ 97-177. License covering applicant and any subsidiary or applicant relying on a guarantor; procedure; requirements.**

(a) The Commissioner may, in the Commissioner's discretion, upon request by an applicant, issue a license to an applicant or to an applicant and one or more of its subsidiaries if all of the following requirements are satisfied:

(1) The applicant or a guarantor of the applicant executes a guaranty agreement, in a form prescribed by the Commissioner, for the payment of all workers' compensation liabilities covered under the Act. For any applicant or guarantor that is a corporation, there shall be submitted,

along with the guaranty agreement, a board of directors' resolution from the respective corporation authorizing the guaranty of the liabilities of the subsidiary company or companies and granting signature authority to each person or officer executing the agreement.

(2) The applicant or guarantor files a statement with the Commissioner that lists the percentage of ownership of voting securities or proxies representing voting securities owned or held by the applicant or guarantor for each subsidiary, or in the case of a not-for-profit entity, documentation acceptable to the Commissioner evidencing control.

(3) The applicant and its guarantor or the applicant and its subsidiaries, whichever applies, satisfy the requirements of G.S. 97-170(c).

(4) All other applicable requirements for licensure under the Act are satisfied.

(b) A license issued by the Commissioner pursuant to this section shall include the name of the applicant, the name of each licensed subsidiary, and the date of issuance for each licensed subsidiary.

(c) If a self-insurer requests to add a subsidiary to its license, the Commissioner shall review the request in accordance with this section. Upon approval, the Commissioner shall issue to the self-insurer a new license that includes the newly licensed subsidiary and the date of license issuance for the newly licensed subsidiary, and the self-insurer shall return the original license to the Commissioner.

(d) A self-insurer shall neither include nor delete a subsidiary from its license without the Commissioner's prior written approval.

(e) If a controlling relationship or guaranty agreement terminates, the self-insurer shall retain all liabilities under the Act that were incurred by the self-insurer during the period of self-insurance and shall account for all such liabilities until discharged, as evidenced by reports filed with the Commissioner. Termination of a guaranty agreement does not affect the guarantor's liability for payment of liabilities arising prior to termination of the agreement."

SECTION 12. G.S. 97-180 reads as rewritten:

"**§ 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~~ presentation shall facilitate the application of ratio and trend analysis. If the self-insurer was issued a license pursuant to G.S. 97-177, the financial statement required under this subsection shall be that of the guarantor.

(b) Every self-insurer shall submit within 120 days after the end of its fiscal year a ~~certification~~ report from a qualified actuary setting forth ~~the actuary's~~ an opinion ~~relating to~~ certifying the loss and loss adjustment expense reserves for workers' compensation obligations ~~for~~ in North Carolina. The ~~certification~~ report 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~~ and the total outstanding workers' compensation liabilities for each loss year, recorded at the close of its fiscal year for the net retained liability.

(d) Upon the request of the Commissioner, every self-insurer shall submit a report of its 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~~ name or address of the ~~businesses it self-insures or intends to self-insure, as well as~~ self-insurer or guarantor; significant changes in the financial ~~condition,~~ condition of the self-insurer, guarantor, or any affiliate, including bankruptcy ~~filings,~~ filings; and changes in its ~~business~~ organizational structure, including its ~~divisions, subsidiaries, affiliates, and internal organization.~~ subsidiaries and affiliates. Any change shall be reported in writing to the Commissioner within 10 days after the effective date of the change. Upon request by the Commissioner, a self-insurer shall provide the Commissioner copies of documents or information deemed necessary to determine whether any change has affected the privilege of the employer to self-insure."

SECTION 13. G.S. 97-185 reads as rewritten:

"**§ 97-185. Deposits; surety bonds; letters of credit.**

~~(a) **(Effective January 1, 2005, until January 1, 2006)** Every self-insurer shall deposit with the Commissioner an amount not less than seventy-five percent (75%) 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 greater 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.~~

~~(a) **(Effective January 1, 2006)** Every self-insurer shall deposit with the Commissioner an amount not less than one hundred percent (100%) 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 greater 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.~~

(a1) All individual self-insurers as defined in G.S. 97-130(5b) shall participate in the Association Aggregate Security System established under G.S. 97-131 unless excluded by the Board of Directors of the North Carolina Self-Insurance Security

Association. The Board of Directors of the North Carolina Self-Insurance Security Association shall exclude all of the following from the Association Aggregate Security System:

(1) Individual self-insurers whose licenses have previously been revoked by the Commissioner.

(2) Individual self-insurers with a debt rating as established by Standard & Poor's Rating Service or by Moody's Investor Service, below the minimum Standard & Poor's and Moody's ratings established in the written plan for the Association Aggregate Security System submitted by the Association and approved by the Commissioner under G.S. 97-133(a)(2a).

(3) Individual self-insurers that have defaulted on the payment of its self-insured workers' compensation liabilities from participation in the Association Aggregate Security System.

The Board of Directors of the North Carolina Self-Insurance Security Association shall notify the Commissioner of the individual self-insurers that are excluded from participating in the Association Aggregate Security System.

(b) Repealed by Session Laws 2003-115, s. 3, effective January 1, 2004.

~~(b1) Notwithstanding subsection (a) of this section, member self-insurers with a debt rating of BBB or better from Standard and Poor's Rating Service, a division of McGraw Hill, Inc., or an equivalent rating from another national rating agency shall deposit with the Commissioner an amount not less than 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). The Commissioner shall consider and may, in the Commissioner's discretion, increase or reduce the deposit to a greater or lesser percentage of the member self-insurer's claims liability based on the financial strength of the self-insurer and other financial information submitted by the self-insurer.~~

(b2) An individual self-insurer that is excluded from participation in the Association Aggregate Security System, including individual self-insurers that are granted a license to self-insure after the North Carolina Self-Insurance Security Association annually implements the Association Aggregate Security System, shall deposit with the Commissioner an amount not less than one hundred percent (100%) of the individual self-insurer's total undiscounted outstanding claims liability per the most recent report from a qualified actuary as required by G.S. 97-180(b), but not less than five hundred thousand dollars ($500,000), or such greater amount as the Commissioner prescribes based on, but not limited to, the financial condition of the individual self-insurer and the risk retained by the individual self-insurer.

(b3) During any period of time that no Association Aggregate Security System is in effect, individual self-insurers with a debt rating of BBB or better from Standard and Poor's Rating Service, a division of McGraw Hill, Inc., or an equivalent rating from another national rating agency shall deposit with the Commissioner an amount not less than twenty five percent (25%) of the individual self-insurer's total undiscounted outstanding claims liability per the most recent report from a qualified actuary as

required by G.S. 97 180(b), but not less than five hundred thousand dollars ($500,000). An individual self-insurer licensed pursuant to G.S. 97-177 may utilize the debt rating of its guarantor for the purpose of establishing the application of this subsection. The Commissioner shall consider and may, in the Commissioner's discretion, increase or reduce the deposit to a greater or lesser percentage of the individual self-insurer's claims liability based on the financial strength of the individual self -insurer and other financial information submitted by the individual self-insurer. All other individual self-insurers shall deposit with the Commissioner an amount not less than one hundred percent (100%) of the individual self-insurer's total undiscounted outstanding claims liability per the most recent report from a qualified actuary as required by G.S. 97-180(b), but not less than five hundred thousand dollars ($500,000), or such greater amount as the Commissioner prescribes based on, but not limited to, the financial condition of the individual self-insurer and the risk retained by the individual self-insurer.

(c) Deposits received, changes to existing deposits, or deposits exchanged after the effective date of this section, shall ~~comprise~~ be comprised of 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. A surety bond deposited pursuant to this subsection shall require that the surety reimburse the Commissioner, or his successors, assigns, or transferees, for any costs incurred in the collection of the proceeds of the surety bond, including reasonable attorneys' fees, and any costs incurred in administering the insolvent self- insurer's workers' compensation claims.

(4a) Irrevocable letters of credit in a form acceptable to the Commissioner issued by a bank acceptable to the Commissioner. An irrevocable letter of credit deposited pursuant to this subsection shall require that the bank reimburse the Commissioner, or his ~~successor,~~ successors, assigns, or transferees for any costs incurred in the collection of the proceeds of the letter of credit, including reasonable attorneys' fees.

(4b) The reimbursement of attorneys' fees and collections cost provided for in subdivisions (4) and (4a) of this subsection shall be no greater than fifteen percent (15%) of the penal amount of the bond and shall not come from the proceeds of the bond or the letter of credit but shall be in addition to the proceeds of the bond or the letter of credit.

(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 the market value is less than the 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 or guarantor'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 or guarantor 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. In the case of a letter of credit, the Commissioner may draw the full amount of a letter of credit if the letter of credit is not renewed within 90 days prior to its expiration or at any time that the bank issuing the letter of credit is no longer acceptable to the Commissioner. Interest accruing on any negotiable security deposited under this Article shall be collected and transmitted to the self-insurer if the self-insurer or guarantor 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~~ Pursuant to the provisions of this section and with the approval of the Commissioner, deposits 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.~~ acceptable forms of deposit in amount determined by the Commissioner. Any ~~surety bond may~~ deposit to 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.~~ another form of deposit shall not be released until the approved replacement deposit is received by the Commissioner.

(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.~~ Any self-insurer that ceases to self-insure, whether by voluntary termination or by revocation of license, shall continue to secure and be liable for its obligations under the Act and shall continue to report to the Commissioner pursuant to G.S. 97-180. Upon the request of the Commissioner, a self-insurer that ceases to self-insure shall submit filings, as prescribed in G.S. 97-180, to determine whether the deposit is sufficient to satisfy those workers' compensation obligations incurred during the period that the self-insurer was licensed as a self-insurer. The Commissioner may require an increase in the deposit amount, or may grant a reduction

in the deposit amount to ensure that the deposit is sufficient to cover all existing and future obligations incurred by the self-insurer while subject to the provisions of 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."

SECTION 14. G.S. 97-190 reads as rewritten:

§ 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 or guarantor's financial condition.

(b) An excess insurance policy required by this section shall be issued by either ~~a licensed~~ an insurance company licensed in this State or an ~~approved~~ eligible surplus lines ~~insurance company~~insurer as defined in G.S. 58-21-10 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."

SECTION 15. G.S. 97-195 reads as rewritten:

"**§ 97-195. ~~Revocation of license.~~ Revocation, suspension or restriction 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.~~

(a1) The Commissioner may, upon at least 45 days notice and opportunity for a hearing, revoke, suspend, or restrict the license of a self-insurer if any of the following apply:

(1) The self-insurer fails or refuses to comply with any law, order, or rule applicable to the self-insurer.

(2) There is a determination of insolvency by a court of competent jurisdiction.

(3) The self-insurer is in a hazardous financial condition.

(4) The self-insurer has experienced a material loss or deteriorating operating trends, or has reported a deficit financial position.

(5) Any affiliate or subsidiary is insolvent, threatened with insolvency, or delinquent in payment of its monetary or any other obligation.

(6) The self-insurer has failed to pay premium taxes pursuant to Article 8B of Chapter 105 of the General Statutes.

(7) 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.

(8) 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.

(9) 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.

(10) The self-insurer has experienced, or will experience in the foreseeable future, cash flow or liquidity problems.

(11) The self-insurer has failed to make proper and timely payment of claims, as required by this Article.

(12) Failure to pay any North Carolina Self-Insurance Security Association assessments made pursuant to G.S. 97-133.

(13) Failure to participate in the Association Aggregate Security System or, if excluded from participation in the Association Aggregate Security System, failure to provide and maintain the deposit required by G.S. 97-185.

~~(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) Repealed by Session Laws 2003-221, s. 15, effective June 19, 2003.~~

~~(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~~ revocation, suspension, or restriction under subsection ~~(a) or (b)~~ (a1) 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."

SECTION 16. Article 5 of Chapter 97 of the General Statutes is amended by adding the following new section:

"**§ 97-196. Civil penalties or restitution for violations; administrative procedure.**

(a) Whenever the Commissioner has reason to believe that a self-insurer has violated any of the provisions of this Article, and the violation subjects the license of the self-insurer to suspension or revocation, the Commissioner may, after notice and opportunity for a hearing, proceed under the appropriate subsections of this section.

(b) If the Commissioner finds a violation of this Article, the Commissioner may, in addition to or instead of suspending or revoking the license, order the payment or a monetary penalty as provided in subsection (c) of this section or petition the Superior Court of Wake County for an order directing payment of restitution as provided in subsection (d) of this section, or both. Each day during which a violation occurs constitutes a separate violation.

(c) If the Commissioner orders the payment of a monetary penalty pursuant to subsection (b) of this section, the penalty shall not be 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 clear proceeds of the penalty shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2. 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.

(d) Upon petition of the Commissioner, the court may order the self-insurer who committed a violation specified in subsection (b) of this section to make restitution in an amount that would make whole any person harmed by the violation. The petition may be made at any time, and the petition may be made in any appeal of the Commissioner's order.

(e) 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.

(f) Nothing in this section prevents the Commissioner from negotiating a mutually acceptable agreement with any self-insurer as to the status of the self-insurer's license or as to any civil penalty or restitution.

(g) Unless otherwise specifically provided for, all administrative proceedings under this Article are governed by Chapter 150B of the General Statutes. Appeals of the Commissioner's orders under this section shall be governed by G.S. 58-2-75."

SECTION 17. G.S. 58-2-161(a)(1)p. reads as rewritten:

"**§ 58-2-161. False statement to procure or deny benefit of insurance policy or certificate.**

(a) For the purposes of this section:

(1) "Insurer" has the same meaning as in G.S. 58-1-5(3) and also includes:

...

p. The North Carolina Self-Insurance ~~Guaranty~~ Security Association under Article 4 of Chapter 97 of the General Statutes.

..."

SECTION 18. G.S. 58-30-10(7) reads as rewritten:

"**§ 58-30-10. Definitions.**

As used in this Article, unless the context clearly indicates otherwise:

...

(7) "Domestic guaranty association" means the Postassessment Insurance Guaranty Association in Article 48 of this Chapter, as amended; the North Carolina Self-Insurance ~~Guaranty~~ Security Association in Article 4 of Chapter 97 of the General Statutes; the Life and Accident and Health Insurance Guaranty Association in Article 62 of this Chapter, as amended; or any other similar entity hereafter created by the General Assembly for the payment of claims of insolvent insurers.

..."

SECTION 19. G.S. 58-47-65(f)(14) reads as rewritten:

"(f) The license application shall comprise the following information:

. . .

(14) A letter stipulating the applicant's acceptance of membership in the North Carolina Self-Insurance ~~Guaranty~~ Security Association under Article 4 of Chapter 97 of the General Statutes.

. . ."

SECTION 20. G.S. 105-259(b)(16a) reads as rewritten:

"(b) Disclosure Prohibited. – An officer, an employee, or an agent of the State who has access to tax information in the course of service to or employment by the State may not disclose the information to any other person unless the disclosure is made for one of the following purposes:

. . .

(16a) To provide the North Carolina Self-Insurance ~~Guaranty~~ Security Association information on self-insurers' premiums as determined under G.S. 105-228.5(b), (b1), and (c) for the purpose of collecting the assessments authorized in G.S. 97-133(a).

. . ."

SECTION 21. This act becomes effective January 1, 2006.

H

SENATE BILL 319:
Workers' Comp. Self-Insurance Security

BILL ANALYSIS

Committee:	House Insurance	**Date:**	August 1, 2005
Introduced by:	Sen. Clodfelter	**Summary by:**	Tim Hovis
Version:	Proposed Committee Substitute		Committee Counsel

SUMMARY: The Proposed Committee Substitute for Senate Bill 319 would amend the Workers' Compensation self-insurance laws by repealing the North Carolina Self-Insurance Guaranty Fund and replacing it with the North Carolina Self-Insurance Security Fund.

CURRENT LAW: Current law allows an employer to be licensed as a self-insurer for workers' compensation purposes when the employer meets certain conditions, including having at least $500,000 of total fix assets and demonstrating that the employer is sufficiently financially sound to cover its workers' compensation claims. Employers who are licensed as self-insurers are not required to purchase workers' compensation insurance coverage. All self-insurers must also participate in the NC Self-Insurance Guaranty Fund. This Fund is to guarantee workers' compensation payments in the event the employer becomes insolvent and is unable to meet its workers' compensation obligations. The Fund is funded by an assessment of all self-insurers of 2% of the annual premiums the employer would have had to pay for workers' compensation insurance coverage. If the assets of the Fund are insufficient to cover all claims of insolvent employers, additional assessments may be made.

BILL ANALYSIS: Senate Bill 319 would amend the workers' compensation self-insurance laws by eliminating the statutory assessment limits and replacing it with a system where the amount of the annual assessments for a member is determined by the NC Self-Insurance Security Association. Members of the Association would be divided into group self-insurers and individual self-insurers as defined in the bill and would pay assessments to the Association.

In addition, individual self-insurers would participate in the "Association Aggregate Security System" which the bill defines as a system allowing individual self-insurers to aggregate their workers compensation liabilities and pay assessments to the NC Self-Insurance Security Association Fund based on the following:

- The total amount of assessments necessary to provide aggregate security for all participating members.
- The member's total workers' compensation liabilities under the workers' compensation law.
- The financial strength and creditworthiness of the member.
- Any other relevant factors.

The bill also gives the Association the authority to exclude from the Association Aggregate Security System those individual self-insurers whose debt ratings by Moody's and Standard & Poor's fall below the minimum rating established by the Association upon the approval of the Commissioner of Insurance. A self-insurer excluded from the Association Aggregate Security System would have to deposit 100% of the employer's total undiscounted outstanding claims liability, but not less than $500,000, to continue as a self-insured employer.

Other provisions include the following:

- Adds definitions of affiliate, control, guarantor, holding company system, and subsidiary

- Creates a new section, G.S. 97-177, specifying the conditions under which the Commissioner may issue a license to self-insure for a company and its affiliates or subsidiaries
- Clarifies that if a license to a self-insurer is issued under the newly proposed G.S. 97-177, the financial documents required under G.S. 97-180 must be those of the guarantor
- Rewrites the old provision for revocation, suspension or restriction of a self-insurer's license, including every former basis for such action by the Commissioner such that it more uniformly reflects the procedures applied in other license revocation procedures.

EFFECTIVE DATE: This act becomes effective January 1, 2006.

S0319e3-SMRG

This summary was contributed to by O. Walker Reagan, Staff Attorney, Research Division.

ATTACHMENT III

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE _____

S. B. No. 319 Amendment No. _____
Proposed cttee Substit. (to be filled in by Principal Clerk)
COMMITTEE SUBSTITUTE _____

Rep.) Faison
)
Sen.)

moves to amend the bill on page 9 ; line 17

( ) WHICH CHANGES THE TITLE

by substituting a new section (c) as follows

"(c) The Association shall provide in its plan that the functions of administration and adjusting claims shall not be performed by the same entity that provides legal representation to the Association for claims."

SIGNED _____

ADOPTED X FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

Rep. Ross moves to amend

ATTACHMENT IV

Proposed House Committee Substitute for SB 319

~~[as amended,~~

1. On Page 4, by deleting lines 18 through 20 and inserting in lieu therof the following:

"Association. The Board will invest the Fund assets pursuant to an investment policy adopted by the Board and reviewed and approved annually by the Department of the State Treasurer. The earnings from investment of Fund assets shall be placed in or credited to the Fund."

2. On Page 5, by deleting lines 21 through 28 and by inserting in lieu thereof the following:

"a. The Association shall annually prepare and submit to the Commissioner a written plan to provide an Association Aggregate Security System through a combination of cash on deposit in the Fund, securities, surety bonds, irrevocable letters of credit, insurance or other financial instruments or guarantees owned or entered into by the Association and acceptable to the Commissioner. The written plan shall include, but not be limited to: a description of the institutions that will issue or guarantee the securities, surety bonds, irrevocable letters of credit, insurance or other financial instruments or guarantees, including but not limited to the credit rating, financial strength and AM Best rating, if applicable, of the institutions; applicable cash flow information and financial assumptions; a description of the methodology to be used by the Association to assess and collect the Association Aggregate Security System assessments to be made pursuant to subdivision (3a) of this subsection; and, a proposed timetable for the release of existing individual company deposits posted pursuant to G.S. 97-185(c) provided, however, that no individual company deposits posted pursuant to G.S. 97-185(c) shall be released without the written consent of the Commissioner. The noncash elements of the composite security may be one-year or multiple-year instruments."

Signed:

Adopted

Rep. Holliman, moves to amend SB 319 (PCS) as follows

~~SB 319 Amendment # 1~~

ATTACHMENT V

Moves to amend the bill on page 2, lines ~~18~~ 23 - ~~19~~ 25 by rewriting the lines to read:

(9) "Servicing facility" means those persons delegated by the Board and approved by the Commissioner to settle and compromise claims and to expend Fund assets to pay claims."

Signed:

Adopted



HOUSE INSURANCE COMMITTEE
2005-2006

REPRESENTATIVE L. HUGH HOLLIMAN
CHAIRMAN

CAROL BOWERS, COMMITTEE CLERK

2006

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE INSURANCE COMMITTEE
2005 – 2006 SESSION



Rep. Hugh Holliman
Chairman



Rep. Bill Faison
Vice-Chair



Rep. Edward Jones
Vice-Chair



Rep. Edd Nye
Vice-Chair



Rep. Mitchell Setzer
Vice-Chair



Rep. Lucy Allen



Rep. Cary Allred



Rep. David Almond



Rep. Jeff Barnhart



Rep. Harold Brubaker



Rep. William Current



Rep. Robert Grady



Rep. Julia Howard



Rep. Howard Hunter



Rep. Linda Johnson



Rep. Deborah Ross



Rep. Drew Saunders



Rep. Fred Steen



Rep. Ron Sutton



Rep. William Wainwright



Rep. Tom Wright

HOUSE COMMITTEE ON INSURANCE
MEMBERSHIP

MEMBER	ASSISTANT	PHONE	OFFICE	SEAT
Holliman, Hugh, Chairman	Carol Bowers	5-0873	1213	55
Faison Bill, Vice-Chair	Katie Jackelen	5-3019	417A	93
Jones, Edward, Vice Chair	Joan Peacock	3-5878	611	60
Nye Edd, Vice-Chair	Jo Bobbitt	3-5477	639	23
Setzer Mitchell, Vice Chair	Joanna Mills	3-4948	1204	49
Allen, Lucy	Melissa Riddle	3-5860	1307	92
Allred, Cary	Jean Allred	3-5905	606	38
Almond, David	Alice Falcone	3-5741	1315	107
Barnhart, Jeff	Pamela Ahlin	5-2009	608	76
Brubaker, Harold	Cindy Coley	5-4946	1229	2
Current, William	Wendy Miller	3-5809	539	108
Grady, Robert	Neta Grady	5-9644	302A	4
Howard, Julia	Anne Soles	3-5904	1106	3
Hunter, Howard	Barbara Phillips	3-2962	613	68
Johnson, Linda	Rachel Faison	3-5861	1006	28
Ross, Deborah	Margie Penven	3-5773	2223	65
Saunders, Drew	Ruth Fish	3-5606	2217	48
Steen, Fred	Chris Floyd	3-5881	514	64
Sutton, Ron	Juanita Coley	5-0875	1321	71
Wainwright, William	Blinda Edwards	3-5995	532	8
Wright, Tom	Clarestene Stewart	3-5754	528	19
Ex-Officio Members:				
Culpepper, Bill	Dot Crocker	5-3028	404	36
Cunningham, Pete	Valerie Rustin	3-5778	541	7
Eddins, Rick	Dorie Monroe	3-5828	1002	26
Hackney, Joe	Emily Reynolds	3-5752	2207	69

Legislative Staff: Research – 733-2578

Tim Hovis
Kory Goldsmith
Ben Popkin

4/5/05

ATTENDANCE

HOUSE INSURANCE COMMITTEE

2005 SESSION

DATES:	05-23-06	06-06-06	06-08-06	06-20-06	06-22-06	06-27-06	07-06-06	07-13-06							
Rep. Hugh Holliman, Chairman	X	X	X	X	X	X	X	X							
Rep. Bill Faison, Vice-Chair	X	X	X	X	X		X								
Rep. Edward Jones, Vice-Chair	X	X	X	X	X	X	X	X							
Rep. Edd Nye, Vice-Chair															
Rep. Mitchell Setzer, Vice-Chair	X		X		X	X		X							
Rep. Lucy Allen	X	X	X	X	X		X	X							
Rep. Cary Allred	X	X	X												
Rep. David Almond	X	X	X	X	X	X	X								
Rep. Jeff Barnhart		X													
Rep. Harold Brubaker	X	X	X	X	X	X		X							
Rep. William Current	X	X	X	X	X	X	X	X							
Rep. Robert Grady		X	X	X	X	X	X	X							
Rep. Julia Howard	X	X	X	X	X		X	X							
Rep. Howard Hunter															
Rep. Linda Johnson	X			X	X	X	X	X							
Rep. Deborah Ross	X	X	X	X	X	X	X	X							
Rep. Drew Saunders	X	X	X	X	X	X	X	X							
Rep. Fred Steen	X	X	X		X	X									
Rep. Ron Sutton		X	X	X	X	X	X	X							
Rep. William Wainwright	X		X												
Rep. Tom Wright	X	X						X							
Rep. Rick Eddins, Ex-officio															
Rep. Bill Culpepper, Ex-officio															
Rep. Pete Cunningham, Ex-officio															
Rep. Joe Hackney, Ex-officio															
Tim Hovis. Staff Attorney		X	X	X		X	X	X							
Kory Goldsmith, Staff Attorney	X	X	X	X	X	X	X	X							
Ben Popkin, Staff Attorney	X	X	X	X		X		X							

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H0020	Holliman	HEALTH INSURANCE CREDIT/MINIMUM WAGE.	*H	Re-ref Com On Judiciary I	03-10-05	03-17-05
H0644	Holliman	AGENT/BAIL BONDS APPLICANT PETITION DEADLINE.-AB	H	Ref To Com On Insurance	03-16-05	
$ H0645=	**Holliman**	**AMEND WARRANTY/ SERVICE AGMT LAWS/ STUDY**	***H**	**Re-ref Com On Appropriations**	**03-16-05**	**05-12-05**
H0646	Holliman	INSURANCE COMPANY FEE CONSOLIDATION.-AB	*HR	Ch. SL 2005-424	03-16-05	04-18-05
H0647	Holliman	DOI HEARING/UNAUTH. INS. SUMMARY C&D ORDER.-AB	H	Ref To Com On Insurance	03-16-05	
H0653=	Holliman	CREDIT INSURANCE CHANGES.-AB	*HR	Ch. SL 2005-181	03-16-05	06-02-05
H0654	Holliman	CONFIDENTIAL INSURANCE MKT./ FINANCIAL DOC.-AB	*HR	Ch. SL 2005-206	03-16-05	04-21-05
H0655	Holliman	BETTER INSURANCE/ ANNUITY DISCLOSURE.-AB	*HR	Ch. SL 2005-234	03-16-05	04-25-05
H0656=	Holliman	WORKERS' COMP/SELF-INSURED GUARANTY ASSOC.-AB	H	Ref To Com On Insurance	03-16-05	
H0657	Holliman	REVISE INSURANCE RATE DEVIATIONS	*H	Failed Concur In Com Sub	03-16-05	05-25-05
H0657	Holliman	REVISE INSURANCE RATE DEVIATIONS	*H	Failed Concur In Com Sub	06-15-06	07-06-06
$ H0658	**Holliman**	**CODE OFFICIALS PROFESSIONALISM.-AB**	***HR**	**Ch. SL 2005-102**	**03-16-05**	**05-04-05**
H0659=	Holliman	UNAUTHORIZED INSURER MISCONDUCT.-AB	H	Ref To Com On Insurance	03-16-05	
H0660	Holliman	INSURANCE FINANCIAL CHANGES.-AB	*HR	Ch. SL 2005-215	03-16-05	04-18-05
H0672	Holliman	REDUCE HOLDING PERIOD FOR UNCLAIMED PROPERTY.-AB	*HR	Ch. SL 2005-132	03-17-05	05-04-05
H0673	Holliman	INTERSTATE INSURANCE PRODUCT REG. COMPACT.-AB	*HR	Ch. SL 2005-183	03-17-05	05-12-05
H0674	Holliman	INSURANCE PEO EXAMINATION AUTHORITY.-AB	H	Ref To Com On Insurance	03-17-05	
H0675=	Holliman	INSURANCE TECHNICAL CORRECTIONS.-AB	H	Ref To Com On Insurance	03-17-05	
H0727	Holliman	HIPAA COMPLIANCE AND FAIRNESS.-AB	H	Ref To Com On Insurance	03-17-05	
H0733	Holliman	LICENSE INSURANCE STATISTICAL ORGANIZATIONS.-AB	*HR	Ch. SL 2005-210	03-17-05	04-25-05
H0734	Holliman	NAVASSA ZONING JURISDICTION.	*H	Ref To Com On Rules, Calendar, and Operations of the House	03-17-05	05-02-05
H0735	Holliman	ACCIDENT & HEALTH INSUR./RATE STABILIZATION.-AB	*HR	Ch. SL 2005-412	03-17-05	04-27-05

'$' indicates the bill is an appropriation bill.
A bold line indicates the bill is an appropriation bill.
'*' indicates that the text of the original bill was changed by some action.
'=' indicates that the original bill is identical to another bill.

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H0737	Holliman	HEALTH INSURANCE CHANGES.	*HR	Ch. SL 2005-223	03-17-05	04-20-05
H0817=	Pate	AMEND FIREMEN'S RELIEF FUND REQUIREMENT.	H	Ref To Com On Insurance	03-21-05	
H1185	Moore	FIRE DEPARTMENT GRANTS.	H	Ref To Com On Insurance	04-12-05	
H1225	Holliman	INFORM INSURANCE CONSUMERS ABOUT SURCHARGE.	H	Ref To Com On Insurance	04-14-05	
H1236	Holliman	INSURANCE BD. OF GOVERNORS MEMBERSHIP.	*HR	Ch. SL 2005-242	04-18-05	05-25-05
H1244=	Hill	MOTOR VEHICLE REPAIR CONSUMER PROTECTION.	H	Re-ref Com On Judiciary III	04-18-05	05-03-05
H1312=	Wright	INSURANCE PREMIUM DISCOUNT/PREVENTION COURSE.	H	Ref To Com On Insurance	04-20-05	
H1388	Gibson	DEBT COLLECTION LICENSING CHANGES.	*HR	Ch. SL 2006-134	06-30-06	07-06-06
H1524	Wilson	SUPPLEMENTAL INSURANCE/PERS. COMM./ SEIBP	*H	Re-ref Com On Rules, Calendar, and Operations of the House	04-21-05	05-23-05
H1526=	Frye	AVERY COUNTY/HERITAGE PARK AUTHORITY.	*H	Re-ref Com On Finance	04-21-05	05-31-05
$ H1535	**Insko**	**ESTABLISH NC HEALTH INSURANCE RISK POOL.**	**H**	**Ref To Com On Insurance**	**04-21-05**	
$ H1768	**Gibson**	**AMEND WORKERS' COMPENSATION ACT/ FUNDS.**	**H**	**Ref to the Com on Insurance and, if favorable, to the Com on Rules, Calendar, and Operations of the House**	**05-12-05**	
$ H1895=	**Insko**	**ESTABLISH HIGH-RISK POOL.**	***H**	**Ref to Health Care. If fav, re-ref to Appropriations/ Base Budget**	**05-11-06**	**06-12-06**
$ H1895=	**Insko**	**ESTABLISH HIGH-RISK POOL.**	***H**	**Ref to Health Care. If fav, re-ref to Appropriations/ Base Budget**	**07-12-06**	**07-13-06**
H1987	Holliman	HEALTH PLANS/CHANGES TO BASIC AND STD.	*HR	Ch. SL 2006-154	05-16-06	06-26-06
H2168	Gibson	EXEMPT CERTAIN GREENHOUSES FROM BLDG CODE.	H	Ref To Com On Insurance	05-18-06	
$ H2860	**Holliman**	**NC FAIR SHARE HEALTH INSURANCE ACCESS PROGRM.**	**H**	**Assigned To Insurance**	**06-08-06**	
H2885	Wainwright	ESC/EMPLOYERS' PROTEST FILING PERIOD.	*H	Pres. To Gov. 7/ 20/2006	06-19-06	07-06-06
S0140=	Fred Smith	AMEND FIREMEN'S RELIEF FUND	*H	Re-ref Com On Insurance	07-14-05	

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Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		REQUIREMENT.				
S0277	Walter H. Dalton	MOTOR VEHICLE SELF-INSURERS.	*HR	Ch. SL 2006-145	06-02-05	06-28-06
S0319	Daniel G. Clodfe	WORKERS' COMP. SELF-INSURANCE SECURITY.	*HR	Ch. SL 2005-400	07-06-05	08-23-05
S0552=	Walter H. Dalton	DOI HEARING/UNAUTH. INS. SUMMARY C&D ORDER.-AB	*HR	Ch. SL 2005-217	04-25-05	07-05-05
S0577=	Walter H. Dalton	UNAUTHORIZED INSURER MISCONDUCT.-AB	HR	Ch. SL 2005-209	04-11-05	07-05-05
S0615=	Scott Thomas	INSURANCE TECHNICAL CORRECTIONS.	*HR	Ch. SL 2006-105	05-16-05	06-27-06
S0626=	Scott Thomas	HIPAA COMPLIANCE AND FAIRNESS.-AB	*HR	Ch. SL 2005-224	04-12-05	07-07-05
S0685	Stan Bingham	REVISE PROFESSIONAL EMPLOYER ORGANIZATION ACT.	*HR	Ch. SL 2005-124	03-29-05	03-30-05
S0687	John H. Kerr III	VOLUNTEER RESCUE/EMS FUNDING.	*HR	Ch. SL 2005-283	05-31-05	07-27-05
S0707=	Philip E. Berger	AGENT/BAIL BONDS APPLICANT PETITION DEADLINE.	*HR	Ch. SL 2005-240	04-12-05	07-07-05
S0881	Linda Garrou	LAPSE IN LIABILITY INSURANCE.	*H	Pres. To Gov. 7/26/2006	08-15-05	06-26-06

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MINUTES
HOUSE COMMITTEE ON INSURANCE
May 23, 2006

The House Committee on Insurance met at 11:00 AM on Tuesday, May 23, 2006 in Room 1228. The following Representatives in attendance were: Chairman H. Holliman, Vice Chairs: B. Faison, Ed Jones, and M. Setzer. Members: L. Allen, C. Allred, D. Almond, H. Brubaker, W. Current, J Howard, L. Johnson, D. Ross, D. Saunders, F. Steen, W. Wainwright and T. Wright.

Chairman Holliman welcomed visitors, House pages and Sgt-At-Arms and committee members back. See Attachment I.

Rep. Holliman asked for a motion to accept the PCS for HB 1895 – Establish High-Risk Pool. Rep. Saunders made the motion and the motion carried. Rep. Holliman announced that the fiscal note on HB 1895 was not complete for the meeting and they would discuss it at the next meeting. He then called on Rep. Insko, sponsor of HB 1895 to speak on the bill. Rep. Insko gave the background of the legislation including the fact this legislation has been researched for 18 years. She reported there are approximately 1.4 million uninsured people in NC and approximately 50% of all bankruptcy claims are due to the high cost of insurance coverage. See Attachment II.

Ben Popkin, Staff Attorney, was called on to explain the bill summary. He explained the Plan of Operation, eligibility and how the pool would be established. See Attachment III

Marlow Foster, NCAHP, shared concerns on funding and the shortfall of cost above and beyond the cost to be covered.
Robert Paschal, representing NCAU and NCAHFA, recognized members from all committees that have been working on this legislation and stated, it was a tough issue and they needed to work together on base funding.
Barbara M. Burke, DOI, explained how the assessment would work, be implemented and the average of the standard rate.

An amendment changing line 19-20 on page 5 was presented and approved. See Attachment IV. The Board of Directors would consist of the North Carolina Commissioner of Insurance (Commissioner), who would serve as an ex-officio non-voting member of the Board, and Nine members appointed as follows:

1) Three members of the general public, one appointed by the Governor, one appointed by the Speaker of the House and one appointed by the Senate President Pro Tempore.
2) Six members appointed by the Commissioner: Two who are insurers, at least one of whom covers the largest number of persons in the State (currently, Blue Cross Blue Shield of North Carolina); one who is licensed to sell health insurance in this State; two who represents the medical provider community, (one each from the Medical Society and the NC Hospital Association) and one who represents small business.

After much committee deliberation, Rep. Holliman announced the committee would continue discussion at the next meeting.
The meeting adjourned at 11:45 AM

Representative L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

HOUSE INSURANCE COMMITTEE

May 23, 2006
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

HB - Establish High-Risk Pool. **Representative Insko**

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **TUESDAY, MAY 23, 2006**

TIME: 11:00 AM

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 1895 – Establish High-Risk Pool – Rep. Insko

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 1:15 PM on May 16, 2005.

___Principal Clerk
___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Holliman (Chair) for the Committee on INSURANCE.

☒Committee Substitute # 2 for
HB 1895 A BILL TO BE ENTITLED AN ACT TO ESTABLISH THE NORTH CAROLINA HEALTH INSURANCE RISK POOL AND TO APPROPRIATE FUNDS THEREFOR.

☒ With a favorable report as to Committee substitute bill 3, which changes the title, unfavorable as to Committee Substitute Bill 2.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House/Senate) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

ATTACHMENT L

House Pages

Name Of Committee: _____ Date: _____

1. Name: Claire Brown
   County: Johnston
   Sponsor: Leo Daughtry
2. Name: Allison Croft
   County: Davidson
   Sponsor: Dockham
3. Name: _____
   County: _____
   Sponsor: _____
4. Name: _____
   County: _____
   Sponsor: _____
5. Name: _____
   County: _____
   Sponsor: _____

Sgt-At-Arms

1. Name: Tom Wilder
2. Name: Charles Williams
3. Name: Neil Casper
4. Name: _____
5. Name: _____

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 23, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
A Jones	DUNS
D Tilson	NCHA
DAVID BARNES	Pognet + Spruill
Susan Volan	Nationwide
Bill Scoggin	KC
Jim Stewart	IFNC
Kristi Sage	Nat. MS Society
Abby C. Emanuelson	Natl MS Society
Alyn Berry	Civitas Institute
Cam Cover	BPMHL
Beth Sammis	UnitedHealthcare

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 23, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Bryan	Natl MS Society
Jennifer Mahan	Mental Health Assoc. in NC
J Craig Frank	NAIS
	NCAHP
PERRI MORGAN	NC100
	JD, M, PA
Marlowe Foster	NCAHP
Barbara Morales Burke	NCDOI
Cameron Contizano	Daily Bulletin
Jeff Wolfe	Daily Bulletin

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 23, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Brent Pasichal	Young, Moore
David Stoller	State Farm
Wendy Kelly	HMW
Holly Bryan	NCATL
[illegible]	NMRS
Jeff Mixon	Civitas Institute
Phil Taylor	Gov. Policy office
W P Polly	NCATL
Paul Mahoney	CAPSTRAT, INC
Harry Lofl	NCLM
Rob Schofield	N.C. Assn. of NP's

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — May 23, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	[signature]
Kathryn Millican	BCBSNC
Elizabeth Dalton	NCRMA
Rob Thompson	NCPDRG
Kelly McCall	UNC-TV

ATTACHMENT II

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 1895
PROPOSED COMMITTEE SUBSTITUTE H1895-CSRD-39 [v.2]

5/22/2006 3:25:49 PM

Short Title: Establish High-Risk Pool. (Public)

Sponsors:

Referred to:

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE NORTH CAROLINA HEALTH INSURANCE RISK POOL AND TO APPROPRIATE FUNDS THEREFOR.

The General Assembly of North Carolina enacts:

SECTION 1.1. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 7. North Carolina Health Insurance Risk Pool.

"**§ 58-50-245. Definitions.**

For the purposes of this Part:

(1) ~~"Administrator" means the Pool Administrator selected by the Board~~ in accordance with this Part.

(2) "Benefit plan" means coverage offered by the Pool to eligible individuals.

(3) "Board" means the Board of Directors of the Pool.

(4) "Covered person" means any individual resident of this State, excluding dependents, who is eligible to receive health benefits from any insurer.

(5) "Church plan" has the meaning given that term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(6) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

a. A group health plan.

b. Health insurance coverage.

c. Part A or Part B of Title XVIII of the Social Security Act. (Medicare)

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.(Medicaid)

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)).

A period of creditable coverage shall not be counted, with respect to the enrollment of an individual who seeks coverage under this Part, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

(7) "Dependent" means a resident spouse or unmarried child under the age of 19 years, a child who is a full-time student under the age of 23 years and who is financially dependent upon the parent, a child who is over 18 years of age and for whom a person may be obligated to pay child support, or a child of any age who is disabled and dependent upon the parent.

(8) "Family member" means a parent, grandparent, brother, sister, or child of a dependent residing with the insured.

(9) "Federally defined eligible individual" means an individual:

a. For whom, as of the date on which the individual seeks coverage under this Part, the aggregate of the periods of creditable coverage is 18 or more months;
b. Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with such a plan;
c. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (Medicare), or a State plan under Title XIX of the Act (Medicaid), or any successor program, and who does not have other health insurance coverage;
d. With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e. Who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected this coverage; and
f. Who has exhausted continuation coverage under this provision or program, if the individual elected the continuation coverage described in sub-subdivision e. of this subdivision.

(10) "Governmental plan" has the meaning given under section 3(32) of the Employee Retirement Income Security Act of 1974 and any governmental plan established or maintained for its employees by the

government of the United States or by an agency or instrumentality of the government of the United States.

(11) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, including items and services paid for as medical care to employees or their dependents, as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(12) "Health insurance coverage" means any hospital and medical expense incurred policy, nonprofit health care services contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise.

"Health insurance coverage" does not include one or more, or any combination of, the following:

a. Coverage only for accident or disability income insurance, or any combination thereof.
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 issued pursuant to P.L. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
i. Limited-scope dental or vision benefits.
j. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.
k. Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act.
l. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services – CHAMPUS).
m. Similar supplemental coverage provided to coverage under a group health plan.

(13) "Insurance arrangement" means a plan, program, contract, or other arrangement through which health care services are provided by an employer to its officers or employees, but does not include health care services covered through an insurer.

(14) "Insured" means an individual who is eligible to receive benefits from the Pool. The term "insured" includes dependents and family members, as applicable.

(15) "Insurer" means any entity that provides health insurance coverage in this State. For the purposes of this Part, insurer includes an insurance company, a hospital or medical service corporation, a health maintenance organization, a multiple employer welfare arrangement, a third-party administrator or claims processor, an administrative service organization, or any other nongovernmental entity providing a health benefit plan subject to State insurance regulation.

(16) "Medical care" means amounts paid for:

a. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

b. Transportation primarily for and essential to medical care referred to in sub-subdivision a. of this subdivision; and

c. Insurance covering medical care referred to in sub-subdivisions a. and b. of this subdivision.

(17) "Plan of operation" means the articles, bylaws, and operating rules and procedures adopted by the Board in accordance with this Part.

(18) "Pool" means the North Carolina Health Insurance Risk Pool.

(19) "Resident" means an individual who:

a. Has been legally domiciled in this State for a period of at least 30 days, except that for a federally defined eligible individual, there shall not be a 30-day requirement;

b. Is legally domiciled in this State on the date of application to the Pool and who is eligible for enrollment in the Pool as a result of the Health Insurance Portability and Accountability Act of 1996; or

c. Is legally domiciled in this State on the date of application to the Pool and is eligible for the credit for health insurance costs under section 35 of the Internal Revenue Code of 1986.

(20) "Significant break in coverage" means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

(21) "Trade Adjustment Assistance Program" (TAA) means Title II of the Trade Act of 2002, P.L. 107-210.

"**§ 58-50-250. Risk Pool established; board of directors; plan of operation.**

(a) High-Risk Pool Established. – There is hereby created a nonprofit entity to be known as the North Carolina Health Insurance Risk Pool. The Pool shall operate under the supervision and control of the Board of Directors of the Pool.

(b) Board of Directors Appointment; Membership. – The Board of Directors of the North Carolina Health Insurance Risk Pool shall consist of the Commissioner of

Insurance, who shall serve as an ex officio nonvoting member of the Board, and seven members appointed as follows:

(1) Two members of the general public who are not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, and can reasonably be expected to qualify for coverage in the Pool. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member. The two members of the general public shall be appointed by the General Assembly, as follows:

a. One member upon the recommendation of the President Pro Tempore of the Senate.

b. One member upon the recommendation of the Speaker of the House of Representatives.

(2) Six members appointed by the Commissioner of Insurance, as follows:

a. Two who are insurers, at least one of whom covers the largest number of persons in the State.

b. One who is licensed to sell health insurance in this State.

c. One who represents the medical provider community, as recommended by the North Carolina Medical Society.

d. One who represents small business, as recommended by the North Carolina Citizens for Business and Industry.

(c) Board of Directors; Terms of Appointment; Vacancies; Compensation. – The initial Board members shall be appointed as follows: two of the members to serve a term of three years; three of the members to serve a term of one year; and two of the members to serve a term of two years. Subsequent Board members shall serve for terms of three years. A Board member's term shall continue until the member's successor is appointed. The Commissioner shall appoint a chair to serve for the initial two years of the Plan's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms. The Commission shall fill vacancies in membership and may remove members from the Board for cause. Board members shall not be compensated in their capacity as Board members but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties.

(d) Plan of Operation. – The Board shall submit to the Commissioner a Plan of Operation for the Pool and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Plan of Operation. The Plan of Operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this Part must be made available. If the Board fails to submit a suitable Plan of Operation within 180 days after the appointment of the Board of Directors, or at any time thereafter fails to submit suitable amendments to the Plan of Operation, the Commissioner shall adopt temporary rules necessary or advisable to effectuate the provisions of this section. The rules shall continue in force until modified by the Commissioner or superseded by a Plan of

Operation submitted by the Board and approved by the Commissioner. The Plan of Operation shall:

(1) Establish procedures for operation of the Pool.

(2) Establish procedures for selecting a Pool Administrator in accordance with G.S. 58-50-255.

(3) Establish procedures to create a fund for administrative expenses, which shall be managed by the Board.

(4) Establish procedures for the collection, handling, accounting, and auditing of assets, monies, and claims of the Pool and the Pool Administrator.

(5) Develop and implement a program to publicize the existence of the Pool, the eligibility requirements, and procedures for enrollment, availability of State premium subsidies, and to maintain public awareness of the Pool.

(6) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the Board in accordance with G.S. 58-50-295.

(7) Establish procedures for identifying and confirming income levels of applicants for Pool coverage who are eligible to receive a State premium subsidy, if a State premium subsidy is available.

(8) Provide for other matters as may be necessary and proper for the execution of the Board's powers, duties, and obligations under this Part.

(e) The Pool shall have the general powers and authority granted under the laws of this State to health insurers and the specific authority to do all of the following:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Part, including the authority, with the approval of the Commissioner, to enter into contracts with similar plans of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions.

(2) Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the Pool.

(3) Take legal action as necessary to:

a. Avoid the payment of improper claims against the Pool or the coverage provided by or through the Plan.

b. Recover any amounts erroneously or improperly paid by the Plan.

c. Recover any amounts paid by the Pool as a result of mistake of fact or law.

d. Recover other amounts due the Pool.

(4) Establish rates and rate schedules in accordance with this Part.

(5) Issue policies of insurance in accordance with the requirements of this Part.

(6) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the Pool, policy, and other contract design, and any other function within the Pool's authority.

(7) Borrow money to effect the purposes of the Pool. Any notes or other evidence of indebtedness of the Pool not in default are legal investments for insurers and may be carried as admitted assets.

(8) Establish policies, conditions, and procedures for reinsuring risks of participating insurers desiring to issue Pool coverage in their own name. Provision of reinsurance shall not subject the Pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

(9) Employ and fix the compensation of employees.

(10) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public.

(11) Provide for reinsurance of risks incurred by the Pool.

(12) Issue additional types of health insurance policies to provide optional coverage, including Medicare supplemental insurance coverage.

(13) Provide for and employ cost containment measures and requirements including preadmission screening, second surgical opinion, concurrent utilization review, disease management, individual case management, and other commonly used benefit plan design features for the purpose of making health insurance coverage offered by the Pool more cost-effective.

(14) Design, utilize, contract, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

(15) Adopt bylaws, policies, and procedures as may be necessary or convenient for the implementation of this Part and the operation of the Pool.

(f) The Board shall operate the Pool in a manner so that the estimated cost of providing health insurance coverage during any fiscal year will not exceed the total income the Pool expects to receive from policy premiums and other revenue available to the Pool. The financing mechanisms recommended to and approved by the General Assembly shall provide for a means to adjust those mechanisms annually, or more frequently if necessary, in order to assure that the Pool has the financial capacity to insure the projected number of enrollees.

(g) The Board shall make an annual report to the Commissioner, to the Speaker of the House of Representatives, and to the President Pro Tempore of the Senate. The report shall summarize the activities of the Pool in the preceding calendar year, including the net written and earned premiums, benefit plan enrollment, the expense of administration, and the paid and incurred losses.

(h) Neither the Board nor its employees are liable for any obligations of the Pool. No current or former member or employee of the Board is liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this Part, unless such act or omission constitutes willful or wanton misconduct. The Board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

(i) The members of the Board shall comply with the provisions of G.S. 14-234 prohibiting conflicts of interest.

"**§ 58-50-255. Administrator.**

(a) The Board shall select through a competitive bidding process one or more insurers or a third-party administrator to administer the Pool. The Board shall evaluate bids submitted based on criteria established by the Board. The criteria shall allow for the comparison of information about each bidding administrator and selection of a Pool Administrator based on at least the following:

(1) Proven ability to handle health insurance coverage to individuals.

(2) Efficiency and timeliness of the claim processing procedures.

(3) Estimated total charges for administering the Pool.

(4) Ability to apply effective cost containment programs and procedures and to administer the Pool in a cost-efficient manner.

(5) Financial condition and stability.

If a member of the Board has submitted a bid to be selected by the Board as Pool Administrator, that bidding member of the Board shall not participate in the selection process or in the Board's final decision on the selection of the Administrator.

(b) The Administrator shall serve for a period specified in the contract between the Pool and the Administrator subject to removal for cause and subject to any terms, conditions, and limitations of the contract between the Pool and the Administrator. At least one year before the expiration of each period of service by an Administrator, the Board shall invite eligible entities, including the current Administrator, to submit bids to serve as the Administrator. Selection of the Administrator for the succeeding period shall be made at least six months before the end of the current period.

(c) The Administrator shall perform such functions relating to the Pool as may be assigned to it, including:

(1) Determination of eligibility.

(2) Payment of claims.

(3) Establishment of a premium billing procedure for collection of premiums from individuals covered under the Pool.

(4) Other necessary functions to assure timely payment of benefits to covered persons under the Pool.

(d) The Administrator shall submit regular reports to the Board regarding the operation of the Pool. The contract between the Board and the Administrator shall specify the frequency, content, and form of the report.

(e) Following the close of each calendar year, the Administrator shall determine net written and earned premiums, the expense of administration, and the paid and

incurred losses for the year and report this information to the Board and the Commissioner on a form prescribed by the Commissioner.

(f) The Administrator shall be paid as provided in the contract between the Board and the Administrator.

"**§ 58-50-260. Risk Pool rates.**

(a) The Pool shall adopt and modify, as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of the Pool. Rates and rate schedules may be adjusted for appropriate factors such as age, sex, and geographic variation in claim cost and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices.

(b) The Pool shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for the coverage. Pool rates shall be one hundred fifty percent (150%) of rates established as applicable for individual standard rates.

(c) The Pool shall provide for premium discounts for covered individuals who are nonsmokers or who are actively participating in a smoking cessation program. Approval of smoking cessation programs, criteria for active participation in smoking cessation programs, and discount rates shall be established by the Board, subject to the approval of the Commissioner.

(d) Provider reimbursement rates under Pool coverage shall be limited to the rates allowed for providers under the Medicare Program.

(e) The Pool shall submit all rates and rate schedules to the Commissioner for approval, and the Commissioner must approve the rates and rate schedules before the Pool may use them. The Commissioner, in evaluating the rates and rate schedules, shall consider the factors provided in this section.

"**§ 58-50-265. Eligibility for Pool coverage.**

(a) Any individual who is and continues to be a resident of this State is eligible for Pool coverage if evidence is provided of:

(1) A notice of rejection or refusal to issue substantially similar insurance for health reasons by an insurer. A rejection or refusal by an insurer offering only stop-loss, excess loss, or reinsurance coverage with respect to the applicant is not sufficient evidence of eligibility;

(2) An offer to issue insurance only with a conditional rider that limits coverage for the individual's high-risk medical condition;

(3) A refusal by an insurer to issue insurance except at a rate exceeding the Pool rate;

(4) A diagnosis of the individual with one of the medical or health conditions listed by the Board in accordance with this section. An individual diagnosed with one or more of these conditions is eligible for Pool coverage without applying for other health insurance coverage;

(5) In the case of an individual who is eligible for coverage under the Health Insurance Portability and Accountability Act of 1996, the individual's maintenance of health insurance coverage, of which the most recent coverage was through an employer-sponsored plan, for the previous 18 months with no gap in coverage greater than 63 days and exhaustion of any available COBRA or State continuation benefits; or

(6) An individual who is legally domiciled in this State and is eligible for the credit for health insurance costs under the Trade Adjustment Assistance Reform Act of 2002, section 35 of the Internal Revenue Code of 1986.

(b) The Board shall adopt a list of medical or health conditions for which a person shall be eligible for Pool coverage without applying for health insurance pursuant to subsection (a) of this section. The Board may amend the list as the Board considers appropriate.

(c) Each dependent of an individual who is eligible for Pool coverage shall also be eligible for Pool coverage.

(d) An individual is not eligible for coverage under the Pool if:

(1) The individual has or obtains health insurance coverage substantially similar to or more comprehensive than a Pool policy, or would be eligible to have coverage if the person elected to obtain it, except that:

a. An individual may maintain other coverage for the period of time the individual is satisfying any preexisting condition waiting period under a Pool policy; and

b. An individual may maintain Pool coverage for the period of time the individual is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the Pool policy.

(2) The individual is determined to be eligible for enrollment in the State Medical Assistance Plan.

(3) The individual has previously terminated Pool coverage unless 12 months have lapsed since the termination, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual or to an applicant eligible for or receiving benefits under the Trade Adjustment Assistance Program.

(4) The individual is an inmate or resident of a public institution, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual.

(5) The individual's premiums are paid for or reimbursed under any government-sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider. This subdivision shall not apply for individuals receiving benefits under the Trade Adjustment Assistance Program or to

individuals receiving premium subsidies made available by the State based on individual income levels.

(6) The individual has in effect on the date Pool coverage takes effect health insurance coverage from an insurer or insurance arrangement.

(e) Coverage under the Pool shall cease:

(1) On the date an individual is no longer a resident of this State.

(2) On the date an individual requests coverage to end.

(3) Upon the death of the covered individual.

(4) On the date State law requires cancellation of the Pool policy.

(5) At the option of the Pool, 30 days after the Pool makes any inquiry concerning the individual's eligibility or residence to which the individual does not reply.

(6) Because the individual has failed to make the payments required under this Part.

(f) Except as provided in subsection (e) of this section, an individual who ceases to meet the eligibility requirements of this section may be terminated at the end of the Pool period for which the necessary premiums have been paid.

"**§ 58-50-270. Unfair referral to Pool.**

It is an unfair trade practice under Article 63 of this Chapter for an insurer, insurance producer, as defined in G.S. 58-33-10(7), or third-party administrator to refer an individual employee to the Pool or arrange for an individual employee to apply to the Pool for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment, or for the purpose of separating an individual covered by health insurance offered in the individual market.

"**§ 58-50-275. Minimum Pool benefits.**

(a) The Pool shall offer at least two types of health insurance coverage for individuals eligible under G.S. 58-50-265, including preferred provider organizations with different levels of deductibles and cost-sharing, and at least one choice of a health savings account. The covered services and benefit levels may vary between the types of coverage, but at least two types of coverage must, at a minimum, cover the benefits and services outlined in the National Association of Insurance Commissioners' Model Health Pool for Uninsurable Individuals Act and be consistent with comprehensive coverage generally available to persons who are eligible for health insurance other than Medicare. All health insurance products offered by the Pool shall include disease or case management services.

(b) Health insurance products offered by the Pool shall include not less than one million dollars ($1,000,000) lifetime limit and a sliding scale annual limit of two thousand dollars ($2,000) to five thousand dollars ($5,000) on out-of-pocket expenses. The sliding scale shall be based on family income. The Board shall adjust limitations at least once every five years to reflect changes in the medical component of the Consumer Price Index.

"**§ 58-50-280. Preexisting conditions.**

(a) Except as otherwise provided by law, pool coverage shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage as

to any condition for which medical advice, care, or treatment was recommended or received as to such conditions during the 12-month period immediately preceding the effective date of coverage, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual.

(b) Subject to subsection (a) of this section, the preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage that was involuntarily terminated, provided that:

(1) Application for Pool coverage is made not later than 63 days following the involuntary termination, and in such case coverage in the Pool shall be effective from the date on which the prior coverage was terminated; and

(2) The applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to Pool coverage.

"**§ 58-50-285. Nonduplication of benefits.**

(a) The Pool shall be payor of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under coverage shall be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or no-fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any State or federal law or program.

(b) The Pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the Pool may be reduced or refused as a setoff against any amount recoverable under this subsection.

"**§ 58-50-290. Assessments.**

(a) For the purposes of providing the funds necessary to carry out the powers and duties of the Pool, the Board shall assess all insurers at such time and for such amounts as the Board finds necessary. Assessments shall be due in not less than 30 days after prior written notice to the member insurers and shall accrue interest at twelve percent (12%) per annum on and after the due date.

(b) Each insurer shall be assessed in an amount not to exceed two dollars ($2.00) per covered individual insured or reinsured by each insurer per month. The assessment will be based on actual and expected losses, actuarially appropriate reserves, and administrative expenses in excess of expected and collected premiums and federal loss reimbursements, if any, received by the Pool.

(c) The Board shall make reasonable efforts designed to ensure that each covered individual is counted only once with respect to any assessment. For that purpose, the Board shall require each insurer that obtains excess or stop-loss insurance to include in its count of covered individuals all individuals whose coverage is insured (including by way of excess or stop-loss coverage) in whole or in part. The Board shall allow a reinsurer to exclude from its number of covered individuals those who have been

counted by the primary insurer or by the primary reinsurer or primary excess or stop-loss insurer for the purposes of determining its assessment under this section.

(d) The Board may verify each insurer's assessment based on annual statements and other reports deemed to be necessary by the Board. The Board may use any reasonable method of estimating the number of covered individuals of an insurer if the specific number is unknown.

(e) If assessments and other receipts by the Pool, Board, or administering insurer exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the Board to offset future losses or to reduce plan premiums. Future losses include reserves for claims incurred but not reported.

(f) The Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any member insurer that fails to pay an assessment. As an alternative, the Commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture may not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100.00) per month.

"**§ 58-50-295. Complaint procedures.**

An applicant or participant in coverage from the Pool is entitled to have complaints against the Pool reviewed by a grievance committee appointed by the Board. Members of the Board shall not serve on the grievance committee. The grievance process shall comply with G.S. 58-50-62. The grievance committee shall report to the Board after completion of the review of each complaint. The Board shall retain all written complaints regarding the Pool at least until the third anniversary of the date the Pool received the complaint. An applicant or participant may file for external review of the applicant's grievance after having exhausted the Pool's internal grievance procedure. External review shall be conducted in accordance with Part 4 of this Article.

"**§ 58-50-300. Audit.**

The State Auditor shall conduct annually a special audit of the Pool. The State Auditor's report shall include a financial audit and an economic and efficiency audit. The State Auditor shall report the cost of each audit conducted under this Part to the Board and the Comptroller, and the Board shall remit that amount to the Comptroller for deposit to the General Fund.

"**§ 58-50-305. Taxation.**

The Pool established under this Part is exempt from any and all taxes.

"**§ 58-50-310. Rules.**

The Commissioner may adopt rules, including temporary rules, to implement this Part.

"**§ 58-50-315. Collective action.**

The participation in the Pool as participating insurers, the establishment of rates, forms, or procedures, and any other joint or collective action required by this Part may not be the basis of any legal action or criminal or civil liability or penalty against the Pool or any participating insurer."

SECTION 1.2. The Board of Directors of the North Carolina Health Insurance Risk Pool, as appointed under Section 1 of this act, shall monitor methods of

financing the Pool to ensure a stable funding source and allow for its continued operation. This monitoring shall include supplementary sources of funding, such as funds obtained from public and private not-for-profit foundations, or other appropriate and available State or non-State funds. The Board shall also review on a regular basis:

(1) The number of individuals in this State who are uninsured as of a date certain because of high-risk conditions.

(2) The number of uninsured individuals who would qualify for coverage under the Pool based on G.S. 58-50-265 and its Plan of Operation.

(3) The cost of coverage under each of the health insurance plans developed by the Board, including administrative costs.

The Board shall report its findings and recommendations to the General Assembly on March 1, 2007, and annually thereafter.

SECTION 1.3. The North Carolina Health Insurance Risk Pool Administrator shall study methods for encouraging healthy behaviors and report its findings to the Board of Directors of the Pool and to the General Assembly not later than one year after initial implementation of the Pool.

SECTION 1.4. The Board of Directors of the Pool shall apply for grant funds available from the federal government to help support the implementation and ongoing costs of operating a high-risk pool. If federal funds are available for purposes for which funds were appropriated in this act from the General Fund, such federal funds shall be used to reimburse the General Fund, to the maximum extent allowable, for amounts appropriated for this purpose.

SECTION 1.5. Notwithstanding G.S. 58-50-280(a), individuals enrolling in the North Carolina Health Insurance Risk Pool within six months of the date that enrollment into the Pool first begins shall be subject to a six month preexisting condition waiting period.

SECTION 2. G.S. 58-6-25(d) is amended by adding the following new subdivision to read:

...

"(d) Use of Proceeds. – The Insurance Regulatory Fund is created in the State treasury, under the control of the Office of State Budget and Management. The proceeds of the charge levied in this section and all fees collected under Articles 69 through 71 of this Chapter and under Articles 9 and 9C of Chapter 143 of the General Statutes shall be credited to the 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 may be spent only pursuant to appropriation by the General Assembly and in accordance with the line item budget enacted by the General Assembly. The Fund is subject to the provisions of the Executive Budget Act, except that no unexpended surplus of the Fund shall revert to the General Fund. All money credited to the Fund shall be used to reimburse the General Fund for the following:

...

(6) Money appropriated to the Department of Insurance for the Special Reserve for the North Carolina Health Insurance Risk Pool."

SECTION 3.1. There is appropriated from the General Fund to the Department of Insurance the sum of $ for the 2006-2007 fiscal year. These funds shall be used to support # additional full-time positions in the Department to carry out the Department's responsibilities under the North Carolina Health Insurance Risk Pool.

SECTION 3.2. There is appropriated from the General Fund to the Department of Insurance the sum of two hundred thousand dollars ($200,000) for the 2006-2007 fiscal year. These funds shall be placed in a Special Reserve for the North Carolina Health Insurance Risk Pool in the Department of Insurance and shall be allocated for the reasonable expenses of the Board in conducting its duties under Section 1 of this act. The North Carolina Health Insurance Risk Pool shall not offer or provide coverage under Section 1 of this act until the effective date of an act of the General Assembly that establishes or approves a method or methods for financing the Pool as specified in this act.

SECTION 3.3. There is appropriated to the Special Reserve for the North Carolina Health Insurance Risk Pool the sum of $ for the 2006-2007 fiscal year. These funds shall be used to provide a premium subsidy on a sliding scale basis for individuals with incomes up to three hundred percent (300%) of the federal poverty guidelines who are participating in the North Carolina Health Insurance Risk Pool. The subsidy shall pay for ninety-five percent (95%) of the premium costs for individuals with incomes below one hundred percent (100%) of the federal poverty guidelines, to be phased out when a family's income reaches three hundred percent (300%) of the federal poverty guidelines, and will be based on the lowest cost plan offered through the High-Risk Pool. Individuals who are eligible for a federal premium subsidy under the Trade Adjustment Act (TAA) must apply for premium subsidy under that Act. The amount of the State premium subsidy, if any, shall be reduced by any federal premium subsidy provided. Funds appropriated under this section shall not revert to the General Fund but shall remain in the Special Reserve for the purposes specified in this section.

SECTION 4. Sections 3.1, 3.2, and 3.3 of this act become effective July 1, 2006. The remainder of this act is effective when it becomes law. Enrollment in the North Carolina Health Insurance Risk Pool shall commence no earlier than January 1, 2007.

ATTACHMENT III

HOUSE BILL 1895: Establish High-Risk Pool

BILL ANALYSIS

Committee:	House Insurance	**Date:**	May 22, 2006
Introduced by:	Reps. Insko, England, Nye, Wright	**Summary by:**	Ben Popkin
Version:	PCS to First Edition H1895-CSRD		Committee Counsel

SUMMARY: House Bill 1895 would establish the North Carolina Health Insurance Risk Pool, the purpose of which would be to enable individuals with high-risk health conditions to obtain health insurance at premium rates that are more affordable than currently available. Pool financing would be achieved through a combination of premiums, assessments, and State funds. House Bill 1895 is a recommendation of the House Select Committee on Health Care.

[As introduced, this bill was identical to S1681, as introduced by Sen. Purcell, which is currently in Senate Appropriations/Base Budget.]

Sections of the act appropriating funds to the Department of Insurance and to the Special Reserve for the North Carolina Health Insurance Risk Pool would become effective July 1, 2006. The remainder of the act would be effective when it becomes law and enrollment would commence no earlier than January 1, 2007.

The Proposed Committee Substitute to House Bill 1895 would implement the recommendations of the North Carolina Institute of Medicine Task Force on Covering the Uninsured, making the following changes to earlier drafts of this bill: Eligibility requirements – Reduce from two to one, the number of insurer refusals to issue similar coverage, the number of refusals to issue coverage unless at a rate exceeding the Pool rate, and the number of offers to issue insurance with a conditional rider excluding coverage of the high-risk condition. The PCS also provides a shortened preexisting condition waiting period of six months for individuals enrolling in the Pool within the first six months that enrollment is made available.

BILL ANALYSIS:

House Bill 1895 would create a new Part 7 of Article 50 of Chapter 58 of the General Statutes that would create the North Carolina Health Insurance Risk Pool. The Pool would be a nonprofit entity subject to oversight of the Board of Directors of the Pool and administered by one or more insurers or a third-party administrator selected by the Board through a competitive bidding process. The Pool would operate according to a Plan of Operation developed by the Board and approved by the Commissioner of Insurance.

Plan of Operation for the Pool – The act would specify the content of the Board of Directors' Plan of Operation for the Pool and would authorize the Pool to perform all functions necessary to establish and administer the Pool[1]. The Board would be required to submit a Plan of Operation for the Commissioner's approval and to submit an annual report to the Commissioner, to the Speaker of the House of Representatives, and to the President Pro Tempore of the Senate regarding earned premiums, plan enrollment, administrative expenses, and losses.

[1] Proposed G.S. 58-50-250.

Eligibility and Exclusions*[2]*:

- An individual who is a resident of the State would be eligible for Pool coverage if evidence is provided of:
  - a notice of rejection from an insurer to provide substantially similar health insurance because of the individual's health;
  - an offer to issue insurance only with a conditional rider limiting coverage of the individual's high-risk condition;
  - refusal by an insurer to issue insurance except at a rate exceeding the Pool rate;
  - a diagnosis of the individual with of one of the medical or health conditions listed by the Board;
  - the individual's maintenance of health insurance coverage under federal criteria without a significant break in coverage and the exhaustion of COBRA or state continuation benefits;
  - the individual's legal domicile in State and eligibility for health insurance costs under the Trade Adjustment Assistance Reform Act of 2002; or
  - the individual's status as a dependent of an individual eligible for Pool coverage.

- An individual would be excluded from Pool coverage if:
  - they have health insurance coverage substantially similar to that offered by Pool (with the exception of coverage during preexisting condition waiting period);
  - they are eligible for enrollment in the State Medical Assistance Plan;
  - they have terminated Pool coverage within the past 12 months;
  - they have reached the lifetime maximum benefit ceiling;
  - they are an inmate or resident of a public institution;
  - they have their premiums paid by a government-sponsored program or government agency or health care provider; or
  - they have health insurance coverage from an insurer or insurance arrangement on the date Pool coverage takes effect.

Pool Administration, Rates and Preexisting Conditions – The Board would select a Pool administrator through a competitive bidding process applying criteria set forth in statute and otherwise established by the Board[3]. The Pool would establish risk rates of 150% of rates established by other health insurers as applicable for individual standard risks[4]. The Pool would offer at least two types of coverage including preferred provider organizations with different deductible levels and cost sharing and at least one choice of a health savings account. At least two types of coverage must, at a minimum, provide benefits outlined in the National Association of Insurance Commissioners' Model Health Plan for Uninsurable Individuals Act and be consistent with comprehensive health insurance coverage generally available[5].

Insurance products offered by the Pool would include a lifetime benefit limit of not less than one million dollars and a sliding scale annual limit on out-of-pocket expenses (from two to five thousand dollars, based on family income) [6]. During the first 12 months of coverage, the Pool would not cover health

[2] Proposed G.S. 58-50-265.
[3] Proposed G.S. 58-50-255.
[4] Proposed G.S. 58-50-260.
[5] Proposed G.S. 58-50-275.
[6] Proposed G.S. 58-50-275(b).

conditions existing within 12 months prior to coverage (except for federally defined eligible individuals)[7]. For individuals enrolling into the Pool during the first six months that enrollment is made available, the preexisting condition waiting period would be reduced to six months. The Pool would allow for a waiver of exclusion where similar exclusions have been satisfied under another health insurance plan, and coverage lapsed for no more than 63 days and the applicant was ineligible for substantially similar continuation insurance.

Pool Financing, Complaint Procedures and Miscellaneous Provisions – The Board would assess member insurers in the amount deemed necessary to fulfill the Board's duties[8]. Each insurer's assessment would not exceed $2 per covered individual insured or reinsured by the insurer per month. $200,000 would be appropriated from the General Fund and placed in the Special Reserve for the North Carolina Health Insurance Risk Pool in the Department of Insurance for the 2006-2007 fiscal year to cover Board expenses conducting its duties under this act. A grievance committee appointed by the Board would review complaints against the Pool and report to the Board[9]. The State Auditor would conduct an annual special audit of the Pool[10]. The Pool would be exempt from taxation[11].

BACKGROUND:

In its 2006 Interim Report to the General Assembly, the House Select Committee on Health Care recommended that the General Assembly enact legislation to implement a health insurance high-risk pool to enable individuals with high-risk health conditions to obtain health insurance at premium rates that are more affordable than currently available. Both the Subcommittee on Access and the Subcommittee on Cost of Health Care and Health Insurance for Employees and Employers explored the issue of health insurance high-risk pools in detail. House Bill 1895 is the product of these efforts and was presented as Recommendation 2 of the Subcommittee on Access recommendations to the House Select Committee on Health Care.

The North Carolina Institute of Medicine, Task Force on Covering the Uninsured recently issued a final report addressing a range of issues relating to the uninsured population of this State, including high-risk pools. Recommendation 6.5 calls for the General Assembly to enact legislation to implement a high-risk pool. House Bill 1895 incorporates many of the details put forth in Recommendation 6.5.

Currently, 33 states have established or are establishing high-risk health insurance pools. The Federal Trade Act of 2002 provided for a federal grant of up to $1,000,000 to each state establishing new pools. This seed money went to the costs of creating the pool, not the actual financing of it. The act also provided for a matching federal grant of up to 50% of the losses incurred by a state in connection with the operation of the pool. $40,000,000 was appropriated for each fiscal year 2003 and 2004. In 2003, Congress passed legislation extending and providing addition federal funding through 2009.

EFFECTIVE DATE:

The act would become effective when it becomes law. Coverage under the North Carolina Health Insurance Risk Pool would only be offered upon passage of an act of the General Assembly establishing a method for financing the Pool, as specified in this act.

H1895e1-SMRD-CSRD

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[7] Proposed G.S. 58-50-280.
[8] Proposed G.S. 58-50-290.
[9] Proposed G.S. 58-50-295.
[10] Proposed G.S. 58-50-300.
[11] Proposed G.S. 58-50-305.

ATTACHMENT IV

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1895

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

H1895-ARD-38 [v.1]

Date _____,2006

Comm. Sub. [YES]
Amends Title [NO]
First Edition

Representative _____

moves to amend the bill on page 5, line 14 by deleting the word "Five" and substituting the word "Six";

and on page 5, lines 19-20, by rewriting the lines to read:

"c. Two who represent the medical provider community, one as recommended by the North Carolina Medical Society and one as recommended by the North Carolina Hospital Association.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____



Covering the Uninsured

Expanding Health Insurance Coverage to More North Carolinians

April 2006

Expanding Health Insurance Coverage to People with Pre-existing Health Problems

Individuals who have pre-existing health problems face significant barriers obtaining health insurance coverage in the nongroup market. In employer-sponsored plans, those with pre-existing health problems cannot be excluded from coverage or charged higher premiums. However, the same rules do not apply in the nongroup market.

Many insurance companies refuse to issue policies or limit coverage for people with pre-existing health problems in the nongroup market. For example, a national study conducted for the Kaiser Family Foundation found that 8% of insurers refused to issue a policy to a 24-year-old female with hay fever, and 55% refused to issue a policy to a 55-year-old, overweight, male smoker with high blood pressure.[1]

BlueCross BlueShield of North Carolina (BCBSNC) is the only insurer in the state to offer health insurance in the nongroup market on a guaranteed issue basis. Premiums vary, based on the age, geographic location, and health status of the individual. The premiums are established to cover the anticipated costs of care for people with pre-existing health problems. Since there are no other sources of payments for these individuals with high medical costs, premiums may be as much as seven times the standard rate charged to someone with average health risks. For example, nongroup health insurance coverage for a 35-year-old man with major health problems could cost more than $800/month (for a $1,000 deductible, 30% coinsurance plan), or more than $1,800/month for a 55-year-old man. Coverage for women is generally more expensive, especially if they want maternity coverage. *People with pre-existing health problems are most in need of health insurance to help pay for healthcare services, but the premiums needed to cover the costs of care often make this coverage unaffordable in the nongroup market.*

Thirty-three states have established high-risk pools to help spread the costs of providing insurance to people with significant pre-existing health problems.[2] Research suggests that about 1% of the population have difficulties obtaining insurance due to their health status. This population is often called the "medically uninsurable."[3] Experience from other states with high-risk pools suggest that 10%-30% of these individuals may enroll in a high-risk pool, depending on the premium price and whether the state offers additional subsidies for low-income people.[2]

States typically limit the maximum premium charged to medically uninsurable individuals to no more than 150% of the standard rate in order to make it more affordable. Some states provide a further subsidy to help lower-income individuals pay their premiums. The premiums paid do not cover the full cost of the claims incurred in these high-risk pools. Therefore, most states fund the deficits through an assessment on insurance companies, state appropriations, or other means.

The NC Institute of MedicineTask Force on Covering the Uninsured recommended that the NC General Assembly create a high-risk pool that limits premiums to 150% of the standard risk, so that more people with pre-existing health problems can afford coverage. Losses should be covered through an assessment on insurers, including traditional insurance companies, Health Maintenance Organizations (HMOs), Multiple Employer Welfare Arrangements (MEWAs), third party administrators, and stop-loss and reinsurance carriers.[4,2] Providers would be paid using Medicare payment rates, which are less than what is typically offered through commercial insurance. The General Assembly should also help subsidize premium costs for lower-income individuals.[5]

Federal funding is available to help defray some of the costs of the high-risk pool. Congress appropriated funds to provide start-up grants of up to $1 million for states that have not yet established a high-risk pool. In addition, Congress appropriated $75 million/year through 2010 to help offset some of the ongoing operational costs of state high-risk pools: 40% of the money will be distributed equally among states that operate high-risk pools, 30% based on the numbers of uninsured in the state, and 30% based on the number of participants in the state's high-risk pool.

References

1 Pollitz K, Sorian R, Thomas K. How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health? The Kaiser Family Foundation. Executive Summary. June 2001. Available at: http://www.kff.org/insurance/20010620a-index.cfm. Accessed April 11, 2006.

2 Abbe B. Overview: State High Risk Health Insurance Pools Today. Communicating for Agriculture and the Self-Employed. Available at: http://www.selfemployedcountry.org/riskpools/overview.html. Accessed December 6, 2005.

3 Conover C, Hall M. Assessment of Potential Impact on Accessibility and Affordability of Health Care. Section VIII. Potential Impact on Accessibility. Report submitted to the NC Department of Insurance. Available at: http://www.hpolicy.duke.edu/cyberexchange/Regulate/Redacted.pdf. Accessed March 17, 2006.

4 Twenty-seven states use an assessment on insurers to help fund the losses in the high-risk pool. Of this, 11 states provide full or partial tax credit offsets for the assessment, thereby shifting the costs back to the state (AL, AR, IN, IA, KS, MO, MT, NM, ND, SC, WY); another 11 states have no tax credit offset [AL, CT, FL, ID, IL for its HIPAA pool, KY (partial funding source), LA (only for its HIPAA pool), MN, OK, TX, WA]. Seven of the states have a broad assessments on insurers, including commercial insurance carriers, stop-loss, reinsurance carriers, and Third Party Administrators (TPA's) on a per-person/per-month basis (CO, IN, MS, NH, OR, SD, and WA). Two states pay for the high-risk pool through surcharge on hospital bills (MD, WV) and six states use general revenue or other sources of funding (CA, IL, KY, LA, NE, UT).

5 Seven states help subsidize the premium costs for lower-income individuals (CO, CT, MT, NM, OR, WA, WI).

This issue brief is one in a series, produced as part of North Carolina's "State Planning Grant" effort, led by the NC Department of Health and Human Services, to examine options to expand health insurance coverage to the uninsured. The State Planning Grant supported a Task Force on Covering the Uninsured, which brought together stakeholders from a variety of interest groups to examine these issues and develop a set of recommendations for improving healthcare coverage across the state. Collaborating organizations include: the NC Department of Insurance, Cecil G. Sheps Center for Health Services Research at The University of North Carolina at Chapel Hill, and North Carolina Institute of Medicine. The State Planning Grant was funded by the Health Resources and Services Administration of the US Department of Health and Human Services. For other issue briefs or a copy of the final report of the *NC IOM Task Force on Covering the Uninsured*, visit the NC IOM website at: http://www.nciom.org.

For more information contact: Pam Silberman, JD, DrPH, President & CEO or Mark Holmes, PhD, Vice President. North Carolina Institute of Medicine. 5501 Fortunes Ridge Drive, Suite E, Durham, NC 27713. 919-401-6599 Email at:pam_silberman@nciom.org or mark_holmes@nciom.org. www.nciom.org.

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 6, 2006

The House Committee on Insurance met at 11:00 AM on Thursday, June 6, 2006 in Room 1228. The following Representatives in attendance were: Chairman H. Holliman, Vice Chairs: B. Faison and Ed Jones Members: L. Allen, C. Allred, D. Almond, J. Barnhart, H. Brubaker, , W. Current, R. Grady, J. Howard, Ross, D. Saunders, F. Steen, R. Sutton, and T. Wright.

Chairman Holliman welcomed visitors, House pages and Sgt-At-Arms and Visitors. See Attachment I.

Rep. Holliman asked for a motion to approve committee minutes from May 23, 2006 meeting. Rep. Wright made the motion and the motion passed.

Rep. Holliman introduced Mark Holmes, NC Institute of Medicine to speak on HB 1895 Establish High Risk Pool. Mr. Holmes shared an overview of recommendations through a power point presentation and outlined the bill. See Attachment II.

Rep. Insko, sponsor of HB 1895 was asked to answer questions from the committee. Ben Popkin, Staff Attorney explained how the new PCS reflects changes from the original bill. After much discussion, Rep. Holliman asked for a vote to remove Section 2.3 page 13 of the bill. The committee voted unanimously to remove that section on state subsidy. See Attachment III

Dave Nance, NC State Auditor's office was asked to speak on the involvement of the auditor in this legislation. Mr. Nance spoke to Section 1.1 page 12 part 58-50-300. He explained that a performance audit generally takes place as needed rather than on an annually basis. Rep. Ross and Rep Insko asked that audits be conducted every two years for the first four years of the program and as needed after that and asked staff to include language to that effect in the next draft of the bill.

Chairman Holliman announced the committee would meet on Thursday, June 8. The meeting adjourned at 11:55

Representative. L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

HOUSE INSURANCE COMMITTEE

June 6, 2006
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

HB - Establish High-Risk Pool. **Representative Insko**

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: THURSDAY, JUNE 1, 2006

TIME: 11:00 AM

LOCATION: 1228 LB

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 1895 – Establish High-Risk Pool – Rep. Insko

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 9:45 AM on May 24, 2005.

___Principal Clerk
___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

TOMORROW'S MEETING CANCELLED RESCHEDULE FOR TUESDAY, JUNE 6

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: TUESDAY, JUNE 6, 2006

TIME: 11:00 AM

LOCATION: 1228 LB

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 1895 – Establish High-Risk Pool – Rep. Insko

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 9:45 AM on May 24, 2005.

X ___Principal Clerk
X ___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

ATTACHMENT 1

House Pages

Name Of Committee: INSURANCE Date: 6-6-06

1. Name: Tremaine Williams
   County: Halifax
   Sponsor: Edward Jones
2. Name: Tayler Cave
   County: Davie
   Sponsor: Rep. Howard
3. Name: Laura Vanover
   County: Davie
   Sponsor: Rep. Howard
4. Name: _____
   County: _____
   Sponsor: _____
5. Name: _____
   County: _____
   Sponsor: _____

Sgt-At-Arms

1. Name: Martha Gadison
2. Name: Charles Williams
3. Name: _____
4. Name: _____
5. Name: _____

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — June 6, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	STATE AUDITOR
Abby Emanuel	Nat'l MS Society
Jeff Wolfe	Daily Bulletin
David Smith	NAMI-Durham
Barbara Brooks Burke	NCDOI
Susie Cunningham	NCMS
	NCMS
	NCAHP
	BCBSNC
	AARP
	AARP-NC

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — June 6, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Aaron Augustino	NCIOM intern
Natasha Harrison	NCIOM (intern)
Ed Turlington	BP
Jeff Drozda	USIC
Jamie Druett	JD, AC, PA
John Bowdish	AstraZeneca
Brian Shank	AstraZeneca
Lori Ann Harris	NAIFA
[illegible]	NCALA
Josh Otto	Poyner & Spruill LLP
David Barnes	Poyner Spruill

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — June 6, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Martha Jo McConnell	Carolinas HealthCare System
Lauralyn Hawkins	DHHS
Roger Bone	Bone McAllister,
J. Craig	DHHS

ATTACHMENT 11

NC IOM Task Force on Covering the Uninsured: *High Risk Pool*

Presentation to: House Insurance Committee
Mark Holmes, PhD
Vice President
NC Institute of Medicine
6 June 2006
mark_holmes@nciom.org

Overview of Presentation

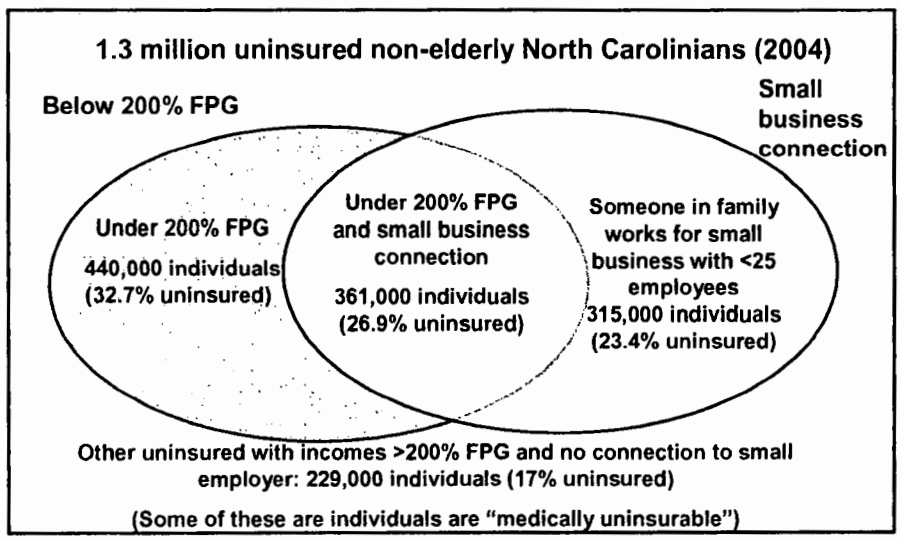
- Brief overview of the uninsured
- High Risk Pool ("HRP")

Changes in Health Insurance Coverage (NC): 2000-2004

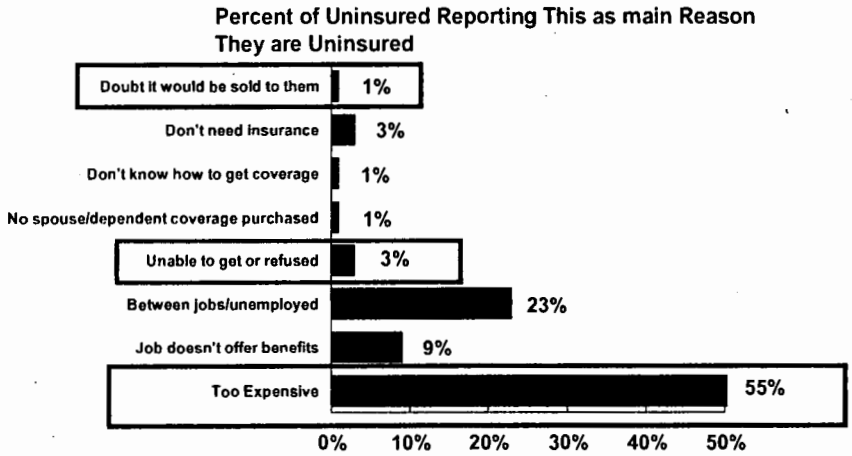
- More than 1.3 million nonelderly (18%) were uninsured in NC in 2004.
- Between 1999-2000 and 2003-04:
  - North Carolina experienced larger increase in the percentage of nonelderly who were uninsured than nationally (NC: 15%, US: 10% increase)
  - A greater percentage of North Carolinians lost employer-sponsored insurance than nationally (NC: 9%, US: 6% decrease)

Uninsured in North Carolina:

Primarily Low Income or Connected to Small Firm



Primary Reason for Not Having Health Insurance, NC, 2005



Source: State Center for Health Statistics. Behavioral Health Risk Factor Surveillance Survey. NC Department of Health and Human Services.

Coverage for People with Pre-existing Health Problems

- National estimates suggest that approximately 1% of population is medically uninsurable
- BCBSNC is the only insurer to voluntarily offer health insurance coverage to any individual, regardless of health status
- People with preexisting health problems most in need of health insurance to pay for care, but premiums make this coverage unaffordable in the non-group market

Coverage for People with Pre-existing Health Problems

- 33 other states have high-risk pools to help subsidize the costs of insurance provided to high-cost individuals
- Federal funds are available to help support high-risk pool (part of the Deficit Reduction Act)
  - Congress appropriated $15 million for FFY 2006 (up to $1 million per state) to help states establish high-risk pools
  - Congress appropriated $75 million through 2010 to help offset ongoing operational costs

NCIOM Task Force on Covering the Uninsured

- Co-Chairs:
  - Secretary Carmen Hooker Odom, Tom Lambeth
- Task Force members
  - 55 members representing legislators, county commissioners, hospitals, physicians, insurers, large and small businesses, consumer groups, faith community
- Five priority recommendations, including High Risk Pool
- NCIOM recommended design of HRP very similar to current H1895

Eligibility

- To be eligible for HRP, individuals must have
  - Received rejection/refusal to issue/ conditional riders / rate exceeds HRP rate from two insurers OR
  - Been diagnosed with certain medical conditions OR
  - Deemed eligible for HIPAA guarantee issue or Trade Adjustment Act (TAA) OR
  - Be a dependent of an HRP eligible
- AND NOT
  - Be currently insured OR
  - Eligible for Medicaid OR
  - Have premiums paid by gov't agency (except TAA)

Pool Design

- Premiums capped at no more than 150% of standard risk
  - Discounts provided for nonsmokers or people actively participating in smoking cessation program
- Plan options include at least one PPO and at least one HSA
  - Benefits and services conform to NAIC model
  - No less than $1 million lifetime, limits on cost-sharing
  - Products include disease and/or case management to help individuals with chronic and/or complex health problems manage their health conditions.
- Additional premium subsidy for individuals with incomes below 300% of the federal poverty guidelines

Premiums

- Cap on premium
  - Cap at 150% standard risk
  - The majority of other states have caps at or below 150% standard risk
- Additional premium subsidy
  - NCIOM recommended sliding scale premium subsidy for individuals with incomes <300% FPG
  - Seven states help subsidize the premium for lower-income individuals: CO, CT, MT, NM, OR, WA, WI
  - These states generally have higher participation (as percentage of state population)

Financing

- Federal grant funds can be used to defray some of the pool losses
  - Up to $1 million available to states to assist with startup
  - Additional funds available to offset part of pool losses
- Assessment no more than $2 / covered life / month
  - Broad-based assessment: Applies to commercial insurers, BCBSNC, third party administrators, reinsurers, multiple employer welfare arrangements, etc.
  - Roughly 5 million privately covered lives => $125 million total
  - *Note: the NC IOM did not recommend a specific monthly assessment amount*
- Providers reimbursed at Medicare rates
  - Would lead to an approximate 15% reduction in provider reimbursement from commercial PPO rates (averaged across hospitals, physicians and pharmacy)

Premium Subsidy

- Sliding scale premium subsidy: 100% FPG (95% subsidy) to 300% FPG (0% subsidy)
  - Increase enrollment in HRP
- Estimated cost of premium subsidy: ≈$1800 per enrollee => $33m for 18,000 enrollees
  - Based on estimated distribution of HRP enrollees

Cost estimates

in millions of dollars
(with assistance of BCBSNC)

	No Prem. Subsidy	Prem. Subsidy
Providers	10	20
Households	32.4	31.6
State Approp.	0	33.2
Insurers (Assessed)	30	60

- Some of these costs could be covered through available federal funds
- State cost does not include insurer assessment
- Does not include household cost-sharing (deductibles, copayments)

Everyone Will Gain If More North Carolinians Have Insurance

- Workers who are unhealthy are less productive.
- Children who are sick are less able to concentrate on their school work.
- Healthcare providers are under financial stress trying to care for the increasing numbers of uninsured
- Covering more uninsured should help moderate the costs of health insurance coverage for those with insurance

For More Information

- Final report of the NC IOM Covering the Uninsured Task Force available on the NC IOM website at: http://www.nciom.org, along with fact sheet on HRP
- Pam Silberman, JD, DrPH, President & CEO, NC IOM: pam_silberman@nciom.org
- Mark Holmes, PhD, Vice President, NC IOM mark_holmes@nciom.org
- Phone: 919-401-6599



ATTACHMENT III

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

HOUSE BILL 1895
PROPOSED COMMITTEE SUBSTITUTE H1895-CSRD-39 [v.7]

6/5/2006 3:25:30 PM

Short Title: Establish High-Risk Pool. (Public)

Sponsors:

Referred to:

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE NORTH CAROLINA HEALTH INSURANCE RISK POOL AND TO APPROPRIATE FUNDS THEREFOR.

The General Assembly of North Carolina enacts:

SECTION 1.1. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 7. North Carolina Health Insurance Risk Pool.

"**§ 58-50-245. Definitions.**

For the purposes of this Part:

(1) "Administrator" means the Pool Administrator selected by the Board in accordance with this Part.

(2) "Benefit plan" means coverage offered by the Pool to eligible individuals.

(3) "Board" means the Board of Directors of the Pool.

(4) "Covered person" means any individual resident of this State, excluding dependents, who is eligible to receive health benefits from any insurer.

(5) "Church plan" has the meaning given that term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(6) "Creditable coverage" has the same meaning as prescribed in G.S. 58-68-30(c)(1).

(7) "Dependent" means a resident spouse or unmarried child under the age of 19 years, a child who is a full-time student under the age of 23 years and who is financially dependent upon the parent, a child who is over 18 years of age and for whom a person may be obligated to pay child support, or a child of any age who is disabled and dependent upon the parent.

(8) "Family member" means a parent, grandparent, brother, sister, or child of a dependent residing with the insured.

(9) "Federally defined eligible individual" has the same meaning as "eligible individual" as prescribed in G.S. 58-68-60(b).

(10) "Governmental plan" has the same meaning as prescribed in G.S. 58-68-60(h)(2).

(11) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, including items and services paid for as medical care to employees or their dependents, as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(12) "Health insurance coverage" shall have the same meaning as prescribed in G.S. 58-68-25(a)(5). Health insurance coverage does not include benefits described in G.S. 58-68-25(b).

(13) "Insurance arrangement" means a plan, program, contract, or other arrangement through which health care services are provided by an employer to its officers or employees, but does not include health care services covered through an insurer.

(14) "Insured" means an individual who is eligible to receive benefits from the Pool. The term "insured" includes dependents and family members, as applicable.

(15) "Insurer" means any entity that provides health insurance coverage in this State. For the purposes of this Part, insurer includes an insurance company, a hospital or medical service corporation, a health maintenance organization, a multiple employer welfare arrangement, a third-party administrator or claims processor, an administrative service organization, or any other nongovernmental entity providing a health benefit plan subject to State insurance regulation.

(16) "Medical care" means amounts paid for:

a. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

b. Transportation primarily for and essential to medical care referred to in sub-subdivision a. of this subdivision; and

c. Insurance covering medical care referred to in sub-subdivisions a. and b. of this subdivision.

(17) "Plan of operation" means the articles, bylaws, and operating rules and procedures adopted by the Board in accordance with this Part.

(18) "Pool" means the North Carolina Health Insurance Risk Pool.

(19) "Resident" means an individual who:

a. Has been legally domiciled in this State for a period of at least 30 days, except that for a federally defined eligible individual, there shall not be a 30-day requirement;

b. Is legally domiciled in this State on the date of application to the Pool and who is eligible for enrollment in the Pool as a result of the Health Insurance Portability and Accountability Act of 1996; or

c. Is legally domiciled in this State on the date of application to the Pool and is eligible for the credit for health insurance costs under section 35 of the Internal Revenue Code of 1986.

(20) "Significant break in coverage" means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

(21) "Trade Adjustment Assistance Program" (TAA) means Title II of the Trade Act of 2002, P.L. 107-210.

"**§ 58-50-250. Risk Pool established; board of directors; plan of operation.**

(a) High-Risk Pool Established. – There is hereby created a nonprofit entity to be known as the North Carolina Health Insurance Risk Pool. The Pool shall operate under the supervision and control of the Board of Directors of the Pool.

(b) Board of Directors Appointment; Membership. – The Board of Directors of the North Carolina Health Insurance Risk Pool shall consist of the Commissioner of Insurance, who shall serve as an ex officio nonvoting member of the Board, and nine members appointed as follows:

(1) Three members of the general public who are not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, and can reasonably be expected to qualify for coverage in the Pool. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member. The three members of the general public shall be appointed as follows:

a. One member upon the recommendation of the Governor.

b. One member upon the recommendation of the President Pro Tempore of the Senate.

c. One member upon the recommendation of the Speaker of the House of Representatives.

(2) Six members appointed by the Commissioner of Insurance, as follows:

a. Two who are insurers, at least one of whom covers the largest number of persons in the State.

b. One who is licensed to sell health insurance in this State.

c. Two who represent the medical provider community, one as recommended by the North Carolina Medical Society and one as recommended by the North Carolina Hospital Association.

d. One who represents small business, as recommended by the North Carolina Citizens for Business and Industry.

(c) Board of Directors; Terms of Appointment; Vacancies; Compensation. – The initial Board members shall be appointed as follows: two of the members to serve a

term of three years; three of the members to serve a term of one year; and two of the members to serve a term of two years. Subsequent Board members shall serve for terms of three years. A Board member's term shall continue until the member's successor is appointed. The Commissioner shall appoint a chair to serve for the initial two years of the Plan's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms. The Commissioner shall fill vacancies in membership and may remove members from the Board for cause. Board members shall not be compensated in their capacity as Board members but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties.

(d) Plan of Operation. – The Board shall submit to the Commissioner a Plan of Operation for the Pool and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Plan of Operation. The Plan of Operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this Part must be made available. If the Board fails to submit a suitable Plan of Operation within 180 days after the appointment of the Board of Directors, or at any time thereafter fails to submit suitable amendments to the Plan of Operation, the Commissioner shall adopt temporary rules necessary or advisable to effectuate the provisions of this section. The rules shall continue in force until modified by the Commissioner or superseded by a Plan of Operation submitted by the Board and approved by the Commissioner. The Plan of Operation shall:

(1) Establish procedures for operation of the Pool.

(2) Establish procedures for selecting a Pool Administrator in accordance with G.S. 58-50-255.

(3) Establish procedures to create a fund for administrative expenses, which shall be managed by the Board.

(4) Establish procedures for the collection, handling, disbursing, accounting, assessing and auditing of assets, monies, and claims of the Pool and the Pool Administrator.

(5) Develop and implement a program to publicize the existence of the Pool, the eligibility requirements, and procedures for enrollment, availability of State premium subsidies, and to maintain public awareness of the Pool.

(6) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the Board in accordance with G.S. 58-50-295.

(7) Establish procedures for identifying and confirming income levels of applicants for Pool coverage who are eligible to receive a State premium subsidy, if a State premium subsidy is available.

(8) Provide for other matters as may be necessary and proper for the execution of the Board's powers, duties, and obligations under this Part.

(e) The Pool shall have the general powers and authority granted under the laws of this State to health insurers and the specific authority to do all of the following:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Part, including the authority, with the approval of the Commissioner, to enter into contracts with similar plans of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions.

(2) Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the Pool.

(3) Take legal action as necessary to:

a. Avoid the payment of improper claims against the Pool or the coverage provided by or through the Plan.

b. Recover any amounts erroneously or improperly paid by the Plan.

c. Recover any amounts paid by the Pool as a result of mistake of fact or law.

d. Recover other amounts due the Pool.

(4) Establish rates and rate schedules in accordance with this Part.

(5) Issue policies of insurance in accordance with the requirements of this Part.

(6) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the Pool, policy, and other contract design, and any other function within the Pool's authority.

(7) Borrow money to effect the purposes of the Pool. Any notes or other evidence of indebtedness of the Pool not in default are legal investments for insurers and may be carried as admitted assets.

(8) Establish policies, conditions, and procedures for reinsuring risks of participating insurers desiring to issue Pool coverage in their own name. Provision of reinsurance shall not subject the Pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

(9) Employ and fix the compensation of employees.

(10) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public.

(11) Provide for reinsurance of risks incurred by the Pool.

(12) Issue additional types of health insurance policies to provide optional coverage, including Medicare supplemental insurance coverage.

(13) Provide for and employ cost containment measures and requirements including preadmission screening, second surgical opinion, concurrent utilization review, disease management, individual case management, and other commonly used benefit plan design features for the purpose of making health insurance coverage offered by the Pool more cost-effective.

(14) Design, utilize, contract, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

(15) Adopt bylaws, policies, and procedures as may be necessary or convenient for the implementation of this Part and the operation of the Pool.

(f) The Board shall operate the Pool in a manner so that the estimated cost of providing health insurance coverage during any fiscal year will not exceed the total income the Pool expects to receive from policy premiums and other revenue available to the Pool. The financing mechanisms recommended to and approved by the General Assembly shall provide for a means to adjust those mechanisms annually, or more frequently if necessary, in order to assure that the Pool has the financial capacity to insure the projected number of enrollees.

(g) The Board shall make an annual report to the Commissioner, to the Speaker of the House of Representatives, and to the President Pro Tempore of the Senate. The report shall summarize the activities of the Pool in the preceding calendar year, including the net written and earned premiums, benefit plan enrollment, the expense of administration, and the paid and incurred losses.

(h) Neither the Board nor its employees are liable for any obligations of the Pool. No current or former member or employee of the Board is liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this Part, unless such act or omission constitutes willful or wanton misconduct. The Board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

(i) The members of the Board shall comply with the provisions of G.S. 14-234 prohibiting conflicts of interest.

"**§ 58-50-255. Administrator.**

(a) The Board shall select through a competitive bidding process one or more authorized insurers or a third-party administrator to administer the Pool. The Board shall evaluate bids submitted based on criteria established by the Board. The criteria shall allow for the comparison of information about each bidding administrator and selection of a Pool Administrator based on at least the following:

(1) Proven ability to handle health insurance coverage to individuals.

(2) Efficiency and timeliness of the claim processing procedures.

(3) Estimated total charges for administering the Pool.

(4) Ability to apply effective cost containment programs and procedures and to administer the Pool in a cost-efficient manner.

(5) Financial condition and stability.

If a member of the Board has submitted a bid to be selected by the Board as Pool Administrator, that bidding member of the Board shall not participate in the selection process or in the Board's final decision on the selection of the Administrator.

(b) The Administrator shall serve for a period specified in the contract between the Pool and the Administrator subject to removal for cause and subject to any terms,

conditions, and limitations of the contract between the Pool and the Administrator. At least one year before the expiration of each period of service by an Administrator, the Board shall invite eligible entities, including the current Administrator, to submit bids to serve as the Administrator. Selection of the Administrator for the succeeding period shall be made at least six months before the end of the current period.

(c) The Administrator shall perform such functions relating to the Pool as may be assigned to it, including:

(1) Determination of eligibility.

(2) Payment of claims.

(3) Establishment of a premium billing procedure for collection of premiums from individuals covered under the Pool.

(4) Other necessary functions to assure timely payment of benefits to covered persons under the Pool.

(d) The Administrator shall submit regular reports to the Board regarding the operation of the Pool. The contract between the Board and the Administrator shall specify the frequency, content, and form of the report.

(e) Following the close of each calendar year, the Administrator shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the Board and the Commissioner on a form prescribed by the Commissioner.

(f) The Administrator shall be paid as provided in the contract between the Board and the Administrator.

"**§ 58-50-260. Risk Pool rates.**

(a) The Pool shall adopt and modify, as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of the Pool. Rates and rate schedules may be adjusted for appropriate factors such as age, sex, and geographic variation in claim cost and shall take into consideration appropriate rating factors in accordance with established actuarial and underwriting practices.

(b) The Pool shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for the coverage. Pool rates shall be one hundred fifty percent (150%) of rates established as applicable for individual standard rates.

(c) The Pool shall provide for premium discounts for covered individuals who are nonsmokers or who are actively participating in a smoking cessation program. Approval of smoking cessation programs, criteria for active participation in smoking cessation programs, and discount rates shall be established by the Board, subject to the approval of the Commissioner.

(d) Provider reimbursement rates under Pool coverage shall be limited to the rates allowed for providers under the Medicare Program.

(e) The Pool shall submit all rates and rate schedules and amendments thereto the Commissioner for approval, and the Commissioner must approve the rates and rate

schedules before the Pool may use them. The Commissioner, in evaluating the rates and rate schedules, shall consider the factors provided in this section.

"**§ 58-50-265. Eligibility for Pool coverage.**

(a) Any individual who is and continues to be a resident of this State is eligible for Pool coverage if evidence is provided of:

(1) A notice of rejection or refusal to issue substantially similar health insurance coverage for health reasons by an insurer. A rejection or refusal by an insurer offering only stop-loss, excess loss, or reinsurance coverage with respect to the applicant is not sufficient evidence of eligibility;

(2) An offer to issue health insurance coverage only with a conditional rider that limits coverage for the individual's high-risk medical condition;

(3) A refusal by an insurer to issue health insurance coverage except at a rate exceeding the Pool rate;

(4) A diagnosis of the individual with one of the medical or health conditions listed by the Board in accordance with this section. An individual diagnosed with one or more of these conditions is eligible for Pool coverage without applying for other health insurance coverage;

(5) In the case of a federally defined eligible individual, the individual's maintenance of health insurance coverage, of which the most recent coverage was through an employer-sponsored plan, for the previous 18 months with no gap in coverage greater than 63 days and exhaustion of any available COBRA or State continuation benefits; or

(6) An individual who is legally domiciled in this State and is eligible for the credit for health insurance costs under the Trade Adjustment Assistance Reform Act of 2002, section 35 of the Internal Revenue Code of 1986.

(b) The Board shall adopt a list of medical or health conditions for which a person shall be eligible for Pool coverage without applying for health insurance pursuant to subsection (a) of this section. The Board may amend the list as the Board considers appropriate.

(c) Each dependent of an individual who is eligible for Pool coverage shall also be eligible for Pool coverage.

(d) An individual is not eligible for coverage under the Pool if:

(1) The individual has or obtains health insurance coverage substantially similar to or more comprehensive than a Pool policy, or would be eligible to have coverage if the person elected to obtain it, except that:

a. An individual may maintain other coverage for the period of time the individual is satisfying any preexisting condition waiting period under a Pool policy; and

b. An individual may maintain Pool coverage for the period of time the individual is satisfying a preexisting condition waiting

period under another health insurance policy intended to replace the Pool policy.

(2) The individual is determined to be eligible for enrollment in the State Medical Assistance Plan.

(3) The individual has previously terminated Pool coverage unless 12 months have lapsed since the termination, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual or to an applicant eligible for or receiving benefits under the Trade Adjustment Assistance Program.

(4) The individual is an inmate or resident of a public institution, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual.

(5) The individual's premiums are paid for or reimbursed under any government-sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider. This subdivision shall not apply for individuals receiving benefits under the Trade Adjustment Assistance Program or to individuals receiving premium subsidies made available by the State based on individual income levels.

(6) The individual has in effect on the date Pool coverage takes effect health insurance coverage from an insurer or insurance arrangement.

(e) Coverage under the Pool shall cease:

(1) On the date an individual is no longer a resident of this State.

(2) On the date an individual requests coverage to end.

(3) Upon the death of the covered individual.

(4) On the date State law requires cancellation of the Pool policy.

(5) At the option of the Pool, 30 days after the Pool makes any inquiry concerning the individual's eligibility or residence to which the individual does not reply.

(6) Because the individual has failed to make the payments required under this Part.

(f) Except as provided in subsection (e) of this section, an individual who ceases to meet the eligibility requirements of this section may be terminated at the end of the Pool period for which the necessary premiums have been paid.

"**§ 58-50-270. Unfair referral to Pool.**

It is an unfair trade practice under Article 63 of this Chapter for an insurer, insurance producer, as defined in G.S. 58-33-10(7), or third-party administrator to refer an individual employee to the Pool or arrange for an individual employee to apply to the Pool for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment, or for the purpose of separating an individual covered by health insurance offered in the individual market.

"**§ 58-50-275. Minimum Pool benefits.**

(a) The Pool shall offer at least two types of health insurance coverage for individuals eligible under G.S. 58-50-265, including preferred provider organizations with different levels of deductibles and cost-sharing, and at least one choice of a health savings account. The covered services and benefit levels may vary between the types of coverage, but at least two types of coverage must, at a minimum, cover the benefits and services outlined in the National Association of Insurance Commissioners' Model Health Pool for Uninsurable Individuals Act and be consistent with comprehensive coverage generally available to persons who are eligible for health insurance other than Medicare. All health insurance products offered by the Pool shall include disease or case management services.

(b) Health insurance products offered by the Pool shall include not less than one million dollars ($1,000,000) lifetime limit and a sliding scale annual limit of two thousand dollars ($2,000) to five thousand dollars ($5,000) on out-of-pocket expenses. The sliding scale shall be based on family income. The Board shall adjust limitations at least once every five years to reflect changes in the medical component of the Consumer Price Index.

"**§ 58-50-280. Preexisting conditions.**

(a) Except as otherwise provided by law, pool coverage shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage as to any condition for which medical advice, care, or treatment was recommended or received as to such conditions during the 12-month period immediately preceding the effective date of coverage, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual.

(b) Subject to subsection (a) of this section, the preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage that was involuntarily terminated, provided that:

(1) Application for Pool coverage is made not later than 63 days following the involuntary termination, and in such case coverage in the Pool shall be effective from the date on which the prior coverage was terminated; and

(2) The applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to Pool coverage.

"**§ 58-50-285. Nonduplication of benefits.**

(a) The Pool shall be payor of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under coverage shall be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or no-fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any State or federal law or program.

(b) The Pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due

from the Pool may be reduced or refused as a setoff against any amount recoverable under this subsection.

"**§ 58-50-290. Assessments.**

(a) For the purposes of providing the funds necessary to carry out the powers and duties of the Pool, the Board shall assess all insurers at such time and for such amounts as the Board finds necessary. Assessments shall be due in not less than 30 days after prior written notice to the insurers and shall accrue interest at twelve percent (12%) per annum on and after the due date.

(b) Each insurer shall be assessed in an amount not to exceed two dollars ($2.00) per covered individual insured or reinsured by each insurer per month. The assessment will be based on actual and expected losses, actuarially appropriate reserves, and administrative expenses in excess of expected and collected premiums and federal loss reimbursements, if any, received by the Pool.

(c) The Board shall make reasonable efforts designed to ensure that each covered individual is counted only once with respect to any assessment. For that purpose, the Board shall require each insurer that obtains excess or stop-loss insurance to include in its count of covered individuals all individuals whose coverage is insured (including by way of excess or stop-loss coverage) in whole or in part. The Board shall allow a reinsurer to exclude from its number of covered individuals those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop-loss insurer for the purposes of determining its assessment under this section.

(d) The Board may verify each insurer's assessment based on annual statements and other reports deemed to be necessary by the Board. The Board may use any reasonable method of estimating the number of covered individuals of an insurer if the specific number is unknown.

(e) If assessments and other receipts by the Pool, Board, or administering insurer exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the Board to offset future losses or to reduce plan premiums. Future losses include reserves for claims incurred but not reported.

(f) The Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any insurer that fails to pay an assessment. As an alternative, the Commissioner may levy a forfeiture on any insurer that fails to pay an assessment when due. The forfeiture may not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100.00) per month.

"**§ 58-50-295. Complaint procedures.**

An applicant or participant in coverage from the Pool is entitled to have complaints against the Pool reviewed by a grievance committee appointed by the Board. Members of the Board shall not serve on the grievance committee. The grievance process shall comply with G.S. 58-50-62. The grievance committee shall report to the Board after completion of the review of each complaint. The Board shall retain all written complaints regarding the Pool at least until the third anniversary of the date the Pool received the complaint. An applicant or participant may file for external review of the applicant's grievance after having exhausted the Pool's internal grievance procedure.

External review, including eligibility determinations, shall be conducted in accordance with Part 4 of this Article.

"**§ 58-50-300. Audit.**

Every two years the State Auditor shall conduct a special audit of the Pool which shall include a financial audit and an economic and efficiency audit. Funds to cover the cost of the audit shall be paid from the Special Reserve for the North Carolina Health Insurance Risk Pool.

"**§ 58-50-305. Taxation.**

The Pool established under this Part is exempt from any and all taxes.

"**§ 58-50-310. Rules.**

The Commissioner may adopt rules, including temporary rules, to implement this Part.

"**§ 58-50-315. Collective action.**

The establishment of rates, forms, or procedures, and any other joint or collective action required by this Part may not be the basis of any legal action or criminal or civil liability or penalty against the Pool or any insurer."

SECTION 1.2. The Board of Directors of the North Carolina Health Insurance Risk Pool, as appointed under Section 1 of this act, shall monitor methods of financing the Pool to ensure a stable funding source and allow for its continued operation. This monitoring shall include supplementary sources of funding, such as funds obtained from public and private not-for-profit foundations, insurer assessments, or other appropriate and available State or non-State funds. The Board shall also review on a regular basis:

(1) The number of individuals in this State who are uninsured as of a date certain because of high-risk conditions.

(2) The number of uninsured individuals who would qualify for coverage under the Pool based on G.S. 58-50-265 and its Plan of Operation.

(3) The cost of coverage under each of the health insurance plans developed by the Board, including administrative costs.

(4) The extent to which assessments meet or exceed amounts necessary for coverage and Board operations.

(5) The status of a request by the State to the Centers for Medicare and Medicaid Services for approval of the North Carolina Health Insurance Risk Pool to be considered an acceptable "alternative mechanism" under the federal Health Insurance Portability and Accountability Act in accordance with 45 CFR 148.128(e).

The Board shall report its findings and recommendations to the General Assembly on March 1, 2007, and annually thereafter.

SECTION 1.3. The North Carolina Health Insurance Risk Pool Administrator shall study methods for encouraging healthy behaviors and report its findings to the Board of Directors of the Pool and to the General Assembly not later than one year after initial implementation of the Pool.

SECTION 1.4. The Board of Directors of the Pool shall apply for grant funds available from the federal government to help support the implementation and

ongoing costs of operating a high-risk pool. If federal funds are available for purposes for which funds were appropriated in this act from the General Fund, such federal funds shall be used to reimburse the General Fund, to the maximum extent allowable, for amounts appropriated for this purpose.

SECTION 1.5. Notwithstanding G.S. 58-50-280(a), individuals enrolling in the North Carolina Health Insurance Risk Pool within six months of the date that enrollment into the Pool first begins shall be subject to a six month preexisting condition waiting period.

SECTION 2.1. There is appropriated from the General Fund to the Department of Insurance the sum of $78,919 for the 2006-2007 fiscal year. These funds shall be used to support one additional full-time position in the Department to carry out the Department's responsibilities under the North Carolina Health Insurance Risk Pool. It is the intent of the General Assembly that funding for this purpose shall become of the continuation budget of the Department of Insurance.

SECTION 2.2. There is appropriated from the General Fund to the Department of Insurance the sum of one million dollars ($1,000,000) for the 2006-2007 fiscal year. These funds shall be placed in a Special Reserve for the North Carolina Health Insurance Risk Pool in the Department of Insurance and shall be allocated for the reasonable expenses of the Board in conducting its duties under Section 1 of this act that are incurred on or before July 1, 2008. The Special Reserve is subject to the to the Executive Budget Act, except that Article 3C of Chapter 143 of the General Statutes does not apply to G.S. 58-50-250(e).

SECTION 2.3. There is appropriated to the Premium Subsidy Fund for the North Carolina Health Insurance Risk Pool the sum of $ for the 2006-2007 fiscal year. These funds shall be used to provide a premium subsidy on a sliding scale basis for individuals with incomes up to three hundred percent (300%) of the federal poverty guidelines who are participating in the North Carolina Health Insurance Risk Pool. The subsidy shall pay for ninety-five percent (95%) of the premium costs for individuals with incomes below one hundred percent (100%) of the federal poverty guidelines, to be phased out when a family's income reaches three hundred percent (300%) of the federal poverty guidelines, and will be based on the lowest cost plan offered through the High-Risk Pool. Individuals who are eligible for a federal premium subsidy under the Trade Adjustment Act (TAA) must apply for premium subsidy under that Act. The amount of the State premium subsidy, if any, shall be reduced by any federal premium subsidy provided. Funds appropriated under this section shall not revert to the General Fund but shall remain in the Special Reserve and the Premium Subsidy Fund for the purposes specified in this section.

SECTION 4. Sections 2.1, 2.2, and 2.3 of this act become effective July 1, 2006. The remainder of this act is effective when it becomes law. Enrollment in the North Carolina Health Insurance Risk Pool shall commence no later than January 1, 2008.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

III

EDITION No. _____

H. B. No. 1895 (PCS v. 7) DATE 6-6-06

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
) Ross
Sen.)

1 moves to amend the bill on page 13, line s 23-37

2 ( ) WHICH CHANGES THE TITLE

3 by deleting those lines;

4

5 and by renumbering the remaining sections

6 ~~accordingly~~ accordingly.

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SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)



Fact Sheet

Expanding Health Insurance Coverage to More North Carolinians

April 2006

Expanding Health Insurance Coverage to People with Pre-existing Health Problems

Individuals who have pre-existing health problems face significant barriers obtaining health insurance coverage in the nongroup market. In employer-sponsored plans, those with pre-existing health problems cannot be excluded from coverage or charged higher premiums. However, the same rules do not apply in the nongroup market.

Many insurance companies refuse to issue policies or limit coverage for people with pre-existing health problems in the nongroup market. For example, a national study conducted for the Kaiser Family Foundation found that 8% of insurers refused to issue a policy to a 24-year-old female with hay fever, and 55% refused to issue a policy to a 55-year-old, overweight, male smoker with high blood pressure.[1]

BlueCross BlueShield of North Carolina (BCBSNC) is the only insurer in the state to offer health insurance in the nongroup market on a guaranteed issue basis. Premiums vary, based on the age, geographic location, and health status of the individual. The premiums are established to cover the anticipated costs of care for people with pre-existing health problems. Since there are no other sources of payments for these individuals with high medical costs, premiums may be as much as seven times the standard rate charged to someone with average health risks. For example, nongroup health insurance coverage for a 35-year-old man with major health problems could cost more than $800/month (for a $1,000 deductible, 30% coinsurance plan), or more than $1,800/month for a 55-year-old man. Coverage for women is generally more expensive, especially if they want maternity coverage. *People with pre-existing health problems are most in need of health insurance to help pay for healthcare services, but the premiums needed to cover the costs of care often make this coverage unaffordable in the nongroup market.*

Thirty-three states have established high-risk pools to help spread the costs of providing insurance to people with significant pre-existing health problems.[2] Research suggests that about 1% of the population have difficulties obtaining insurance due to their health status. This population is often called the "medically uninsurable."[3] Experience from other states with high-risk pools suggest that 10%-30% of these individuals may enroll in a high-risk pool, depending on the premium price and whether the state offers additional subsidies for low-income people.[2]

States typically limit the maximum premium charged to medically uninsurable individuals to no more than 150% of the standard rate in order to make it more affordable. Some states provide a further subsidy to help lower-income individuals pay their premiums. The premiums paid do not cover the full cost of the claims incurred in these high-risk pools. Therefore, most states fund the deficits through an assessment on insurance companies, state appropriations, or other means.

The NC Institute of MedicineTask Force on Covering the Uninsured recommended that the NC General Assembly create a high-risk pool that limits premiums to 150% of the standard risk, so that more people with pre-existing health problems can afford coverage. Losses should be covered through an assessment on insurers, including traditional insurance companies, Health Maintenance Organizations (HMOs), Multiple Employer Welfare Arrangements (MEWAs), third party administrators, and stop-loss and reinsurance carriers.[4,2] Providers would be paid using Medicare payment rates, which are less than what is typically offered through commercial insurance. The General Assembly should also help subsidize premium costs for lower-income individuals.[5]

Federal funding is available to help defray some of the costs of the high-risk pool. Congress appropriated funds to provide start-up grants of up to $1 million for states that have not yet established a high-risk pool. In addition, Congress appropriated $75 million/year through 2010 to help offset some of the ongoing operational costs of state high-risk pools: 40% of the money will be distributed equally among states that operate high-risk pools, 30% based on the numbers of uninsured in the state, and 30% based on the number of participants in the state's high-risk pool.

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2 Abbe B. Overview: State High Risk Health Insurance Pools Today. Communicating for Agriculture and the Self-Employed. Available at: http://www.selfemployedcountry.org/riskpools/overview.html. Accessed December 6, 2005.

3 Conover C, Hall M. Assessment of Potential Impact on Accessibility and Affordability of Health Care. Section VIII. Potential Impact on Accessibility. Report submitted to the NC Department of Insurance. Available at: http://www.hpolicy.duke.edu/cyberexchange/Regulate/Redacted.pdf. Accessed March 17, 2006.

4 Twenty-seven states use an assessment on insurers to help fund the losses in the high-risk pool. Of this, 11 states provide full or partial tax credit offsets for the assessment, thereby shifting the costs back to the state (AL, AR, IN, IA, KS, MO, MT, NM, ND, SC, WY); another 11 states have no tax credit offset [AL, CT, FL, ID, IL for its HIPAA pool, KY (partial funding source), LA (only for its HIPAA pool), MN, OK, TX, WA]. Seven of the states have a broad assessments on insurers, including commercial insurance carriers, stop-loss, reinsurance carriers, and Third Party Administrators (TPA's) on a per-person/per-month basis (CO, IN, MS, NH, OR, SD, and WA). Two states pay for the high-risk pool through surcharge on hospital bills (MD, WV) and six states use general revenue or other sources of funding (CA, IL, KY, LA, NE, UT).

5 Seven states help subsidize the premium costs for lower-income individuals (CO, CT, MT, NM, OR, WA, WI).

This issue brief is one in a series, produced as part of North Carolina's "State Planning Grant" effort, led by the NC Department of Health and Human Services, to examine options to expand health insurance coverage to the uninsured. The State Planning Grant supported a Task Force on Covering the Uninsured, which brought together stakeholders from a variety of interest groups to examine these issues and develop a set of recommendations for improving healthcare coverage across the state. Collaborating organizations include: the NC Department of Insurance, Cecil G. Sheps Center for Health Services Research at The University of North Carolina at Chapel Hill, and North Carolina Institute of Medicine. The State Planning Grant was funded by the Health Resources and Services Administration of the US Department of Health and Human Services. For other issue briefs or a copy of the final report of the *NC IOM Task Force on Covering the Uninsured*, visit the NC IOM website at: http://www.nciom.org.

For more information contact: Pam Silberman, JD, DrPH, President & CEO or Mark Holmes, PhD, Vice President. North Carolina Institute of Medicine. 5501 Fortunes Ridge Drive, Suite E, Durham, NC 27713. 919-401-6599 Email at:pam_silberman@nciom.org or mark_holmes@nciom.org. www.nciom.org.

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 8, 2006

The House Committee on Insurance met at 11:00 AM on Thursday, June 8, 2006 in Room 1228. The following Representatives in attendance were: Chairman H. Holliman, Vice Chairs: B. Faison, M Setzer and Ed Jones Members: L. Allen, C. Allred, D. Almond, H. Brubaker, , W. Current, R. Grady, J. Howard, D. Ross, D. Saunders, F. Steen, R. Sutton and W. Wainwright.

Chairman Holliman welcomed visitors, House pages, Sgt-At-Arms and Visitors. See Attachment I.

Richard Popper, Executive Director Maryland Health Insurance Plan, was introduced to speak on the Maryland Health Insurance Plan. He explained how the plan was administered and funded. The MHIP was implemented July, 2003. See Attachment II.

After questions and answers for Mr. Popper from the committee, Ben Popkin, Staff Attorney addressed the changes made in the bill. Chairman Holliman asked for a motion to accept the PCS for HB 1895 – Establish High Risk Pool. Rep. Saunders made the motion and the motion carried. See Attachment III.

Rep. Ross moved to amend the number of board members to reflect an odd number. Motion passes. See Attachment IV.

Rep. Wainwright made a motion for a favorable report to the PCS and have the bill re-referred to House Committee on Appropriations. The motion carried.

The meeting adjourned at 11:50

Representative L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

HOUSE INSURANCE COMMITTEE

June 8, 2006
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

Approve committee minutes from June 1, 2006 meeting

Richard Popper, Maryland Health Insurance Plan

HB 1895 - Establish High-Risk Pool. Representative Insko

Carol Bowers (Rep. Holliman)

From: Carol Bowers (Rep. Holliman)
Sent: Tuesday, June 06, 2006 12:37 PM
Subject: MEETING NOTICE for June 8, 2006.doc

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **THURSDAY, JUNE 8, 2006**

TIME: **11:00 AM**

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 1895 – Establish High-Risk Pool – Rep. Insko

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **12:35 pm on June 6, 2006.**

_x__Principal Clerk
_x_Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

2006 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Holliman (Chair) for the Committee on INSURANCE.

☒Committee Substitute for
HB 1895 A BILL TO BE ENTITLED AN ACT TO ESTABLISH THE NORTH CAROLINA HEALTH INSURANCE RISK POOL AND TO APPROPRIATE FUNDS THEREFOR.

☒ With a favorable report, as amended, and recommendation that the bill be re-referrred to the Committee on APPROPRIATIONS.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

_____ The bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

_____ On motion of Representative_____, Committee Amendment No.(s) ___ is/are adopted by EV (_____).

ATTACHMENT 1

House Pages

INSURANCE

Name Of Committee: _____ Date: 6-8-06

1. Name: Tayler Cave
   County: Davie
   Sponsor: Rep. Julia Howard
2. Name: Lalia Vanhoy
   County: Davie
   Sponsor: Rep. Howard
3. Name: _____
   County: _____
   Sponsor: _____
4. Name: _____
   County: _____
   Sponsor: _____
5. Name: _____
   County: _____
   Sponsor: _____

Sgt-At-Arms

1. Name: Martha Gadison
2. Name: Will Heath
3. Name: Charles Williams
4. Name: _____
5. Name: _____

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — June 8, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Susan Valaam	Nationwide
	S.A
Chad Henton	Civitas Institute
John McMillan	MFDS
Marcus Davis	NC State Health Plan
STEVE KEENE	NCMEL Soc...
PERRI MORGAN	NCIOB
Connie Wilson	SSI
	JDALPA
Andy Ellen	NCRMA

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — June 8, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Andy Ellen	NCBMX
Abby Emanuelson	NMSS
JAMES L. FORTE	OSA
	Young, Moore
	NCAHP
	NMRS
	BCBSNC
	NCLHW
DAVID BARNES	Poyner + Spruill

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — June 8, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	State Auditor
[signature]	UHS
Steve Smith	NC Council of Churches
Barbara Morales Burke	NC DOJ
Cameron Contrizano	Daily Bulletin
Colleen Kochanek	Smith Moore
Ed Turlington	BPMHL
Charlene Carey	NC Right to Life
Joseph Coletti	John Locke Foundation
[signature]	ICCLH
Elizabeth Dalton	NCRMA

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — June 8, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS

ATTACHMENT 11

Coverage for People who are Uninsurable

MHIP

Maryland Health Insurance Plan

8 June 2006
Richard Popper
Executive Director

1

Purpose

As a high-risk pool, the purpose of MHIP is to provide health coverage for the medically uninsurable residents of Maryland, in order to reduce uncompensated care

MHIP is one of 34 state high risk pools in the US, which in total cover approximately 190,000 uninsurable individuals

For more information about risk pools consult the National Association of State Comprehensive Health Insurance Plans at http://www.naschip.org

MHIP
Maryland Health Insurance Plan

2

How is MHIP funded?

- **Policyholders pay premiums that on average are no more than 130% of what is currently charged in the individual market**
- **Member premiums fund 35 to 40% of plan costs**
- **MHIP is supplemented by an annual assessment on hospitals (estimated $69 million in FY06)**

MHIP
Maryland Health Insurance Plan

Who applies/enrolls in MHIP ?

Former SAAC ***26% of enrollment***

Medically eligible ***45% of enrollment***

- have been refused individual health insurance due to a health condition, or offered restricted coverage ***50% of applications***
- one of 60 qualifying conditions ***26% of applications***

HIPAA eligible ***22% of applications*** ***24% of enrollment***

- exhausted group coverage, and
- 18 months of creditable prior coverage, and
- 63 day lapse between prior coverage & MHIP

HCTC eligible ***2% of applications*** ***5% of enrollment***

- Lost group coverage due to international trade, or
- Pension assumed by Pension Benefit Guarantee Corp.

Transfer from other state risk pool ***<1% of enrollment/applications***

MHIP
Maryland Health Insurance Plan

60 Qualifying Medical Conditions			
Addison's	COPD	HIV Positivity	Paraplegia
AIDS	Coronary Artery Disease	Hodgkin's	Parkinson's
Alzheimer's	Coronary Insufficiency	Huntington's	Porphyria
Amyotrophic Lateral Sclerosis	Coronary Occlusion	Hydrocephalus	Pregnancy
Angina Pectoris	Crohn's Disease	Kidney w/ Dialysis	Psychotic Disorders
Ankylosing Spondylitis	Cystic Fibrosis	Leukemia	Quadriplegia
Aplastic Anemia	Dementia	Lupus	Rheumatoid Arthritis
Ascites	Diabetes (Type I & II)	Major Organ Trans.	Scleroderma
Banti's Disease or Synd.	Emphysema	Multiple Myeloma	Sickle Cell Disease
Bipolar Disorder	Esophageal Varicies	Multiple Sclerosis	Stroke
Cancer w/in 5 yrs (ex. skin)	Friederich's Ataxia	Muscular Dystrophy	Syringomyelia
Cardiomyopathy	Guillain Barre Synd.	Myasthenia Gravis	Tay-Sachs Disease
Chemical Dependency	Hemocromatosis	Myotonia	Ulcerative Colitis
Cirrhosis of the Liver	Hemophilia	Non-Hodgkin's Lymphoma	Wilm's Tumor
Congestive Heart Failure	Hepatitis B & C	Palsy	Wilson's Disease

MHIP provides PPO and EPO options

4 PPO Options:

1. A **$500 per person per year deductible** for medical services (maximum $1,000 per family per year) with a maximum out-of-pocket limit of $2,000 per person, $4,000 family
2. A **$1,000 per person per year deductible** for medical services (maximum $2,000 per family per year) with a maximum out-of-pocket limit of $2,500 per person, $5,000 family
3. A **High Deductible Health Plan (HDP)** offering **$1,200 per person** per year deductible for medical AND prescription services (maximum $2,400 per family per year) with a maximum out-of-pocket limit of $2,500 per person, $5,000 family. **The HDP is designed to be used with tax-advantaged Health Savings Accounts approved by Congress in December 2003**
4. **MHIP+ $200 per person per year deductible** for medical services (maximum $400 per family per year) with a maximum out-of-pocket limit of $1,000 per person, $2,000 family

20% coinsurance for most in-network services and 40% coinsurance for most out-of-network services

MHIP

Maryland Health Insurance Plan

MHIP provides EPO and PPO options

Exclusive Provider Organization (EPO) Network:

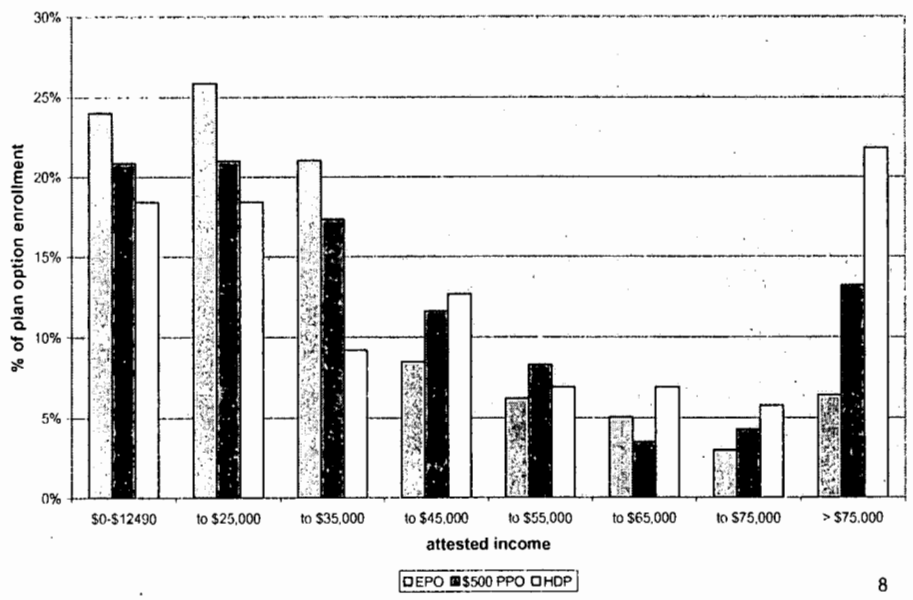
- No deductible
- $20 co-payment for primary care and lab visits
- $30 co-payment for specialty care visits
- Prescription Deductible - $250 per person, $500 per family
- EPO members must use network PCPs or obtain referrals from their primary physician in order to see specialists

Enrollee can switch plans during open season every year

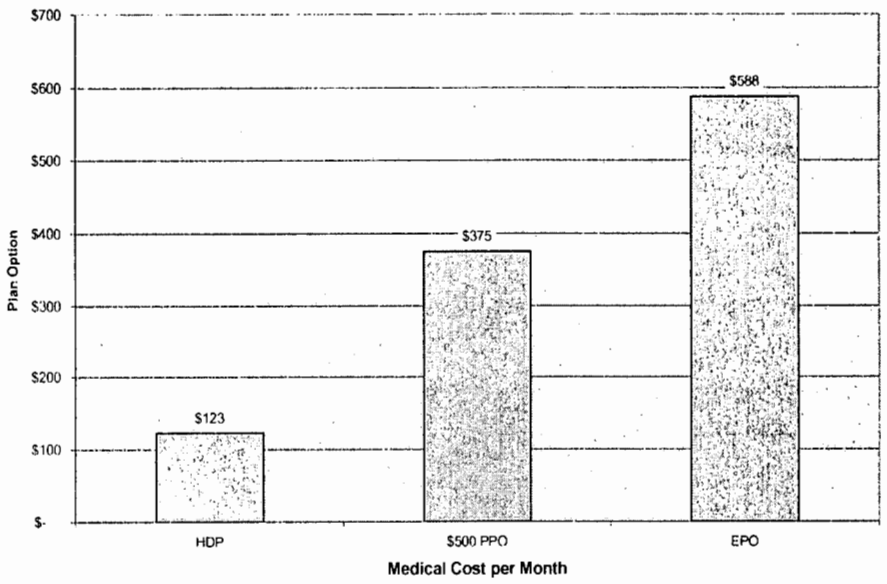
MHIP
Maryland Health Insurance Plan

For more information, visit www.marylandhealthinsuranceplan.state.md.us

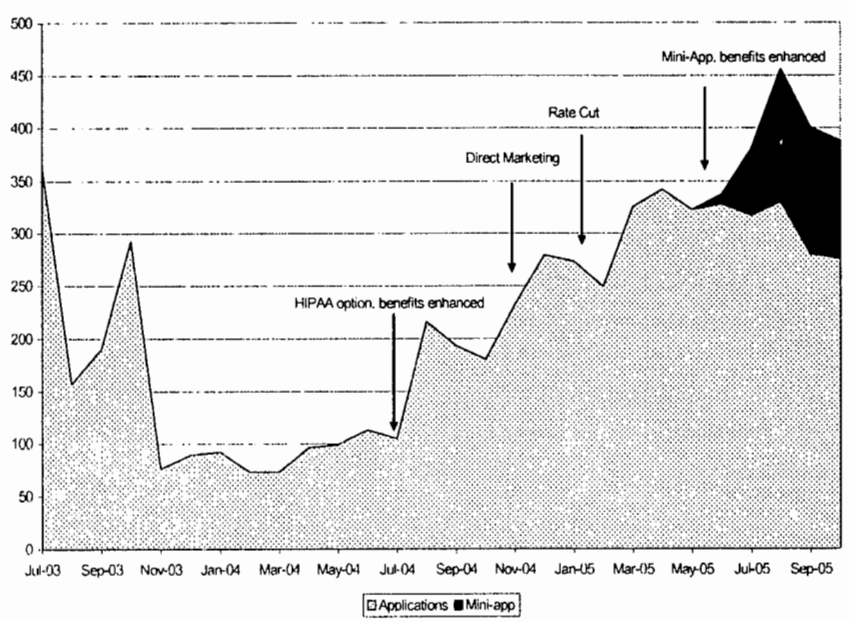
New MHIP Applicants by Option and Income



MHIP: Average Medical Cost Per Month



MHIP: Monthly New Members



MHIP

Maryland Health Insurance Plan

Call toll-free 1-866-780-7105
TTY/TDD: 1-800-367-8939
www.marylandhealthinsuranceplan.state.md.us

ATTACHMENT III

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H D

HOUSE BILL 1895
PROPOSED COMMITTEE SUBSTITUTE H1895-CSRD-39 [v.8]

6/7/2006 5:27:46 PM

Short Title: Establish High-Risk Pool. (Public)

Sponsors:

Referred to:

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE NORTH CAROLINA HEALTH INSURANCE RISK POOL AND TO APPROPRIATE FUNDS THEREFOR.

The General Assembly of North Carolina enacts:

SECTION 1.1. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 7. North Carolina Health Insurance Risk Pool.

"**§ 58-50-245. Definitions.**

For the purposes of this Part:

(1) "Administrator" means the Pool Administrator selected by the Board in accordance with this Part.

(2) "Benefit plan" means coverage offered by the Pool to eligible individuals.

(3) "Board" means the Board of Directors of the Pool.

(4) "Covered person" means any individual resident of this State, excluding dependents, who is eligible to receive health benefits from any insurer.

(5) "Church plan" has the meaning given that term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(6) "Creditable coverage" has the same meaning as prescribed in G.S. 58-68-30(c)(1).

(7) "Dependent" means a resident spouse or unmarried child under the age of 19 years, a child who is a full-time student under the age of 23 years and who is financially dependent upon the parent, a child who is over 18 years of age and for whom a person may be obligated to pay child support, or a child of any age who is disabled and dependent upon the parent.

(8) "Family member" means a parent, grandparent, brother, sister, or child of a dependent residing with the insured.

(9) "Federally defined eligible individual" has the same meaning as "eligible individual" as prescribed in G.S. 58-68-60(b).

(10) "Governmental plan" has the same meaning as prescribed in G.S. 58-68-60(h)(2).

(11) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, including items and services paid for as medical care to employees or their dependents, as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(12) "Health insurance coverage" shall have the same meaning as prescribed in G.S. 58-68-25(a)(5). Health insurance coverage does not include benefits described in G.S. 58-68-25(b).

(13) "Insurance arrangement" means a plan, program, contract, or other arrangement through which health care services are provided by an employer to its officers or employees, but does not include health care services covered through an insurer.

(14) "Insured" means an individual who is eligible to receive benefits from the Pool. The term "insured" includes dependents and family members, as applicable.

(15) "Insurer" means any entity that provides health insurance coverage in this State. For the purposes of this Part, insurer includes an insurance company, a hospital or medical service corporation, a health maintenance organization, a multiple employer welfare arrangement, a third-party administrator or claims processor, an administrative service organization, or any other nongovernmental entity providing a health benefit plan subject to State insurance regulation.

(16) "Medical care" means amounts paid for:

a. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

b. Transportation primarily for and essential to medical care referred to in sub-subdivision a. of this subdivision; and

c. Insurance covering medical care referred to in sub-subdivisions a. and b. of this subdivision.

(17) "Plan of operation" means the articles, bylaws, and operating rules and procedures adopted by the Board in accordance with this Part.

(18) "Pool" means the North Carolina Health Insurance Risk Pool.

(19) "Resident" means an individual who:

a. Has been legally domiciled in this State for a period of at least 30 days, except that for a federally defined eligible individual, there shall not be a 30-day requirement;

b. Is legally domiciled in this State on the date of application to the Pool and who is eligible for enrollment in the Pool as a result of the Health Insurance Portability and Accountability Act of 1996; or

c. Is legally domiciled in this State on the date of application to the Pool and is eligible for the credit for health insurance costs under section 35 of the Internal Revenue Code of 1986.

(20) "Significant break in coverage" means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

(21) "Trade Adjustment Assistance Program" (TAA) means Title II of the Trade Act of 2002, P.L. 107-210.

"**§ 58-50-250. Risk Pool established; board of directors; plan of operation.**

(a) High-Risk Pool Established. – There is hereby created a nonprofit entity to be known as the North Carolina Health Insurance Risk Pool. The Pool shall operate under the supervision and control of the Board of Directors of the Pool.

(b) Board of Directors Appointment; Membership. -- The Board of Directors of the North Carolina Health Insurance Risk Pool shall consist of the Commissioner of Insurance, who shall serve as an ex officio nonvoting member of the Board, and ten members appointed as follows:

(1) ~~Three~~ Two members of the general public who are not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, and can reasonably be expected to qualify for coverage in the Pool. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member. The ~~three~~ two members of the general public shall be appointed as follows:

a. ~~One member upon the recommendation of the Governor~~.

~~A~~. One member upon the recommendation of the President Pro Tempore of the Senate.

~~B~~ One member upon the recommendation of the Speaker of the House of Representatives.

(2) Seven members appointed by the Commissioner of Insurance, as follows:

a. Two who are insurers, at least one of whom covers the largest number of persons in the State.

b. One who is licensed to sell health insurance in this State.

c. Two who represent the medical provider community, one as recommended by the North Carolina Medical Society and one as recommended by the North Carolina Hospital Association.

d. One who represents small business, as recommended by the North Carolina Citizens for Business and Industry.

e. One who is either a health policy researcher or health economist with experience relating to the operation of high risk insurance pools.

(c) Board of Directors; Terms of Appointment; Vacancies; Compensation. – The initial Board members shall be appointed as follows: three of the members to serve a term of three years; four of the members to serve a term of one year; and three of the members to serve a term of two years. Subsequent Board members shall serve for terms of three years. A Board member's term shall continue until the member's successor is appointed. The Commissioner shall appoint a chair to serve for the initial two years of the Plan's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms. The Commissioner shall fill vacancies in membership and may remove members from the Board for cause. Board members shall not be compensated in their capacity as Board members but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties.

(d) Plan of Operation. – The Board shall submit to the Commissioner a Plan of Operation for the Pool and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Plan of Operation. The Plan of Operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this Part must be made available. If the Board fails to submit a suitable Plan of Operation within 180 days after the appointment of the Board of Directors, or at any time thereafter fails to submit suitable amendments to the Plan of Operation, the Commissioner shall adopt temporary rules necessary or advisable to effectuate the provisions of this section. The rules shall continue in force until modified by the Commissioner or superseded by a Plan of Operation submitted by the Board and approved by the Commissioner. The Plan of Operation shall:

(1) Establish procedures for operation of the Pool.

(2) Establish procedures for selecting a Pool Administrator in accordance with G.S. 58-50-255.

(3) Establish procedures to create a fund for administrative expenses, which shall be managed by the Board.

(4) Establish procedures for the collection, handling, disbursing, accounting, assessing and auditing of assets, monies, and claims of the Pool and the Pool Administrator.

(5) Develop and implement a program to publicize the existence of the Pool, the eligibility requirements, and procedures for enrollment, availability of State premium subsidies, and to maintain public awareness of the Pool.

(6) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the Board in accordance with G.S. 58-50-295.

(7) Establish procedures for identifying and confirming income levels of applicants for Pool coverage who are eligible to receive a State premium subsidy, if a State premium subsidy is available.

(8) Provide for other matters as may be necessary and proper for the execution of the Board's powers, duties, and obligations under this Part.

(e) The Pool shall have the general powers and authority granted under the laws of this State to health insurers and the specific authority to do all of the following:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Part, including the authority, with the approval of the Commissioner, to enter into contracts with similar plans of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions.

(2) Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the Pool.

(3) Take legal action as necessary to:

a. Avoid the payment of improper claims against the Pool or the coverage provided by or through the Plan.

b. Recover any amounts erroneously or improperly paid by the Plan.

c. Recover any amounts paid by the Pool as a result of mistake of fact or law.

d. Recover other amounts due the Pool.

(4) Establish rates and rate schedules in accordance with this Part.

(5) Issue policies of insurance in accordance with the requirements of this Part.

(6) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the Pool, policy, and other contract design, and any other function within the Pool's authority.

(7) Borrow money to effect the purposes of the Pool. Any notes or other evidence of indebtedness of the Pool not in default are legal investments for insurers and may be carried as admitted assets.

(8) Establish policies, conditions, and procedures for reinsuring risks of participating insurers desiring to issue Pool coverage in their own name. Provision of reinsurance shall not subject the Pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

(9) Employ and fix the compensation of employees.

(10) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public.

(11) Provide for reinsurance of risks incurred by the Pool.

(12) Issue additional types of health insurance policies to provide optional coverage, including Medicare supplemental insurance coverage.

(13) Provide for and employ cost containment measures and requirements including preadmission screening, second surgical opinion, concurrent

utilization review, disease management, individual case management, and other commonly used benefit plan design features for the purpose of making health insurance coverage offered by the Pool more cost-effective.

(14) Design, utilize, contract, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

(15) Adopt bylaws, policies, and procedures as may be necessary or convenient for the implementation of this Part and the operation of the Pool.

(f) The Board shall operate the Pool in a manner so that the estimated cost of providing health insurance coverage during any fiscal year is not anticipated to exceed the total income the Pool expects to receive from policy premiums and other revenue available to the Pool. The Board may impose a cap on enrollment or may suspend enrollment for an indefinite period if the Board finds that estimated costs are anticipated to exceed income.

(g) The Board shall make an annual report to the Commissioner, to the Speaker of the House of Representatives, and to the President Pro Tempore of the Senate. The report shall summarize the activities of the Pool in the preceding calendar year, including the net written and earned premiums, benefit plan enrollment, the expense of administration, and the paid and incurred losses.

(h) Neither the Board nor its employees are liable for any obligations of the Pool. There shall be no liability on the part of and no cause of action of any nature shall arise against the Pool or its agents or employees, the Board, or the Commissioner or his representatives for any action taken by them in good faith in the performance of their powers and duties under this Article. The Board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

(i) The members of the Board shall comply with the provisions of G.S. 14-234 prohibiting conflicts of interest.

"**§ 58-50-255. Administrator.**

(a) The Board shall select through a competitive bidding process one or more authorized insurers or a third-party administrator to administer the Pool. The Board shall evaluate bids submitted based on criteria established by the Board. The criteria shall allow for the comparison of information about each bidding administrator and selection of a Pool Administrator based on at least the following:

(1) Proven ability to handle health insurance coverage to individuals.

(2) Efficiency and timeliness of the claim processing procedures.

(3) Estimated total charges for administering the Pool.

(4) Ability to apply effective cost containment programs and procedures and to administer the Pool in a cost-efficient manner.

(5) Financial condition and stability.

If a member of the Board has submitted a bid to be selected by the Board as Pool Administrator, that bidding member of the Board shall not participate in the selection process or in the Board's final decision on the selection of the Administrator.

(b) The Administrator shall serve for a period specified in the contract between the Pool and the Administrator subject to removal for cause and subject to any terms, conditions, and limitations of the contract between the Pool and the Administrator. At least one year before the expiration of each period of service by an Administrator, the Board shall invite eligible entities, including the current Administrator, to submit bids to serve as the Administrator. Selection of the Administrator for the succeeding period shall be made at least six months before the end of the current period.

(c) The Administrator shall perform such functions relating to the Pool as may be assigned to it, including:

(1) Determination of eligibility.

(2) Payment of claims.

(3) Establishment of a premium billing procedure for collection of premiums from individuals covered under the Pool.

(4) Other necessary functions to assure timely payment of benefits to covered persons under the Pool.

(d) The Administrator shall submit regular reports to the Board regarding the operation of the Pool. The contract between the Board and the Administrator shall specify the frequency, content, and form of the report.

(e) Following the close of each calendar year, the Administrator shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the Board and the Commissioner on a form prescribed by the Commissioner.

(f) The Administrator shall be paid as provided in the contract between the Board and the Administrator.

"**§ 58-50-260. Risk Pool rates and policy forms.**

(a) The Pool shall adopt and modify, as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of the Pool. Rates and rate schedules may be adjusted for appropriate factors such as age, sex, and geographic variation in claim cost and shall take into consideration appropriate rating factors in accordance with established actuarial and underwriting practices.

(b) The Pool shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for the coverage. Pool rates shall be one hundred fifty percent (150%) of rates established as applicable for individual standard rates.

(c) The Pool shall provide for premium discounts for covered individuals who are nonsmokers or who are actively participating in a smoking cessation program. Approval of smoking cessation programs, criteria for active participation in smoking

cessation programs, and discount rates shall be established by the Board, subject to the approval of the Commissioner.

(d) Provider reimbursement rates under Pool coverage shall be limited to the rates allowed for providers under the Medicare Program.

(e) The Pool shall submit all rates and rate schedules and amendments thereto the Commissioner for approval, and the Commissioner shall approve the rates and rate schedules before the Pool may use them. The Commissioner, in evaluating the rates and rate schedules, shall consider the factors provided in this section. The Pool shall provide all individuals enrolled in the Pool with at least 45 days notice of any change in Pool rates or rate schedules.

(f) The Pool shall submit all policy forms to the Commissioner for approval, and the Commissioner shall approve the forms before the Pool may use them. Except for any provisions that are specifically treated otherwise under this Part, the provisions of Chapter 58 that apply to benefit plans and policy forms of health insurers generally shall apply to the benefit plans offered and policy forms used by the Pool.

"**§ 58-50-265. Eligibility for Pool coverage.**

(a) Any individual who is and continues to be a resident of this State is eligible for Pool coverage if evidence is provided of:

(1) A notice of rejection or refusal to issue substantially similar health insurance coverage for health reasons by an insurer. A rejection or refusal by an insurer offering only stop-loss, excess loss, or reinsurance coverage with respect to the applicant is not sufficient evidence of eligibility;

(2) An offer to issue health insurance coverage only with a conditional rider that limits coverage for the individual's high-risk medical condition;

(3) A refusal by an insurer to issue health insurance coverage except at a rate exceeding the Pool rate;

(4) A diagnosis of the individual with one of the medical or health conditions listed by the Board in accordance with this section. An individual diagnosed with one or more of these conditions is eligible for Pool coverage without applying for other health insurance coverage;

(5) In the case of a federally defined eligible individual, the individual's maintenance of health insurance coverage, of which the most recent coverage was through an employer-sponsored plan, for the previous 18 months with no gap in coverage greater than 63 days and exhaustion of any available COBRA or State continuation benefits; or

(6) An individual who is legally domiciled in this State and is eligible for the credit for health insurance costs under the Trade Adjustment Assistance Reform Act of 2002, section 35 of the Internal Revenue Code of 1986.

(b) The Board shall adopt a list of medical or health conditions for which a person shall be eligible for Pool coverage without applying for health insurance

pursuant to subsection (a) of this section. The Board may amend the list as the Board considers appropriate.

(c) Each dependent of an individual who is eligible for Pool coverage shall also be eligible for Pool coverage.

(d) An individual is not eligible for coverage under the Pool if:

(1) The individual has or obtains health insurance coverage substantially similar to or more comprehensive than a Pool policy, or would be eligible to have coverage if the person elected to obtain it, except that:

a. An individual may maintain other coverage for the period of time the individual is satisfying any preexisting condition waiting period under a Pool policy; and

b. An individual may maintain Pool coverage for the period of time the individual is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the Pool policy.

(2) The individual is determined to be eligible for enrollment in the State Medical Assistance Plan.

(3) The individual has previously terminated Pool coverage unless 12 months have lapsed since the termination, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual or to an applicant eligible for or receiving benefits under the Trade Adjustment Assistance Program.

(4) The individual is an inmate or resident of a public institution, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual.

(5) The individual's premiums are paid for or reimbursed under any government-sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider. This subdivision shall not apply for individuals receiving benefits under the Trade Adjustment Assistance Program or to individuals receiving premium subsidies made available by the State based on individual income levels.

(6) The individual has in effect on the date Pool coverage takes effect health insurance coverage from an insurer or insurance arrangement.

(e) Coverage under the Pool shall cease:

(1) On the date an individual is no longer a resident of this State.

(2) On the date an individual requests coverage to end.

(3) Upon the death of the covered individual.

(4) On the date State law requires cancellation of the Pool policy.

(5) At the option of the Pool, 30 days after the Pool makes any inquiry concerning the individual's eligibility or residence to which the individual does not reply.

(6) Because the individual has failed to make the payments required under this Part.

(f) Except as provided in subsection (e) of this section, an individual who ceases to meet the eligibility requirements of this section may be terminated at the end of the Pool period for which the necessary premiums have been paid.

"**§ 58-50-270. Unfair referral to Pool.**

It is an unfair trade practice under Article 63 of this Chapter for an insurer, insurance producer, as defined in G.S. 58-33-10(7), or third-party administrator to refer an individual employee to the Pool or arrange for an individual employee to apply to the Pool for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment, or for the purpose of separating an individual covered by health insurance offered in the individual market.

"**§ 58-50-275. Minimum Pool benefits.**

(a) The Pool shall offer at least two types of health insurance coverage for individuals eligible under G.S. 58-50-265, including preferred provider organizations with different levels of deductibles and cost-sharing, and at least one choice of a health savings account. The covered services and benefit levels may vary between the types of coverage, but at least two types of coverage must, at a minimum, cover the benefits and services outlined in the National Association of Insurance Commissioners' Model Health Pool for Uninsurable Individuals Act and be consistent with comprehensive coverage generally available to persons who are eligible for health insurance other than Medicare. All health insurance products offered by the Pool shall include disease or case management services.

(b) Health insurance products offered by the Pool shall include not less than one million dollars ($1,000,000) lifetime limit and a sliding scale annual limit of two thousand dollars ($2,000) to five thousand dollars ($5,000) on out-of-pocket expenses. The sliding scale shall be based on family income. The Board shall adjust limitations at least once every five years to reflect changes in the medical component of the Consumer Price Index.

"**§ 58-50-280. Preexisting conditions.**

(a) Except as otherwise provided by law, pool coverage shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage as to any condition for which medical advice, care, or treatment was recommended or received as to such conditions during the 12-month period immediately preceding the effective date of coverage, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual.

(b) Subject to subsection (a) of this section, the preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage that was involuntarily terminated, provided that:

(1) Application for Pool coverage is made not later than 63 days following the involuntary termination, and in such case coverage in the Pool shall be effective from the date on which the prior coverage was terminated; and

(2) The applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to Pool coverage.

"**§ 58-50-285. Nonduplication of benefits.**

(a) The Pool shall be payor of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under coverage shall be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or no-fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any State or federal law or program.

(b) The Pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the Pool may be reduced or refused as a setoff against any amount recoverable under this subsection.

"**§ 58-50-290. Assessments.**

(a) For the purposes of providing the funds necessary to carry out the powers and duties of the Pool, the Board shall assess all insurers at such time and for such amounts as the Board finds necessary. Assessments shall be due in not less than 30 days after prior written notice to the insurers and shall accrue interest at twelve percent (12%) per annum on and after the due date.

(b) Each insurer shall be assessed in an amount not to exceed two dollars ($2.00) per covered individual insured or reinsured by each insurer per month. The assessment will be based on actual and expected losses, actuarially appropriate reserves, and administrative expenses in excess of expected and collected premiums and federal loss reimbursements, if any, received by the Pool.

(c) The Board shall make reasonable efforts designed to ensure that each covered individual is counted only once with respect to any assessment. For that purpose, the Board shall require each insurer that obtains excess or stop-loss insurance to include in its count of covered individuals all individuals whose coverage is insured (including by way of excess or stop-loss coverage) in whole or in part, except that lives covered under the Pool and reinsured or administered by a third-party administrator shall not be included in the count. The Board shall allow a reinsurer to exclude from its number of covered individuals those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop-loss insurer for the purposes of determining its assessment under this section.

(d) The Board may verify each insurer's assessment based on annual statements and other reports deemed to be necessary by the Board. The Board may use any reasonable method of estimating the number of covered individuals of an insurer if the specific number is unknown.

(e) If assessments and other receipts by the Pool, Board, or administering insurer exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the Board to offset future losses or to reduce plan premiums. Future losses include reserves for claims incurred but not reported.

(f) The Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any insurer that fails to pay an assessment. As an alternative, the Commissioner may levy a forfeiture on any insurer that fails to pay an assessment when due. The forfeiture may not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100.00) per month.

"**§ 58-50-295. Complaint procedures.**

An applicant or participant in coverage from the Pool is entitled to have complaints against the Pool reviewed by a grievance committee appointed by the Board. Members of the Board shall not serve on the grievance committee. The grievance process shall comply with G.S. 58-50-62. The grievance committee shall report to the Board after completion of the review of each complaint. The Board shall retain all written complaints regarding the Pool at least until the third anniversary of the date the Pool received the complaint. An applicant or participant may file for external review of the applicant's grievance after having exhausted the Pool's internal grievance procedure. External review, including eligibility determinations, shall be conducted in accordance with Part 4 of this Article.

"**§ 58-50-300. Audit.**

An audit of the Pool shall be conducted annually under the oversight of the State Auditor. The cost of the audit shall be reimbursed to the State Auditor from the Special Reserve for the North Carolina Health Insurance Risk Pool.

"**§ 58-50-305. Taxation.**

The Pool established under this Part is exempt from any and all taxes.

"**§ 58-50-310. Rules.**

The Commissioner may adopt rules, including temporary rules, to implement this Part.

"**§ 58-50-315. Collective action.**

The establishment of rates, forms, or procedures, and any other joint or collective action required by this Part may not be the basis of any legal action or criminal or civil liability or penalty against the Pool or any insurer."

SECTION 1.2. On or before January 1, 2007, the Department of Insurance shall notify the Centers for Medicare and Medicaid Services that the State has established the North Carolina Health Insurance Risk Pool and shall request that the North Carolina Health Insurance Risk Pool be approved as an acceptable "alternative mechanism" under the federal Health Insurance Portability and Accountability Act in accordance with 45 CFR 148.128(e).

SECTION 1.3. The Board of Directors of the North Carolina Health Insurance Risk Pool, as appointed under Section 1 of this act, shall monitor methods of financing the Pool to ensure a stable funding source and allow for its continued operation. This monitoring shall include supplementary sources of funding, such as funds obtained from public and private not-for-profit foundations, insurer assessments, or other appropriate and available State or non-State funds. The Board shall also review on a regular basis:

(1) The number of individuals in this State who are uninsured as of a date certain because of high-risk conditions.
(2) The number of uninsured individuals who would qualify for coverage under the Pool based on G.S. 58-50-265 and its Plan of Operation.
(3) The cost of coverage under each of the health insurance plans developed by the Board, including administrative costs.
(4) The extent to which assessments meet or exceed amounts necessary for coverage and Board operations.
(5) The status of a request by the State to the Centers for Medicare and Medicaid Services for approval of the North Carolina Health Insurance Risk Pool to be considered an acceptable "alternative mechanism" under the federal Health Insurance Portability and Accountability Act in accordance with 45 CFR 148.128(e).

The Board shall report its findings and recommendations to the General Assembly on March 1, 2007, and annually thereafter.

SECTION 1.4. The North Carolina Health Insurance Risk Pool Administrator shall study methods for encouraging healthy behaviors and report its findings to the Board of Directors of the Pool and to the General Assembly not later than one year after initial implementation of the Pool.

SECTION 1.5. The Board of Directors of the Pool shall apply for grant funds available from the federal government to help support the implementation and ongoing costs of operating a high-risk pool. If federal funds are available for purposes for which funds were appropriated in this act from the General Fund, such federal funds shall be used to reimburse the General Fund, to the maximum extent allowable, for amounts appropriated for this purpose.

SECTION 1.6. Notwithstanding G.S. 58-50-280(a), individuals enrolling in the North Carolina Health Insurance Risk Pool within six months of the date that enrollment into the Pool first begins shall be subject to a six month preexisting condition waiting period.

SECTION 2.1. There is appropriated from the General Fund to the Department of Insurance the sum of seventy-eight thousand nine hundred nineteen dollars ($78,919) for the 2006-2007 fiscal year. These funds shall be used to support one additional full-time position in the Department to carry out the Department's responsibilities under the North Carolina Health Insurance Risk Pool. It is the intent of the General Assembly that funding for this purpose shall become part of the continuation budget of the Department of Insurance.

SECTION 2.2. There is appropriated from the General Fund to the Department of Insurance the sum of one million dollars ($1,000,000) for the 2006-2007 fiscal year. These funds shall be placed in a Special Reserve for the North Carolina Health Insurance Risk Pool in the Department of Insurance and shall be allocated for the reasonable expenses of the Board in conducting its duties under Section 1 of this act that are incurred on or before July 1, 2008. The Special Reserve is subject to the to the Executive Budget Act, except that Article 3C of Chapter 143 of the General Statutes does not apply to G.S. 58-50-250(e).

SECTION 3. Sections 2.1 and 2.2 of this act become effective July 1, 2006. The remainder of this act is effective when it becomes law. Enrollment in the North Carolina Health Insurance Risk Pool shall commence no later than January 1, 2008.

HOUSE BILL 1895: Establish High-Risk Pool

BILL ANALYSIS

Committee:	House Insurance	**Date:**	June 2, 2006
Introduced by:	Reps. Insko, England, Nye, Wright	**Summary by:**	Ben Popkin
Version:	PCS to First Edition H1895-CSRD		Committee Counsel

SUMMARY: ***House Bill 1895 would establish the North Carolina Health Insurance Risk Pool, the purpose of which would be to enable individuals with high-risk health conditions to obtain health insurance at premium rates that are more affordable than currently available. Pool financing would be achieved through a combination of premiums and assessments with an initial State appropriation to fund Board operating expenses and Pool start-up costs. House Bill 1895 is a recommendation of the House Select Committee on Health Care.***

Sections of the act appropriating funds to the Department of Insurance and to the Special Reserve for the North Carolina Health Insurance Risk Pool would become effective July 1, 2006. The remainder of the act would be effective when it becomes law and enrollment would commence no later than January 1, 2008.

The Proposed Committee Substitute to House Bill 1895 would implement the recommendations of the North Carolina Institute of Medicine Task Force on Covering the Uninsured, making the following changes to earlier drafts of this bill: Eligibility requirements – Reduce from two to one, the number of insurer refusals to issue similar coverage, the number of refusals to issue coverage unless at a rate exceeding the Pool rate, and the number of offers to issue insurance with a conditional rider excluding coverage of the high-risk condition. The PCS also would adjust Board makeup, eliminate a proposed premium subsidy fund, provide a shortened preexisting condition waiting period of six months for individuals enrolling in the Pool within the first six months that enrollment is made available, and would make technical changes to terminology of the bill.

BILL ANALYSIS:

House Bill 1895 would create a new Part 7 of Article 50 of Chapter 58 of the General Statutes that would create the North Carolina Health Insurance Risk Pool. The Pool would be a nonprofit entity subject to oversight of the Board of Directors of the Pool and administered by one or more insurers or a third-party administrator selected by the Board through a competitive bidding process. The Pool would operate according to a Plan of Operation developed by the Board and approved by the Commissioner of Insurance.

Plan of Operation for the Pool – The act would specify the content of the Board of Directors' Plan of Operation for the Pool and would authorize the Pool to perform all functions necessary to establish and administer the Pool[1]. The Board would be required to submit a Plan of Operation for the Commissioner's approval and to submit an annual report to the Commissioner, to the Speaker of the House of Representatives, and to the President Pro Tempore of the Senate regarding earned premiums, plan enrollment, administrative expenses, and losses. The Board would be authorized to cap or suspend enrollment if expenses were anticipated to exceed available funds.

[1] Proposed G.S. 58-50-250.

***Eligibility and Exclusions*[2]:**

- An individual who is a resident of the State would be eligible for Pool coverage if evidence is provided of:
  - a notice of rejection from an insurer to provide substantially similar health insurance because of the individual's health;
  - an offer to issue insurance only with a conditional rider limiting coverage of the individual's high-risk condition;
  - refusal by an insurer to issue insurance except at a rate exceeding the Pool rate;
  - a diagnosis of the individual with of one of the medical or health conditions listed by the Board;
  - the individual's maintenance of health insurance coverage under federal criteria without a significant break in coverage and the exhaustion of COBRA or state continuation benefits;
  - the individual's legal domicile in State and eligibility for health insurance costs under the Trade Adjustment Assistance Reform Act of 2002; or
  - the individual's status as a dependent of an individual eligible for Pool coverage.

- An individual would be excluded from Pool coverage if:
  - they have health insurance coverage substantially similar to that offered by Pool (with the exception of coverage during preexisting condition waiting period);
  - they are eligible for enrollment in the State Medical Assistance Plan;
  - they have terminated Pool coverage within the past 12 months;
  - they have reached the lifetime maximum benefit ceiling;
  - they are an inmate or resident of a public institution;
  - they have their premiums paid by a government-sponsored program or government agency or health care provider; or
  - they have health insurance coverage from an insurer or insurance arrangement on the date Pool coverage takes effect.

Pool Administration, Rates and Preexisting Conditions – The Board would select a Pool administrator through a competitive bidding process applying criteria set forth in statute and otherwise established by the Board[3]. The Pool would establish risk rates of 150% of rates established by other health insurers as applicable for individual standard risks[4]. The Pool would offer at least two types of coverage including preferred provider organizations with different deductible levels and cost sharing and at least one choice of a health savings account. At least two types of coverage must, at a minimum, provide benefits outlined in the National Association of Insurance Commissioners' Model Health Plan for Uninsurable Individuals Act and be consistent with comprehensive health insurance coverage generally available[5].

Insurance products offered by the Pool would include a lifetime benefit limit of not less than one million dollars and a sliding scale annual limit on out-of-pocket expenses (from two to five thousand dollars, based on family income) [6]. During the first 12 months of coverage, the Pool would not cover health

[2] Proposed G.S. 58-50-265.
[3] Proposed G.S. 58-50-255.
[4] Proposed G.S. 58-50-260.
[5] Proposed G.S. 58-50-275.
[6] Proposed G.S. 58-50-275(b).

conditions existing within 12 months prior to coverage (except for federally defined eligible individuals)[7]. For individuals enrolling into the Pool during the first six months that enrollment is made available, the preexisting condition waiting period would be reduced to six months. The Pool would allow for a waiver of exclusion where similar exclusions have been satisfied under another health insurance plan, and coverage lapsed for no more than 63 days and the applicant was ineligible for substantially similar continuation insurance.

Pool Financing, Complaint Procedures and Miscellaneous Provisions – The Board would assess insurers in the amount deemed necessary to fulfill the Board's duties[8]. Each insurer's assessment would not exceed $2 per covered individual insured or reinsured by the insurer per month. $1,000,000 would be appropriated from the General Fund and placed in the Special Reserve for the North Carolina Health Insurance Risk Pool in the Department of Insurance for the 2006-2007 fiscal year to cover Board operating expenses and Pool start-up costs. Federal seed monies, if awarded, could be used to reimburse the General Fund this appropriation. A grievance committee appointed by the Board would review complaints against the Pool and report to the Board[9]. The State Auditor would either perform or oversee an annual audit of the Pool[10]. The Pool would be exempt from taxation[11].

BACKGROUND:

In its 2006 Interim Report to the General Assembly, the House Select Committee on Health Care recommended that the General Assembly enact legislation to implement a health insurance high-risk pool to enable individuals with high-risk health conditions to obtain health insurance at premium rates that are more affordable than currently available. Both the Subcommittee on Access and the Subcommittee on Cost of Health Care and Health Insurance for Employees and Employers explored the issue of health insurance high-risk pools in detail. House Bill 1895 is the product of these efforts and was presented as Recommendation 2 of the Subcommittee on Access recommendations to the House Select Committee on Health Care.

The North Carolina Institute of Medicine, Task Force on Covering the Uninsured recently issued a final report addressing a range of issues relating to the uninsured population of this State, including high-risk pools. Recommendation 6.5 calls for the General Assembly to enact legislation to implement a high-risk pool. House Bill 1895 incorporates many of the details put forth in Recommendation 6.5.

Currently, 33 states have established or are establishing high-risk health insurance pools. The Federal Trade Act of 2002 provides a federal grant of up to $1,000,000 to each state establishing new pools. This seed money went to the costs of creating the pool, not the actual financing of it. The act also provided for a matching federal grant of up to 50% of the losses incurred by a state in connection with the operation of the pool. $40,000,000 was appropriated for each fiscal year 2003 and 2004. In 2003, Congress passed legislation extending and providing addition federal funding through 2009.

EFFECTIVE DATE:

The act would become effective when it becomes law. Coverage under the North Carolina Health Insurance Risk Pool would only be offered upon passage of an act of the General Assembly establishing a method for financing the Pool, as specified in this act. *H1895e1-SMRD-CSRD*

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[7] Proposed G.S. 58-50-280.
[8] Proposed G.S. 58-50-290.
[9] Proposed G.S. 58-50-295.
[10] Proposed G.S. 58-50-300.
[11] Proposed G.S. 58-50-305.

ATTACHMENT IV

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 1895 (PCS v. 8) DATE _____

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.) Ross
)
Sen.)

moves to amend the bill on page 1, line 22

( ) WHICH CHANGES THE TITLE

by deleting the word "three" and substituting the word "Two"

and on page 1, line 27;

by deleting the word "three" and substituting the word "two";

and on page 3, line 29,

by deleting that line and relettering the remaining subdivisions accordingly.

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 20, 2006

The House Committee on Insurance met at 11:00 AM on Tuesday, June 20, 2006 in Room 1228. The following Representatives in attendance were: Chairman H. Holliman, Vice Chairs: B. Faison and Ed Jones Members: L. Allen, D. Almond, H. Brubaker, W. Current, R. Grady, J. Howard, L. Johnson, D. Ross, D. Saunders and R. Sutton.

Chairman Holliman welcomed visitors, House pages, Sgt-At-Arms and Visitors. See Attachment I.

Rep. Holliman asked for a motion to approve the minutes for the June 8, 2006 committee meeting. Rep. Saunders made the motion and the motion passed.

Rep. Holliman called on Barbara M. Burke, DOI to explain the changes and corrections made in the Proposed Committee Substitute (PCS) for SB 615 – Insurance Technical Corrections. She explained that DOI and the Industry supported these changes. See Attachment II.

Rep. Folwell spoke to the importance of the provisions in Sections 2.1 and 2.2 of the PCS concerning disposal of seized registration plates. Rep. Folwell explained that all law enforcement supports this legislation. He called on Captain Mark Nichols with the State Highway Patrol to report on how officers seize and store registration plates. After some discussion, Rep. Holliman asked for an amendment to clarify the wording in Sections 2.1 and 2.2 of the bill. See Attachment III. The motion was accepted and passed.

Rep. Holliman then moved to amend the bill on page 7, line 12. The amendment was adopted. See Attachment IV.

Rep. Saunders moved to amend the bill on page 4 lines 41-42. The amendment was adopted. See Attachment V.

After committee discussion, Rep. Saunders moved to accept the PCS as amended, unfavorable to the original bill. The motion passed unanimously.

Rep. Saunders made a motion to accept the PCS for HB 1987 Health Plans/Changes to Basic and Std. Motion was accepted. Barbara M. Burke of DOI was called on to speak on the changes made and noted the Department and the Industry supported the PCS. Rep. Sutton made a motion for a favorable report to the PCS unfavorable to the original bill. The motion passed unanimously. See Attachment VI.

The meeting adjourned at 11:56

Representative. L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

HOUSE INSURANCE COMMITTEE

June 20, 2006
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

Approve Minutes from June 8, 2006 meeting.

HB 1987 – Health Plans/Changes to Basic and Std.

SB 615 - Insurance Technical Corrections

Carol Bowers (Rep. Holliman)

From: Carol Bowers (Rep. Holliman)
Sent: Thursday, June 15, 2006 8:35 AM
Subject: MEETING NOTICE for June 20, 2006.doc

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: TUESDAY, JUNE 20, 2006

TIME: 11:00 AM

LOCATION: 1228 LB

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 1987 – Health Plans/Changes to Basic and Std.	Rep. Holliman Rep. Underhill
SB 615 Insurance Technical Corrections	Sen. Bland

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 8:3OAM on June 15, 2005.

_X__Principal Clerk
_X__Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Holliman (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for
HB 1987 A BILL TO BE ENTITLED AN ACT TO MAKE CHANGES TO THE STATUTORY BASIC AND STANDARD HEALTH PLANS FOR SMALL EMPLOYERS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE.

☒ With a favorable report as to the committee substitute bill, unfavorable as to the original bill.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House/Senate) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Holliman (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for
SB 615 A BILL TO BE ENTITLED AN ACT TO MAKE TECHNICAL CORRECTIONS TO THE INSURANCE LAWS OF THE STATE.

☒ With a favorable report as to the House committee substitute bill, which changes the title, unfavorable as to the original bill..

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House/Senate) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

ATTACHMENT 1

House Pages

Name Of Committee: ~~Insurance~~ Date: 6/20/06

1. Name: Jessie Oldham
   County: Wake
   Sponsor: Owens
2. Name: Alyssa Jaklitsch
   County: Mecklenburg
   Sponsor: Speaker Black
3. Name: Molly Herlong
   County: Mecklenburg
   Sponsor: Speaker Black
4. Name: Anna Carr Ivey
   County: New Hanover
   Sponsor: Danny McComas
5. Name: April Hodges
   County: Carteret
   Sponsor: Jean Preston

Sgt-At-Arms

1. Name: Martha Gadison
2. Name: Gerald Jersey
3. Name: Charles Williams
4. Name:
5. Name:

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — June 20, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jeanne Greer	Genworth Mortgage Ins Cop. Raleigh NC
Holly Bryan	NCATL
Chris Medlin	NCATL
Dale Taylor	NCATL
C P Pate	NCATL
Marcus Davis	NC State Health Plan
Cassandra White	NC CCPS
Marc Nichols	NCSHP
[illegible]	JD, AL, PA
Frank Gray	CNA Surety
Amy Jo Horne	NC Medical Society

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — June 20, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Susan Valauri	Nationwide
[signature]	IFNC
[signature]	NFIS
Jon Carr	Jordan Price
Robert Paschal	Young, Moore
[signature]	NCAIP
Bill Scoggin	KCCH
[signature]	JA
Kathleen Edwards	UNC-CH Daily Bulletin
John Taggart	Genworth Mortgage Insurance
[signature]	HMW

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — June 20, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
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GARY SALAMIDO	GSK
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ATTACHMENT 11

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S D

SENATE BILL 615
PROPOSED HOUSE COMMITTEE SUBSTITUTE S615-CSRG-38 [v.5]

6/20/2006 10:03:23 AM

Short Title: Insurance Technical Corrections. (Public)

Sponsors:

Referred to:

March 17, 2005

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL AND SUBSTANTIVE CORRECTIONS AND CLARIFICATIONS TO THE INSURANCE LAW AND TO AMEND THE INSURANCE HOLDING COMPANY ACT AND A RELATED STATUTE TO STRENGTHEN THE SOLVENCY OF NORTH CAROLINA INCORPORATED INSURERS.

The General Assembly of North Carolina enacts:

PART I. TECHNICAL CORRECTIONS AND CLARIFICATIONS.

SECTION 1.1. G.S. 58-2-150 reads as rewritten:

"§ 58-2-150. Oath required for compliance with law.

Before issuing a license to any insurance company to transact the business of insurance in this State, the Commissioner shall require, in every case, in addition to the other requirements provided for by law, that the company file with the Commissioner the affidavit of its president or other chief officer that it accepts the terms and obligations of ~~Articles 1 through 67 of~~ this Chapter as a part of the consideration of the license."

SECTION 1.2. G.S. 58-7-1 reads as rewritten:

"§ 58-7-1. Application of ~~Articles 1 through 64 of~~ this Chapter and general laws.

The general provisions of law relative to the powers, duties, and liabilities of corporations apply to all incorporated domestic insurance companies where pertinent and not in conflict with other provisions of law relative to such companies or with their charters. All insurance companies of this State shall be governed by ~~Articles 1 through 64 of~~ this Chapter, notwithstanding anything in their special charters to the contrary, provided notice of the acceptance of ~~Articles 1 through 64 of~~ this Chapter is filed with the Commissioner."

SECTION 1.3. G.S. 58-7-26(a) reads as rewritten:

"(a) An asset or a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of G.S. 58-7-21 shall be

allowed in an amount not exceeding the liabilities carried by the ceding insurer. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified United States financial institution as defined in subsection (c) of this section. This security may be in the form of:

(1) Cash;

(2) Securities that are listed by the Securities Valuation Office of the NAIC and qualifying as admitted assets;

(3) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in subsection (b) of this section, effective no later than December 31 of the year for which the filing is being made, and in the possession of, or in trust for, the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever occurs first; or

(4) Any other form of security acceptable to the Commissioner."

SECTION 1.4. G.S. 58-30-125 reads as rewritten:

"**§ 58-30-125. Notice to creditors and others.**

(a) Unless the Court otherwise directs, the liquidator shall give or cause to be given notice of the liquidation order as soon as possible:

(1) By first-class mail and either by ~~telecopier, telegram,~~ facsimile, electronic mail, or telephone to the insurance regulator of each jurisdiction in which the insurer is doing business;

(2) By first-class mail to any domestic or foreign guaranty association that is or may become obligated as a result of the liquidation;

(3) By first-class mail to all insurance agents of the insurer;

(4) By first-class mail to all persons known or reasonably expected to have claims against the insurer, including all policyholders, at their last known addresses indicated by the records of the insurer; and

(5) By publication in a newspaper of general circulation in the county in which the insurer has its principal place of business and in such other locations as the liquidator deems to be appropriate.

(b) Notice to potential claimants under subsection (a) of this section shall require claimants to file with the liquidator their claims, together with proper proofs thereof under G.S. 58-30-190, on or before a date the liquidator specifies in the notice. ~~The liquidator need not require persons claiming cash surrender values or other investment values in life insurance and annuities to file claims.~~ All claimants have a

duty to keep the liquidator informed of any changes of address. The liquidator need not require the following to file claims under this section:

(1) Persons claiming cash surrender values or other investment values in life insurance and annuities.

(2) Persons claiming unearned premiums on property or casualty insurance.

(c) If notice is given in accordance with this section, the distribution of assets of the insurer under this Article shall be conclusive with respect to all claimants, whether or not they receive notice."

SECTION 1.5. G.S. 58-30-180(a) reads as rewritten:

"(a) Within ~~120 days of~~ one year after a final determination of insolvency of an insurer by the Court, the liquidator shall make application to the Court for approval of a proposal to disburse assets out of marshalled assets, from time to time as such assets become available, to a domestic or foreign guaranty association having obligations because of such insolvency. If the liquidator determines that there are insufficient assets to disburse, the application required by this section shall be considered satisfied by a filing by the liquidator stating the reasons for this determination."

SECTION 1.6. G.S. 58-36-95(c) reads as rewritten:

"(c) It is a violation of G.S. ~~58-2-180~~ 58-3-180 for an automobile repair facility or parts person to place a nonoriginal crash repair part, nonoriginal windshield, or nonoriginal auto glass on a motor vehicle and to submit an invoice for an original repair part."

SECTION 1.7. G.S. 58-37-35(b)(1) reads as rewritten:

"(1) For the following coverages of motor vehicle insurance and in at least the following amounts of insurance:

a. Bodily injury liability: thirty thousand dollars ($30,000) each person, sixty thousand dollars ($60,000) each accident;

b. Property damage liability: twenty-five thousand dollars ($25,000) each ~~person;~~ accident;

c. Medical payments: one thousand dollars ($1,000) each person; except that this coverage shall not be available for motorcycles;

d. Uninsured motorist: thirty thousand dollars ($30,000) each person; sixty thousand dollars ($60,000) each accident for bodily injury; twenty-five thousand dollars ($25,000) each accident property damage (one hundred dollars ($100.00) deductible);

e. Any other motor vehicle insurance or financial responsibility limits in the amounts required by any federal law or federal agency regulation; by any law of this State; or by any rule duly adopted under Chapter 150B of the General Statutes or by the North Carolina Utilities Commission."

SECTION 1.8. G.S. 58-50-40(i) reads as rewritten:

"(i) Upon the termination of a group health insurance contract by the insurer, the insurer shall notify every subscriber and certificate holder under the contract of the

termination of the contract along with the certification required to be provided under G.S. 58-68-30(e). Upon the termination of a group health insurance contract by the insurance fiduciary, the insurance fiduciary shall notify every subscriber and certificate holder under the contract of the termination of the contract along with the certification required to be provided under G.S. 58-68-30(e)."

SECTION 1.9. G.S. 58-50-100 reads as rewritten:

"**§ 58-50-100. Title and reference.**

This section and G.S. 58-50-105 through G.S. ~~58-50-150~~ 58-50-156 are known and may be cited as the North Carolina Small Employer Group Health Coverage Reform Act, referred to in those sections as "this Act"."

SECTION 1.10. G.S. 97-7 reads as rewritten:

"**§ 97-7. State or subdivision and employees thereof.**

Neither the State nor any municipal corporation within the State, nor any political subdivision thereof, nor any employee of the State or of any such corporation or subdivision, shall have the right to reject the provisions of this Article relative to payment and acceptance of compensation, and ~~the provisions of G.S. 97-100(j) shall~~ G.S. 97-100(c) does not apply to them: Provided, that all such corporations or subdivisions are hereby authorized to self-insure or purchase insurance to secure its liability under this Article and to include thereunder the liability of such subordinate governmental agencies as the county board of health, the school board, and other political and quasi-political subdivisions supported in whole or in part by the municipal corporation or political subdivision of the State. Each municipality is authorized to make appropriations for these purposes and to fund them by levy of property taxes pursuant to G.S. 153A-149 and G.S. 160A-209 and by the allocation of other revenues whose use is not otherwise restricted by law."

PART II. SUBSTANTIVE CORRECTIONS AND CLARIFICATIONS.

SECTION 2.1. G.S. 20-45(c) reads as rewritten:

"(c) Any sworn law enforcement officer with jurisdiction is authorized to seize the certificate of title, registration card, permit, license, or registration plate, if the officer has electronic or other notification from the Division that the item has been revoked or cancelled, or otherwise has probable cause to believe that the item has been revoked or cancelled under any law or statute, including G.S. 20-309(e). ~~If a criminal proceeding relating to the item is pending, the law enforcement officer in possession of that item shall retain the item pending the entry of a final judgment by a court with jurisdiction. If there is no criminal proceeding pending, the law enforcement officer shall deliver the item to the Division.~~"

SECTION 2.2. G.S. 20-45(d) reads as rewritten:

"(d) Any law enforcement officer who seizes a registration plate pursuant to this section shall report the seizure to the Division within 48 hours of the ~~seizure.~~seizure and shall return the registration plate to the Division within ten business days of the seizure."

SECTION 2.3. G.S. 58-2-240 reads as rewritten:

"**§ 58-2-240. Market conduct analysis, financial analysis, and related information not public record.**

(a) Notwithstanding Chapter 132 of the General Statutes, all market analysis, documents arising from market conduct action, and financial statement analysis ~~documents, ratios, programs, findings, and other information in the custody of the Department~~ work papers are confidential, are not open for public inspection, and are not discoverable or admissible in evidence in a civil action brought by a party other than the Department against a person regulated by the Department, its directors, officers, or employees, unless the court finds that the interests of justice require that the documents be discoverable or admissible in evidence or except as provided in G.S. 58-2-128 and G.S. 58-2-132(g) through (j). The Commissioner, however, may use ~~these documents, materials, findings, or other information~~ market analysis, documents arising from market conduct action, and financial statement analysis work papers in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties.

(b) As used in this Article:

(1) "Market analysis" means work product arising from a process whereby ~~individuals~~ persons employed or contracted by the Commissioner collect and analyze information from filed schedules, surveys, required reports other than periodic reports specifically required by statute, and other sources in order to develop a baseline understanding of the marketplace and to identify patterns or practices of insurers that deviate significantly from the norm or that may pose a potential risk to the insurance consumer.

(2) "Market conduct action" means any of the full range of activities, other than an examination that the Commissioner may initiate to assess and address the market practices of insurers, beginning with market analysis. Additional market conduct actions, including those taken subsequent to market analysis as a result of the findings of or indications from market analysis include: correspondence with an insurer; insurer ~~interviews,~~ interviews; information gathering; policy and procedure reviews; interrogatories; and review of insurer self-evaluation and compliance programs, including membership in a best-practice organization. The Commissioner's activities to resolve an individual consumer complaint or other report of a specific instance of misconduct are not market conduct actions for purposes of this section.

(3) "Financial statement analysis" means a set of systems and procedures designed to provide relevant information derived from basic sources of data for the purpose of evaluating the risk of an insurer's insolvency.

(4) "Financial statement analysis work papers" means:

a. Documents, programs, findings, and other information produced by persons employed or contracted by the Commissioner during and as part of the financial statement analysis of an insurer.

b. Documents, programs, findings, and other information disclosed by an entity to persons employed or contracted by the Commissioner in response to an inquiry from the Commissioner

during and as part of the financial statement analysis of the insurer.

c. Documents, programs, findings, and other information obtained, during and as part of the financial statement analysis of an insurer, by persons employed or contracted by the Commissioner from or through any regulatory or law enforcement agency or the NAIC when the receipt of that information is conditioned upon the Commissioner maintaining the confidentiality of the information shared with the Commissioner.

"Financial statement analysis work papers" includes financial analysis programs and procedures; correspondence between persons employed or contracted by the Commissioner and the insurer during and as part of the financial statement analysis; memos, emails and other correspondence, in any form, produced by persons employed or contracted by the Commissioner detailing findings or recommendations of the financial statement analysis; and the Actuarial Opinion Summary filed by an insurer as required by and in accordance with NAIC Annual Statement Instructions. "Financial statement analysis work papers" does not mean statements filed with the Commissioner under G.S. 58-2-165, CPA audit reports filed with the Commissioner under G.S. 58-2-205, or documents that constitute an initial filing and any supplemental filing necessary to complete a filing made by an insurer, independent of financial statement analysis.

(c) For purposes of subdivisions (b)(3) and (b)(4) of this section only, the term "insurer" has the same meaning as in G.S. 58-30-10(14), and includes a:

(1) Reciprocal that is or should be licensed under Article 15 of this Chapter.

(2) Local government risk pool that chooses to operate under Article 23 of this Chapter.

(3) Fraternal benefit society that is or should be licensed under Article 24 of this Chapter.

(4) Professional employer organization that is or should be licensed under Article 89A of this Chapter.

(d) Nothing in this section limits public access to financial or actuarial information or calculations filed by an insurer or other entity for rating purposes, including rate filings, deviation filings, and loss cost filings."

SECTION 2.4. Article 2 of Chapter 58 is amended by adding the following section:

"§58-2-245. Access to employer taxpayer identification numbers contained in public documents.

Notwithstanding G.S. 132-1.10(b)(5), the Department is not required to redact an employer taxpayer identification number on documents that may be made available to the general public."

SECTION 2.5. G.S. 58-21-35 reads as rewritten:

"§ 58-21-35. **Duty to file ~~reports~~ and retain ~~affidavits.~~ reports.**

(a) Within 30 days after the placing of any surplus lines insurance, the surplus lines licensee shall file with the Commissioner a report in a format prescribed by the Commissioner regarding the insurance and including the following information:

(1) The name of the insured.

(2) The identity of the ~~i~~nsurer or insurers.

(3) A description of the subject and location of the risk.

(4) The amount of premium charged for the insurance.

(5) The amount of premium tax for the insurance.

(6) The policy period.

(7) The policy number.

(7a) A signed statement that the surplus lines licensee has complied with G.S. 58-21-15.

(8) The name, address, telephone number, facsimile telephone number, and electronic mail address of the licensee, as applicable.

(9) Any other relevant information the Commissioner may reasonably require.

(b) The licensee shall complete and retain ~~an affidavit as to the efforts to place the coverage with admitted insurers and the results of the efforts, in accordance with G.S. 58-21-15.~~ a copy of the report in paper or electronic form as required by the Commissioner. The report ~~and affidavit~~ required by this section and the quarterly report required by G.S. 58-21-80 shall be completed on a standardized form or forms prescribed by the Commissioner and are not public records under G.S. 132-1 or G.S. 58-2-100."

SECTION 2.6. G.S. 58-21-45(f) reads as rewritten:

"(f) Every evidence of insurance negotiated, placed, or procured under the provisions of this Article issued by the surplus lines licensee shall bear the name of the licensee and the following legend in ~~10~~ 12 point type and in contrasting ~~color:~~ color or in 12 point type and underlined and in bold print: 'The insurance company with which this coverage has been placed is not licensed by the State of North Carolina and is not subject to its supervision. In the event of the insolvency of the insurance company, losses under this policy will not be paid by any State insurance guaranty or solvency fund.'"

SECTION 2.7. G.S. 58-33-95 reads as rewritten:

"§ **58-33-95. Agents personally liable; representing unlicensed company prohibited; penalty.**

(a) Any person or entity who solicits, negotiates, or sells insurance or acts as a third party administrator in this State for an unauthorized insurer:

(1) Is the representative of that insurer and shall be strictly liable for any losses or unpaid claims if an unauthorized insurer fails to pay in full or in part any claim or loss within the provisions of any insurance contract sold, directly or indirectly, by or through that person or entity on behalf of the unauthorized insurer.

(2) Shall be guilty of a Class 1 misdemeanor if the person or entity does not know that the insurer is an unauthorized insurer. Each solicitation, negotiation, or sale shall constitute a separate offense.

(3) Shall be guilty of a Class H felony if the person or entity knew or should have known that the insurer is an unauthorized insurer. Each solicitation, negotiation, or sale shall constitute a separate offense.

(b) A civil action may be filed or a license revocation proceeding may be initiated under this section regardless of whether a criminal action is brought or a criminal conviction is obtained for the act alleged in the civil action or revocation proceeding.

(c) ~~As used in this section, the terms "negotiate", "sell", and "solicit" shall have the meanings set forth in G.S. 58-33-10. As used in~~ For the purposes of this section, the status of an entity or person as an "unauthorized insurer" shall be determined in accordance with Article 28 of this Chapter and, if applicable, Article 49 of this Chapter.

(d) As used in this section, "third-party administrator" means a person who performs administrative functions, including claims administration and payment, marketing, premium accounting, premium billing, coverage verification, underwriting authority, or certificate issuance in regard to any kind of insurance; but does not include the persons specified in G.S. 58-56-2(5)a through (5)*l*."

SECTION 2.8. G.S. 58-58-145 reads as rewritten:

"**§ 58-58-145. Group annuity contracts defined; requirements; issuance of individual certificates.**

(a) Any policy or contract, except a joint, reversionary or survivorship annuity contract, whereby annuities are payable to more than one person, is a group annuity contract. The person, firm or corporation to whom or to which the contract is issued, is the holder of the contract. The term "annuitant" means any person to whom or which payments are made under the group annuity contract. No authorized insurer shall deliver or issue for delivery in this State any group annuity contract except upon a group of annuitants that conforms to the following: under a contract issued to an employer, or to the trustee of a fund established by an employer or two or more employers in the same industry or kind of business, the stipulated payments on which shall be paid by the holder of the contract either wholly from the employer's funds or funds contributed by the employer, or partly from the funds and partly from funds contributed by the employees covered by such contract, and providing a plan of retirement annuities under a plan which permits all of the employees of such employer or of any specified class or classes thereof to become annuitants. Any such group of employees may include retired employees, and may include officers and managers as employees, and may include the employees of subsidiary or affiliated corporations of a corporation employer, and may include the individual proprietors, partners and employees of affiliated individuals and firms controlled by the holders through stock ownership, contract or otherwise.

(b) The insurer of a group annuity contract shall issue to the policyholder or to the annuitant directly, within 30 days of the annuitant's enrollment in the group annuity contract, an individual certificate for each annuitant which:

(1) Identifies the annuity to which the annuitant is entitled.

(2) States the name of the person to whom the annuity is payable.

(3) Discloses all of the rights and obligations of the insurer, the policyholder, the annuitant, and the persons to whom the annuity is payable with respect to the group annuity contract.

G.S. 58-3-150 applies to the form of the individual certificate required by this subsection.

(c) Each group annuity contract shall include a provision that the insurer will issue to the policyholder within 30 days of the effective date of the contract, for delivery to each annuitant, an individual certificate setting forth the information described in subsection (b) of this section.

(d) This section does not apply to annuities used to fund:

(1) An employee pension plan that is covered by the Employee Retirement Income Security Act of 1974 (ERISA);

(2) A plan described in sections 401(a), 401(k), 403(b), or 457 of the Internal Revenue Code, where the plan, as defined in ERISA, is established or maintained by an employer;

(3) A governmental or church plan defined in section 414 of the Internal Revenue Code or a deferred compensation plan of a state or local government or a tax-exempt organization under section 457 of the Internal Revenue Code; or

(4) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor."

PART III. HOLDING COMPANY ACT AND RELATED AMENDMENTS.

SECTION 3.1. G.S. 58-7-130(b) reads as rewritten:

"(b) ~~No domestic stock insurance company shall declare or pay 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.~~ A domestic stock insurance company shall not declare or pay dividends or other distributions to its stockholders from any source other than unassigned surplus without the Commissioner's prior written approval. For purposes of this section, "unassigned surplus" means an amount equal to the unassigned funds of a company as reflected in the company's most recent financial statement filed with the Commissioner under G.S. 58-2-165, including all or part of the surplus arising from unrealized capital gains or revaluation of assets."

SECTION 3.2. G.S. 58-19-25(d) reads as rewritten:

"(d) Subject to G.S. 58-7-130(b) and G.S. 58-19-30(c), each domestic insurer shall report to the Commissioner all dividends and other distributions to shareholders within ~~15~~ five business days following the declaration ~~thereof.~~ thereof and at least 30 days before the payment thereof. The Commissioner may ~~prescribe the form to be used to report that information.~~ adopt rules to further the requirements of this section."

SECTION 3.3. G.S. 58-19-30(c) reads as rewritten:

"(c) No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until (i) 30 days after the Commissioner has received notice of the declaration thereof and has not within that period disapproved

the payment or (ii) the Commissioner has approved the payment within the 30-day period.

For the purposes of this section, an "extraordinary dividend" or "extraordinary distribution" includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding 12 months exceeds the ~~lesser~~ greater of (i) ten percent (10%) of the insurer's surplus as regards policyholders as of the preceding December 31, or (ii) the net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the 12-month period ending the preceding December 31; but does not include pro rata distributions of any class of the insurer's own securities. ~~In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two calendar years that has not already been paid out as dividends. This carryforward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.~~

Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution that is conditional upon the Commissioner's approval, and the declaration shall confer no rights upon shareholders until (i) the Commissioner has approved the payment of the dividend or distribution or (ii) the Commissioner has not disapproved the payment within the 30-day period referred to above."

SECTION 3.4. G.S. 58-19-30(c) reads as rewritten:

(d) For the purposes of this Article, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, all of the following factors, among others, shall be considered:

(1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria.

(2) The extent to which the insurer's business is diversified among the several kinds of insurance.

(3) The number and size of risks insured in each kind of insurance.

(4) The extent of the geographic dispersion of the insurer's insured risks.

(5) The nature and extent of the insurer's reinsurance program.

(6) The quality, diversification, and liquidity of the insurer's investment portfolio.

(7) The recent past and projected future trend in the size of the insurer's surplus as regards policyholders.

(8) The surplus as regards policyholders maintained by other comparable insurers.

(9) The adequacy of the insurer's reserves.

(10) The quality and liquidity of investments in affiliates. The Commissioner may treat any such investment as a disallowed asset for

purposes of determining the adequacy of surplus as regards policyholders whenever in his judgment such investment so warrants.

(11) The quality of the insurer's earnings and the extent to which the reported earnings of the insurer include extraordinary items."

PART IV. SEVERABILITY.

SECTION 4. If any section or provision of this act is declared unconstitutional, preempted, or otherwise 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, preempted, or otherwise invalid.

PART V. EFFECT OF HEADINGS.

SECTION 5. 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 VI. EFFECTIVE DATES.

SECTION 6. Sections 3.1, 3.2, 3.3, and 3.4 become effective December 31, 2006. The remainder of this act is effective when it becomes law.

Summary
Proposed Committee Substitute for SB 615
Insurance Technical Corrections

PART I. TECHNICAL CORRECTIONS AND CLARIFICATIONS.

SECTION 1.1: Makes a grammatical correction by adding "a" and deletes an obsolete reference to Articles 1-67 of Chapter 58.

SECTION 1.2: Deletes obsolete references to Articles 1-64 of Chapter 58. These references were a result of recodification of Chapter 58 in 1989.

SECTION 1.3: Clarifies a reinsurance law as to effective and issue dates of letters of credit. In some cases the letter of credit is issued after its effective date. Because there is a December 31 deadline for letters of credit to be credited for reinsurance purposes, the law needs to clearly state that it is the effective date that counts rather than the issue date of the letter of credit.

SECTION 1.4: Modernizes references in subsection (a) to methods of transmitting information. Amends a law that currently exempts persons claiming cash surrender values and other investment values in life insurance and annuities from having to file proof of claims with the Commissioner, as liquidator, to include claimants of unearned premiums on property or casualty insurance policies.

SECTION 1.5: Extends the allowable time period from 120 days after a final determination of insurer's insolvency to 12 months after that determination for the Commissioner, as liquidator, to apply to the court for approval of a proposal to distribute assets.

SECTION 1.6: Corrects a statutory cross reference. Because of a typographical error, the statute to which this provision refers has nothing to do with automobile repairs.

SECTION 1.7: Corrects a provision in the Reinsurance Facility law. The amount for property damage liability should be per accident and not per person.

SECTION 1.8: Corrects an inadvertent omission of the situation where an employer and not the insurer terminates a group health insurance policy.

SECTION 1.9: Amends the Small Employer Group Health Coverage Reform Act title and reference to include provisions that have been added to the Act since the original 1991 legislation.

SECTION 1.10: Corrects a cross-reference to a statute dealing with premium taxes on self-insured workers' compensation plans.

PART II. SUBSTANTIVE CORRECTIONS AND CLARIFICATIONS.

SECTIONS 2.1 and 2.2: These sections amend the current law governing the seizure certificates of title, registration cards, permits, licenses or registration plates. Under the current law, a law enforcement officer may seize these items if the officer has electronic or other notification from the Division of Motor Vehicles that the item has been revoked, canceled, or otherwise has probably cause to believe the item has been revoked or canceled.

Section 2.1 deletes the requirement in G.S. 20-45(c) directing the officer to keep the item if a criminal proceeding relating to the item is pending. Section 2.2 adds new language to G.S. 20-45(d) directing the officer to return a seized registration plate to the Division within ten business days of the seizure.

SECTION 2.3: This section clarifies a law that was enacted in 2005. That law was intended to provide confidentiality to Department-generated financial analysis documents and ratios that could be harmful to a company if it fell into a competitor's hands. Unfortunately, the law is overbroad. The changes in this section remove the over breadth and protect only those documents and information as were intended, for example by defining the key term, "financial analysis". Strict legal compliance with this law has resulted in the Department's inability to disclose what should be "public" information, which companies readily use to compete in the marketplace. The changes in this section have the overwhelming support of the insurance industry.

SECTION 2.4: In 2005 comprehensive legislation was enacted to protect individuals from identity theft. Part of that law prohibits government agencies from disclosing an employer's tax identification number (FEIN) to the public. The Department of Insurance receives many documents from insurance companies as a part of the process of approving premium rates and policy provisions. Almost all of these documents are filed electronically in portable document format (PDF), and every document contains the company's FEIN. These documents are public record, but the law prevents access to these documents because the PDF cannot be altered to redact the FEIN. This section makes a minor exception to the identity theft provision, and has the overwhelming support of the insurance industry.

SECTION 2.5: Current law requires a surplus lines insurance broker to execute an affidavit to the effect that the broker has made a diligent search for the coverage from licensed companies without success. Because of the recent changes in the notary public laws, many part-time notaries are not renewing their credentials, thus making it difficult for brokers to get affidavits notarized, which they must be. The change would require the broker to file a signed statement with the Commissioner in which the broker would recite the same facts as in the affidavit.

SECTION 2.6: For years the surplus lines law has required a policy to contain a warning to the buyer stating that the insurer is not licensed by the State and is not subject to State supervision and that any losses under the policy are not covered by any State solvency fund if the company becomes bankrupt. This warning was usually stamped on the policy and had to be in contrasting color and at least 10 point type. Now most of the policies are generated electronically and the contrasting color requirement is unrealistic. This section amends the law to allow an alternative

method, which would be to print the warning in boldface and underline it. This would also enlarge the font to 12 point type, which is what you are reading now.

SECTION 2.7: When this statute was revised in 2004 to reflect a North Carolina Court of Appeals opinion on liability of a person who sells insurance for an unauthorized insurer, the language that also applied to third party administrators was inadvertently deleted. This section corrects that omission and defines the term, "third party administrator."

SECTION 2.8: In 2005 a law dealing with group annuities was amended to require the insurer to issue certificates of coverage to persons covered by the group annuity (usually employees). This was based on an NAIC model act; however, part of the model was not in the legislation. This section puts the model act language in the statute. The new language provides that in the case of annuities that are used to fund employee pension plans, 401(k) and other IRS plans, deferred compensation plans, etc., do not have to issue certificates.

PART III. HOLDING COMPANY ACT AND RELATED AMENDMENTS.

SECTIONS 3.1 through 3.4: These sections contain amendments that will enhance the competitiveness of North Carolina's domestic insurance companies. They increase dividend capacity and the ability to pay extraordinary stock dividends and enhance the ability to prudently deploy capital. For insurance holding companies, increased capacity of their North Carolina operating subsidiaries to pay dividends is important. Dividend capacity is one factor that credit rating agencies like Standard & Poor's and Moody's utilize to assess creditworthiness and claims-paying ability. They want to know that the money is there and available without the necessity of prior approval. Creditworthiness and claims-paying ability are important considerations in determining an insurer's financial strength rating. This financial strength rating is important to the insurer as it may impact the cost of debt the insurer pays. Standard & Poor's has stated that insurance companies operating in states that do not have the language proposed in these sections are at a competitive disadvantage.

EFFECTIVE DATES: The provisions in Part III become effective December 31, 2006. The remainder of the act is effective when signed by the Governor.

Prepared by:

William K. Hale
Special Counsel
N.C. Department of Insurance
June 14, 2006

Additional Information provided by:
Tim Hovis
Research Division
North Carolina General Assembly

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

ATTACHMENT III

EDITION No. _____

H. B. No. _____ DATE 6/20/06

S. B. No. 615 Amendment No. _____ (to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE S615-CSRG-38[v.5]

Rep.) Hollman

Sen.)

1 moves to amend the bill on page 4, lines 32 - 36

2 ( ) WHICH CHANGES THE TITLE

3 by removing the redlining;

4 page 4

5 and on line 33, by rewriting the

6 line to read:

7

8 "relating to ~~the item~~ ~~the~~ certificate

9 of title, registration card, permit, or

10 license is pending, the law

11 enforcement officer in possession

12 of that item";

13

14 and on page 4 line 40 by

15 inserting the ~~following~~ phrase

16 "but not a ficticious registration

17 plate," after the word "plate"

18

19

SIGNED _____

ADOPTED X FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

ATTACHMENT IV

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE 6/20/06

S. B. No. 615 Amendment No. _____

Proposed
COMMITTEE SUBSTITUTE _____ (to be filled in by Principal Clerk)

Rep.)
) Holliman
Sen.)

1 moves to amend the bill on page 7, line 12

2 ( ) WHICH CHANGES THE TITLE

3 by deleting the words "Asigned" and substituting

4 the words "An Acknowledged".

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SIGNED _____

ADOPTED X FAILED _____ TABLED _____

ATTACHMENT V

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 615

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

S615-ARG-18 [v.1]

Date _____,2006

Comm. Sub. [NO]
Amends Title [NO]
PCS

Representative Saunders

moves to amend the bill on page 4, between lines 41 and 42,
by inserting the following:

"**SECTION 2.3.** G.S. 20-288 reads as written:

'**§ 20-288. Application for license; license requirements; expiration of license; bond.**

(a) A new motor vehicle dealer, motor vehicle sales representative, manufacturer, factory branch, factory representative, distributor, distributor branch, distributor representative, or wholesaler may obtain a license by filing an application with the Division. An application must be on a form provided by the Division and contain the information required by the Division. An application for a license must be accompanied by the required fee and by an application for a dealer license plate.

(a1) A used motor vehicle dealer may obtain a license by filing an application, as prescribed in subsection (a) of this section, and providing the following:

(1) The required fee.

(2) Proof that the applicant, within the last 12 months, has completed a 12-hour licensing course approved by the Division if the applicant is seeking an initial license and a six-hour course approved by the Division if the applicant is seeking a renewal license. The requirements of this subdivision do not apply to a used motor vehicle dealer the primary business of which is the sale of salvage vehicles on behalf of insurers or to a manufactured home dealer licensed under G.S. 143-143.11 who complies with the continuing education requirements of G.S. 143-143.11B. The requirement of this subdivision does not apply to persons age 62 or older as of July 1, 2002, who are seeking a renewal license.

(3) If the applicant is an individual, proof that the applicant is at least 18 years of age and proof that all salespersons employed by the dealer are at least 18 years of age.

(4) The application for a dealer license plate.

(b) The Division shall require in such application, or otherwise, information relating to matters set forth in G.S. 20-294 as grounds for the refusing of licenses, and to other pertinent matters commensurate with the safeguarding of the public interest, all of which shall be considered by the Division in determining the fitness of the applicant to engage in the business for which he seeks a license.

(c) All licenses that are granted shall be for a period of one year unless sooner revoked or suspended. The Division shall vary the expiration dates of all licenses that are granted so that an equal number of licenses expire at the end of each month, quarter, or other period consisting of one or more months to coincide with G.S. 20-79(c).

(d) To obtain a license as a wholesaler, an applicant who intends to sell or distribute self-propelled vehicles must have an established office in this State, and an applicant who intends to sell or distribute only trailers or semitrailers of more than 2,500 pounds unloaded weight must have a place of business in this State where the records required under this Article are kept.

To obtain a license as a motor vehicle dealer, an applicant who intends to deal in self-propelled vehicles must have an established salesroom in this State, and an applicant who intends to deal in only trailers or semitrailers of more than 2,500 pounds unloaded weight must have a place of business in this State where the records required under this Article are kept.

An applicant for a license as a manufacturer, a factory branch, a distributor, a distributor branch, a wholesaler, or a motor vehicle dealer must have a separate license for each established office, established salesroom, or other place of business in this State. An application for any of these licenses shall include a list of the applicant's places of business in this State.

(e) Each applicant approved by the Division for license as a motor vehicle dealer, manufacturer, factory branch, distributor, distributor branch, or wholesaler shall furnish a corporate surety bond or cash bond or fixed value equivalent of the bond. The amount of the bond for an applicant for a motor vehicle dealer's license is fifty thousand dollars ($50,000) for one established salesroom of the applicant and twenty-five thousand

dollars ($25,000) for each of the applicant's additional established salesrooms. The amount of the bond for other applicants required to furnish a bond is fifty thousand dollars ($50,000) for one place of business of the applicant and twenty-five thousand dollars ($25,000) for each of the applicant's additional places of business.

A corporate surety bond shall be approved by the Commissioner as to form and shall be conditioned that the obligor will faithfully conform to and abide by the provisions of this Article and Article 15. A cash bond or fixed value equivalent thereof shall be approved by the Commissioner as to form and terms of deposits as will secure the ultimate beneficiaries of the bond; and such bond shall not be available for delivery to any person contrary to the rules of the Commissioner. Any purchaser of a motor vehicle, including a motor vehicle dealer, who shall have suffered any loss or damage by the failure of any license holder subject to this subsection to deliver free and clear title to any vehicle purchased from a license holder or any other act of a license holder subject to this subsection that constitutes a violation of this Article or Article 15 of this Chapter shall have the right to institute an action to recover against the license holder and the surety. Every license holder against whom an action is instituted shall notify the Commissioner of the action within 10 days after served with process. ~~A~~ Except as provided by G.S. 20-288(f) and (g), a corporate surety bond shall remain in force and effect and may not be canceled by the surety unless the bonded person stops engaging in business or the person's license is denied, suspended, or revoked under G.S. 20-294. That cancellation may be had only upon 30 days' written notice to the Commissioner and shall not affect any liability incurred or accrued prior to the termination of such 30-day period. This subsection does not apply to a license holder who deals only in trailers having an empty weight of 4,000 pounds or less. This subsection does not apply to manufacturers of, or dealers in, mobile or manufactured homes who furnish a corporate surety bond, cash bond, or fixed value equivalent thereof, pursuant to G.S. 143-143.12.

(f) A corporate surety bond furnished pursuant to this section or renewal thereof may also be canceled by the surety prior to the next premium anniversary date without the prior written consent of the license holder for the following reasons:

(1) Nonpayment of premium in accordance with the terms for issuance of the surety bond; or

(2) An act or omission by the license holder or his representative that constitutes substantial and material misrepresentation or nondisclosure of a material fact in obtaining the surety bond or renewing the bond.

Any cancellation permitted by this subsection is not effective unless written notice of cancellation has ben delivered or mailed to the license holder and to the Commissioner not less than 30 days before the proposed effective date of cancellation. The notice must be given or mailed by certified mail to the license holder at its last known address. The notice must state the reason for cancellation. Cancellation for nonpayment of premium is not effective if the amount due is paid before the effective date set forth in the notice of cancellation. Cancellation of the surety shall not affect any liability incurred or accrued prior to the termination of the 30-day notice period.

(g) A corporate surety may refuse to renew a surety bond furnished pursuant to this section by giving or mailing written notice of nonrenewal to the license holder and to the Commissioner not less than 30 days prior to the premium anniversary date of the surety bond. The notice maust be given or mailed by certified mail to the license holder at its last known address. Cancellation of the surety bond shall not affect any liability incurred or accrued prior to the premium anniversary date of the surety bond."

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 615

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

S615-ARG-18 [v.1]

and by renumbering the remaining sections of Part II accordingly;

and on page 11, line 15, by rewriting the line to read:

"**SECTION 6.** Section 2.3 becomes effective October 1, 2006. Sections 3.1, 3.2, 3.3, and 3.4 become effective December 31,"

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

ATTACHMENT VI

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H **D**

HOUSE BILL 1987
PROPOSED COMMITTEE SUBSTITUTE H1987-CSRC-107 [v.5]

6/19/2006 6:43:47 PM

Short Title: Health Plans/Changes to Basic and Std. (Public)

Sponsors:

Referred to:

May 16, 2006

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE STATUTORY BASIC AND STANDARD HEALTH PLANS FOR SMALL EMPLOYERS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-125 is amended by adding a new subsection to read:

"(a1) Both the basic health care plan and the standard health care plan provided for in subsection (a) of this section may have optional deductible and co-payment levels as may be determined by the small employer carrier, including high deductible options. A small employer carrier shall file any changes in deductibles or copayment levels with the Commissioner for the Commissioner's approval prior to implementing the changes in this State. The Commissioner may periodically review and update the benefits provided by these plans to address trends in the small group market. The Commissioner shall consult with small employer carriers and representatives of the insurance agent and small employer communities as part of that periodic review."

SECTION 2. 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~~

As a condition of transacting business as a small employer carrier in this State, the carrier shall either offer small employers at least one basic and one standard health care ~~plan.~~ plan or the alternative coverages provided in G.S 58-50-126. 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).~~ G.S. 58-50-130(a)(4b). 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 3. Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-126. Alternative coverage permitted.**

(a) In general. – In the case of health insurance coverage offered in this State, a small employer carrier may elect to limit the coverage offered under G.S. 58-50-125(d) if the carrier offers at least two different policy forms of health insurance coverage and both policy forms meet all of the following:

(1) The policy forms are designed for, made available or actively marketed to, and actually enroll self-employed individuals and other small employer groups.

(2) The policy forms meet the requirements of either subsections (b) or (c) of this section, as elected by the small employer carrier.

(b) Choice of most popular policy forms. – The requirements of this section are met for health insurance coverage policy forms offered by a small employer carrier if the carrier offers the policy forms for small group health insurance coverage with the two highest premium volume numbers of all the policy forms offered by the carrier in this State or in applicable marketing or service areas in the period involved.

(c) Choice of two policy forms with representative coverage. – The requirements of this section are met for health insurance coverage policy forms offered by a small employer carrier in the small group market if the small employer carrier offers both policy forms described in this subsection and each policy form includes benefits substantially similar to other small group health insurance coverage offered by the small employer carrier in this State.

(1) Lower-level coverage policy form. – A policy form is deemed a lower-level coverage policy form 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, as described in subdivision (3) of this subsection.

(2) Higher-level coverage policy form. – A policy form is deemed a higher-level coverage policy form if all of the following apply:

a. 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 subdivision (1) of this subsection offered by the small employer carrier.

b. 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, as described in subdivision (3) of this subsection.

(3) Weighted average. – For the purposes of this subsection, a weighted average is the average actuarial value of the benefits provided by all the health insurance coverage issued, as elected by the small employer carrier, either by that small employer carrier or all small employer carriers in this State in the small group market during the previous year, not including coverage issued under this section, weighted by enrollment for the different coverage.

(d) Election. – The small employer carrier elections of the policies to be offered under this section shall apply uniformly to all small employers in this State for that small employer carrier. The election shall be effective for a period of not less than two years.

(e) Assumptions. – For the purposes of subsection (c) of this section, the actuarial value of benefits provided under small group insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(f) Discontinuation of basic or standard plans. – If a small employer carrier chooses to offer the plans under this section and discontinues coverage under the basic or standard health benefit plans provided for in G.S. 58-50-125, the carrier shall make available to the insured employer whose coverage is to be discontinued both of the plans offered under this section. New coverage made available under this section shall constitute replacement coverage and shall be rated in accordance with G.S. 58-50-130(b)(3).

(g) Different policy forms. – For purposes of this section only, policy forms that have different cost-sharing arrangements or different riders shall be considered to be different policy forms."

SECTION 4. G.S. 58-68-40(e)(2) reads as rewritten:

"(2) A self-employed individual as defined in G.S. 58-50-110(21a), except as otherwise provided for the basic and standard health care plans or other plans under G.S. 58-50-126 under the North Carolina Small Employer Group Health Coverage Reform Act."

SECTION 5. G.S. 58-50-110(5a) reads as rewritten:

"(5a) 'Case characteristics' means the demographic factors age, gender, family size, ~~and~~ geographic ~~location.~~location, and industry."

SECTION 6. G.S. 58-50-110 is amended by adding the following subdivision to read:

"(12a) "Industry" means a demographic factor used to reflect the financial risk associated with a specific industry."

SECTION 7. G.S. 58-50-130(b) reads as rewritten:

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

(1) Small employer carriers shall use an adjusted-community rating methodology in which the premium for each small employer can vary only on the basis of the eligible employee's or dependent's age as determined ~~in accordance with~~ under subdivision (6) of this subsection, the gender of the eligible employee or dependent, number of family members covered, or geographic area as determined under subdivision (7) of this ~~subsection.~~ subsection, or industry as determined under subdivision (9) of this subsection. Premium rates charged during a rating period to small employers with similar case characteristics for same coverage shall not vary from the adjusted community rate by more than ~~twenty percent (20%)~~ twenty-five percent (25%) for any reason, including differences in administrative costs and claims experience.

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

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

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

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

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

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

(6) ~~For the purposes of subsection (b) of this section, a small employer carrier shall, unless~~ Unless the small employer carrier uses composite rating, the small employer carrier shall use the following age brackets:

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

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

(7) ~~For the purposes of subsection (b) of this section, a~~ A carrier shall ~~not apply different geographic rating factors to the rates of small employers located within the same county; and~~define geographic area to mean medical care system. Medical care system factors shall reflect the relative differences in expected costs, shall produce rates that are not excessive, inadequate, or unfairly discriminatory in the medical care system areas, and shall be revenue neutral to the small employer carrier.

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

a. Health benefit plans that use different provider network arrangements may be considered separate plans for the purposes of determining the rating in subdivision (1) of this subsection, provided that the different arrangements are expected to result in substantial differences in claims ~~costs;~~ costs.
b. Except as provided for in sub-subdivision a. of this subdivision, differences in rates charged for different health benefit plans shall be reasonable and reflect objective differences in plan design, but shall not permit differences in premium rates because of the case characteristics of groups assumed to select particular health benefit ~~plans; and~~plans.

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

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

SECTION 8. G.S. 58-50-149 reads as rewritten:

"**§ 58-50-149. Limit on cessions to the Reinsurance Pool.**

In addition to any individual or group previously reinsured in accordance with G.S. 58-50-150(g)(1), the Pool shall only reinsure a health benefit plan issued or delivered for original issue by a reinsuring carrier on or after October 1, 1995, if the health benefit plan provides coverage to a small employer with no more than 25 eligible employees, including self-employed individuals. Notwithstanding any other provision of law, the Pool shall cease to reinsure any individual or group on January 1, 2007. Reinsuring carriers as of that date shall continue to be governed by G.S. 58-50-135(b) and 58-50-150 until and through the termination of the Pool under G.S. 58-50-157."

SECTION 9. Article 50 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-50-157. Termination of the North Carolina Small Employer Health Reinsurance Pool.**

The Pool shall continue in existence subject to the provisions of G.S. 58-50-149 and all other applicable State and federal laws. If the Board and the Commissioner determine that a law results in the termination of the Pool, the Pool shall terminate and conclude its affairs in a manner to be determined by the Board with the approval of the Commissioner. Any funds or assets of any nature held by the Pool following termination and the payment of all claims and expenses of the Pool shall be distributed to the Pool Member small employer carriers existing at that time in accordance with the then-existing assessment formula found in the Pool's Plan of Operation. The Pool may also assess members in accordance with the then-existing assessment formula should there be claims and expenses of the Pool for which current assessments or funds do not provide adequate resources to cover."

SECTION 10. G.S. 58-50-120, 58-50-125(b), (e) and (g), 58-50-135(a), 58-50-140, and 58-50-145 are repealed.

SECTION 11. G.S. 58-50-125(f) reads as rewritten:

"(f) ~~Every~~ To the extent it is required under this section and G.S. 58-68-40, every small employer carrier shall fairly market ~~the basic and standard health care plan~~ all of its small group health benefit plans it offers on a guaranteed issue basis to all small employers in the geographic areas in which the carrier makes coverage available or provides benefits."

SECTION 12. G.S. 58-50-135(b) reads as rewritten:

"(b) A small employer carrier that ~~elects to stop~~ stops participating as a reinsuring carrier ~~and to become a risk-assuming carrier shall not reinsure or continue to reinsure any small employer health benefit plans under G.S. 58-50-145 and G.S. 58-50-150 as soon as the carrier becomes a risk-assuming carrier; however, a reinsuring carrier~~

~~electing to become a risk-assuming carrier~~ shall pay a prorated assessment based upon business issued as a reinsuring carrier for any part of the year that ~~the business was reinsured. A small employer carrier that elects to stop participating as a risk-assuming carrier and to become a reinsuring carrier may reinsure small employer health benefit plans under the provisions of G.S. 58-50-145 and G.S. 58-50-150.~~ an assessment is made under G.S. 58-50-150. "

SECTION 13. G.S. 58-50-150(a) reads as rewritten:

"(a) There is created a nonprofit entity to be known as the North Carolina Small Employer Health Reinsurance Pool. All carriers issuing or providing health benefit plans in this State ~~on and after~~ from January 1, ~~1992,~~ 1992 until the termination of the Pool under G.S. 158-50-157, except any small employer carrier electing to be a risk-assuming carrier, are members of the Pool."

SECTION 14. G.S. 58-3-191(b)(1) reads as rewritten:

"(b) Disclosure requirements. – Each health benefit plan shall provide the following applicable information to plan participants and bona fide prospective participants upon request:

(1) The evidence of coverage (G.S. 58-67-50), subscriber contract (G.S. 58-65-60, 58-65-140), health insurance policy (G.S. 58-51-80, 58-50-125, 58-50-126, 58-50-55), or the contract and benefit summary of any other type of health benefit plan;"

SECTION 15. G.S. 58-50-125(h) reads as rewritten:

"(h) The provisions of ~~subsections (b), (d), and (g) and subdivision (e)(2)~~ subsection (d) of this section apply to every health benefit plan delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after the date the plan becomes operational, as determined by the Commissioner. For purposes of this subsection, the date a health benefit plan is continued is the anniversary date of the issuance of the health benefit plan."

SECTION 16. This act is effective when it becomes law.

HOUSE BILL 1987:
Health Plans/Changes to Basic and Std

BILL ANALYSIS

Committee:	House Insurance	**Date:**	June 19, 2006
Introduced by:	Reps. Holliman, Underhill	**Summary by:**	Kory Goldsmith
Version:	PCS to First Edition H1987-CSRC-107		Committee Counsel

SUMMARY: HB 1987 makes changes to the Basic and Standard health plans for small group insurance carriers. This bill came as a request of the Department of Insurance and as recommended by the House Select Committee on Health Care.

The PCS makes conforming and technical changes.

BILL ANALYSIS:

Section 1 adds a new subsection to G.S. 58-50-125 to allow carriers to include in both the Basic and Standard health plans for small group insurance carriers optional deductible and copayment levels including a high-deductible option. It would also permit the Commissioner to periodically review and update the plan design for the Basic and Standard Plans according to market trends and after consulting with insurers, insurance agents and small employers.

Section 2 amends G.S. 58-50-125(d) to give small group carriers the option of offering two alternative health plans to all small employers on a guaranteed issue basis instead of offering the Basic and Standard Plans. The Basic and Standard Plans (and these alternative plans that the small group carriers would be permitted to offer instead) are the only plans that must be made available to every self-employed individual who wishes to purchase health insurance. Carriers may use underwriting criteria to selectively offer other products to this segment of the small group market.

Section 3 creates G.S. 58-50-126 to set out the standards that the small group carriers must meet when they offer the new alternatives plans instead of the Basic and Standard Plans. The alternative plans must be products that are generally marketed to small groups and are either the two most popular of the small group plans that the carrier sells (as measured by premium volume) or two "representative plans" of the carrier's small group business, with one of the two having 85% to 100% actuarial equivalence to the carrier's weighted average small group business and the other having 100% to 120% actuarial equivalence to the carrier's weighted average small group business thus offering a higher-end and lower-end plan.

Section 4 amends G.S. 58-68-40(e)(2), which mentions the guaranteed-issue nature of the Basic and Standard Plans, to include a reference to the alternative guaranteed-issue plans provided for in Section 3 of the bill.

Section 5 amends G.S. 58-50-110 (5a) to add "industry" to the list of group rating factors known as "case characteristics", to conform to the changes made later in the bill.

Section 6 adds a new subdivision (12)(a) to G.S. 58-50-110 which defines "industry" as a demographic factor.

Section 7 makes numerous substantive and technical changes to G.S. 58-50-130(b). Among the substantive changes are an amendment to (b)(1) to expand the rating bands (which limit the amount by which premium rates for a particular small group may vary from the average rate, based on the group's known or expected claims experience) from +/-20 percent to +/- 25 percent. It also adds employer

industry as a factor that carriers may use when setting the premium for each group. It amends subdivision (b)(2) to add a reference to the new industry rating factor to conform to the changes made in section 5 of the bill. It adds a new subdivision to G.S. 58-50-130(b) which limits the weight given to the rating factor for industry to approximately +/- 10 percent. It also amends subdivision (b)(7) to redefine "geographic area" (a permitted rating factor) to mean "medical care system", and specifies that such factors reflect the relative differences in expected costs due to the different medical care systems that serve different locales. The effect is that geographic factors will now be determined based on the service areas of each medical care system rather than on county lines.

Section 8 amends G.S. 58-50-149 to terminate reinsurance coverage under the North Carolina Small Employer Health Reinsurance Pool for small groups and employees of small groups that small group carriers that have previously ceded to the Pool. This change would become effective January 1, 2007. Carriers have indicated that the pool is no longer needed because they are able to adequately reinsure small group lives in the private reinsurance market.

Section 9 creates a new statute (G.S. 58-50-157) to specify the process for the orderly winding down and future termination of the North Carolina Small Employer Health Reinsurance Pool.

Section 10 repeals G.S. 58-50-120, 58-50-125(b), (e), and (g), 58-50-135(a), 58-50-140, and 58-50-145. These sections and subsections of the Small Employer Group Health Coverage Reform Act are no longer needed either due to other changes made within this bill or because they have become outmoded due to changes in the small group market or changes in federal law that affect the regulation of small group health insurance.

Section 11 amends G.S. 58-50-125(f) to require that small group carriers fairly market all of the small group plans that are required to be sold on a guaranteed issue basis. The change is an update of the law to recognize that the Basic and Standard Plans are no longer the only plans that are required to be offered on a guaranteed-issue basis and have not been ever since North Carolina adopted HIPPA.

Section 12 amends G.S. 58-50-135(b) to reflect the future termination of the North Carolina Small Employer Health Reinsurance Pool.

Section 13 amends G.S. 58-50-150(a) to account for the future termination of the North Carolina Small Employer Health Reinsurance Pool.

Sections 14 and 15 are conforming changes.

EFFECTIVE DATE: The act is effective when it becomes law.

H1987e1-SMRC-CSRC-107

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 22, 2006

The House Committee on Insurance met at 11:00 AM on Thursday, June 22, 2006 in Room 1228. The following Representatives in attendance were: Chairman H. Holliman, Vice Chairs: Ed Jones and M. Setzer. Members: D. Almond, H Brubaker, W. Current, R. Grady, J. Howard, L. Johnson, D. Ross, D. Saunders F. Steen, and R. Sutton.

Chairman Holliman welcomed visitors, House pages, Sgt-At-Arms and Visitors. See Attachment I.

Rep. Holliman asked for a motion to approve the minutes for the June 22, 2006 committee meeting. Rep. Saunders made the motion, motion passed.

Sen Dalton was called on to speak on SB 277 – Motor Vehicle Self-Insurers. Sen Dalton explained Section 5 on page 8 of the bill. See Attachment II.

Chairman Holliman asked for a motion to accept the PCS. Rep. Saunders made the motion, motion passed.

Barbara M. Burke, Chief Deputy Commissioner, NCDOI was asked to speak on the legislation. She explained how the bill addresses disaster preparedness and response situations. Ms. Burke explained the sections in the bill summary and answered questions from the committee members. See Attachment III.

Rep. Jones offered an amendment to amend page 9 lines 22-23. The motion passed unanimously. See Attachment IV.

Rep. Ross moved for a favorable report to the PCS as amended unfavorable to the original bill. The motion carried.

The meeting adjourned at 11:35

Representative L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

HOUSE INSURANCE COMMITTEE

June 22, 2006
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

Approve Committee Minutes for June 20, 2006 meeting.

SB 277 Motor Vehicle Self-Insurers – Sen Dalton

SB 881 Lapse in Liability Insurance – Sen Garrou

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: THURSDAY, JUNE 22, 2006

TIME: 11:00 AM

LOCATION: 1228 LB

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

SB 277 – Motor Vehicle Self-Insurers – Sen. Dalton
SB 881 – Lapse in Liability Insurance – Sen Garrou

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 12:35 PM on June 20, 2005.

_X__Principal Clerk
_X__Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Holliman (Chair) for the Committee on INSURANCE.

☒ Committee Substitute for
SB 277 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE ISSUANCE OF A CERTIFICATE OF MOTOR VEHICLE SELF-INSURANCE FOR CERTAIN GROUPS TO ADDRESS THOSE ORGANIZATIONS EXEMPTED UNDER FEDERAL LAW.

☒ With a favorable report as to the House committee substitute bill, which changes the title, unfavorable as to the ~~original bill~~.. Senate Comm. Sub.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House/Senate) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Holliman (Chair) for the Committee on INSURANCE.

☒ Committee Substitute for bill # 2

SB 881 A BILL TO BE ENTITLED AN ACT TO REVISE THE PENALTIES FOR OPERATING A MOTOR VEHICLE WITHOUT HAVING IN FULL FORCE AND EFFECT A LIABILITY INSURANCE POLICY PROVIDING FINANCIAL RESPONSIBILITY.

☒ With a favorable report as to House committee substitute bill, unfavorable as to the Senate Committee Substitute bill 2, and recommendation that the House committee substitute bill be re-referred to the Committee on Finance.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House/Senate) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

ATTACHMENT 1

House Pages

Name Of Committee: Das Date: 6/22/06

1. Name: Elizabeth Locklear
   County: Robeson
   Sponsor: Rep. Ronnie Sutton
2. Name: Elizabeth Priest
   County: Bladen
   Sponsor: Rep. Edd Nye
3. Name: Matthew Locklear
   County: Robeson
   Sponsor: Rep. Bonnie Sutton
4. Name: Willie Jacobs
   County: Scotland
   Sponsor: Black
5. Name:
   County:
   Sponsor:

Sgt-At-Arms

1. Name: Martha Gadison
2. Name: James Worth
3. Name: Charles Williams
4. Name:
5. Name:

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — June 22, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jeff Butler	AIANC 4209 Atlantic Ave Raleigh NC.
[illegible]	[illegible]
Joe Stewart	IFNC
Susan Valauri	Nationwide
Brenda Freeman	DMV
Cameron Contizano	Daily Bulletin
Johanna Reese	DOT
Bill Scoggin	KCCI
Butch Gunnells	NCBA
Paige Hall	Gov's Office
Lee Hyde	ICCU
Bill Scoggin	

ATTACHMENT II

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

S D

SENATE BILL 881
Commerce Committee Substitute Adopted 6/29/05
Finance Committee Substitute Adopted 8/9/05
PROPOSED HOUSE COMMITTEE SUBSTITUTE S881-CSRC-110 [v.2]

6/21/2006 2:37:12 PM

Short Title: Lapse in Liability Insurance. (Public)

Sponsors:

Referred to:

March 23, 2005

A BILL TO BE ENTITLED

AN ACT TO REVISE THE PENALTIES FOR OPERATING A MOTOR VEHICLE WITHOUT HAVING IN FULL FORCE AND EFFECT A LIABILITY INSURANCE POLICY PROVIDING FINANCIAL RESPONSIBILITY.

The General Assembly of North Carolina enacts:

SECTION 1. Article 13 of Chapter 20 of the General Statutes is amended by adding a new section to read:

"**§ 20-309.2. Insurer shall notify Division of actions on insurance policies.**

(a) Notice Required. – An insurer shall notify the Division upon any of the following with regard to a motor vehicle liability policy:

(1) Issues a new or replacement policy.

(2) Terminates a policy, either by cancellation or failure to renew, unless the same insurer issues a replacement policy complying with this Article at the same time the insurer terminates the old policy and no lapse in coverage results.

(3) Reinstates a policy after the insurer has notified the Division of a cancellation or termination.

(b) Time Period. – An insurer shall notify the Division as required by subsection (a) of this section within 20 business days.

(c) Form of Notice. – Any insurer with twenty-five million dollars ($25,000,000) or more in annual vehicle insurance premium volume shall submit the notices required under this section by electronic means. All other insurers may submit the notices required under this section by either paper or electronic means.

(d) Trade Secret Protection. – The names of insureds and the beginning date and termination date of insurance coverage provided to the Division by an insurer under this section constitutes a designated trade secret under G.S. 132-1.2.

(e) Civil Penalty. – The Commissioner of Insurance may assess a civil penalty of two hundred dollars ($200.00) against an insurer that fails to notify the Division as required by this section. The Commissioner may waive the penalty if the insurer establishes good cause for the failure."

SECTION 2. G.S. 20-311 reads as rewritten:

"**§ 20-311. ~~Revocation of registration when financial responsibility not in effect.~~Action by the Division when notified of a lapse in financial responsibility.**

~~Upon receipt of evidence that financial responsibility for the operation of any motor vehicle registered or required to be registered in this State is not or was not in effect at the time of operation or certification that insurance was in effect, the Division shall revoke the owner's registration plate issued for the vehicle at the time of operation or certification that insurance was in effect or the current registration plate for the vehicle in the year registration has changed for 30 days.~~

~~The vehicle for which registration has been revoked pursuant to this section may be registered at the end of the 30-day revocation period upon certification of financial responsibility and payment by the vehicle owner of a fifty-dollar ($50.00) administrative fee in addition to appropriate license fees. In no event may such vehicle be registered prior to payment of the fifty dollar ($50.00) administrative fee.~~

(a) Action. – When the Division receives evidence, by a notice of termination of a motor vehicle liability policy or otherwise, that the owner of a motor vehicle registered or required to be registered in this State does not have financial responsibility for the operation of the vehicle, the Division shall send the owner a letter. The letter shall notify the owner of the evidence and inform the owner that the owner shall respond to the letter within 10 days of the date on the letter and explain how the owner has met the duty to have continuous financial responsibility for the vehicle. Based on the owner's response, the Division shall take the appropriate action listed:

(1) Division correction. – If the owner responds within the required time and the response establishes that the owner has not had a lapse in financial responsibility, the Division shall correct its records.

(2) Penalty only. – If the owner responds within the required time and the response establishes all of the following, the Division shall assess the owner a penalty in the amount set in subsection (b) of this section:

a. The owner had a lapse in financial responsibility, but the owner now has financial responsibility.

b. The vehicle was not involved in an accident during the lapse in financial responsibility.

c. The owner did not operate the vehicle during the lapse with knowledge that the owner had no financial responsibility for the vehicle.

(3) Penalty and revocation. – If the owner responds within the required time and the response establishes any of the following, the Division shall assess the owner a penalty in the amount set in subsection (b) of

this section and revoke the registration of the owner's vehicle for the period set in subsection (c) of this section:

a. The owner had a lapse in financial responsibility and still does not have financial responsibility.

b. The owner now has financial responsibility even though the owner had a lapse, but the vehicle was involved in an accident during the lapse, the owner operated the vehicle during the lapse with knowledge that the owner had no financial responsibility for the vehicle, or both.

(4) Revocation pending response. – If the owner does not respond within the required time, the Division shall revoke the registration of the owner's vehicle for the period set in subsection (c) of this section. When the owner responds, the Division shall take the appropriate action listed in subdivisions (1) through (3) of this subsection as if the response had been timely.

(b) Penalty Amount. – The following table determines the amount of a penalty payable under this section by an owner who has had a lapse in financial responsibility; the amount is based on the number of times the owner has been assessed a penalty under this section during the three-year period before the date the owner's current lapse began:

Number of Lapses in Previous Three Years	Penalty Amount
None	$75.00
One	$150.00
Two or More	$250.00

(c) Revocation Period. – The revocation period for a revocation based on a response that establishes that a vehicle owner does not have financial responsibility is indefinite and ends when the owner obtains financial responsibility or transfers the vehicle to an owner who has financial responsibility. The revocation period for a revocation based on a response that establishes the occurrence of an accident during a lapse in financial responsibility or the knowing operation of a vehicle without financial responsibility is 30 days. The revocation period for a revocation based on failure of a vehicle owner to respond is indefinite and ends when the owner responds.

(d) Revocation Notice. – When the Division revokes the registration of an owner's vehicle, it shall notify the owner of the revocation. The notice shall inform the owner of the following:

(1) That the owner shall return the vehicle's registration plate and registration card to the Division, if the owner has not done so already, and that failure to do so is a Class 2 misdemeanor under G.S. 20-45.

(2) That the vehicle's registration plate and registration card are subject to seizure by a law enforcement officer.

(3) That the registration of the vehicle cannot be renewed while the registration is revoked.

(4) That the owner shall pay any penalties assessed, a restoration fee, and the fee for a registration plate when the owner applies to the Division to register a vehicle whose registration was revoked.

(e) Registration After Revocation. – A vehicle whose registration has been revoked may not be registered during the revocation period in the name of the owner, a child of the owner, the owner's spouse, or a child of the owner's spouse. This restriction does not apply to a spouse who is living separate and apart from the owner. At the end of a revocation period, a vehicle owner who has financial responsibility may apply to register a vehicle whose registration was revoked. The owner shall pay any penalty assessed, a restoration fee of fifty dollars ($50.00), and the fee for a registration plate."

SECTION 3. G.S. 20-316 reads as rewritten:

"**§ 20-316. Divisional hearings upon lapse of liability insurance coverage.**

Any person whose registration plate has been revoked under G.S. ~~20-309(e) or~~ 20-311 may request a hearing. Upon receipt of such request, the Division shall, as early as practical, afford ~~him~~ an opportunity for hearing. ~~Upon such~~ At the hearing the duly authorized agents of the Division may administer oaths and issue subpoenas for the attendance of witnesses and the production of relevant books and documents. If it appears that continuous financial responsibility existed for the vehicle involved, or if it appears the lapse of financial responsibility is not reasonably attributable to the neglect or fault of the person whose registration plate was revoked, the Division shall withdraw its order of revocation and such person may retain the registration plate. Otherwise, the order of revocation shall be affirmed and the registration plate surrendered."

SECTION 4. G.S. 20-63(h) reads as rewritten:

"(h) Commission Contracts for Issuance of Plates and Certificates. – All registration plates, registration certificates, and certificates of title issued by the Division, outside of those issued from the Raleigh offices of the Division and those issued and handled through the United States mail, shall be issued insofar as practicable and possible through commission contracts entered into by the Division for the issuance of the plates and certificates in localities throughout North Carolina with persons, firms, corporations or governmental subdivisions of the State of North Carolina. The Division shall make a reasonable effort in every locality, except as noted above, to enter into a commission contract for the issuance of the plates and certificates and a record of these efforts shall be maintained in the Division. In the event the Division is unsuccessful in making commission contracts, it shall issue the plates and certificates through the regular employees of the Division. Whenever registration plates, registration certificates, and certificates of title are issued by the Division through commission contract arrangements, the Division shall provide proper supervision of the distribution. Nothing contained in this subsection will allow or permit the operation of fewer outlets in any county in this State than are now being operated.

Commission contracts entered into by the Division under this subsection shall provide for the payment of compensation on a per transaction basis. The collection of the highway use tax shall be considered a separate transaction for which one dollar and twenty-seven cents ($1.27) compensation shall be paid. The performance at the same time of one or more of the remaining transactions listed in this subsection shall be

considered a single transaction for which one dollar and forty-three cents ($1.43) compensation shall be paid.

A transaction is any of the following activities:

...

(7) Receipt of the civil penalty imposed by ~~G.S. 20-309~~ G.S. 20-311 for a lapse in financial responsibility or receipt of the restoration fee imposed by that statute.

..."

SECTION 5. The following statutes are repealed: G.S. 20-309(e), G.S. 20-312, and G.S. 20-316.1.

SECTION 6. This act becomes effective January 1, 2007, and applies to lapses occurring on or after that date.

SENATE BILL 881:
Lapse in Liability Insurance

BILL ANALYSIS

Committee:	House Insurance	**Date:**	June 21, 2006
Introduced by:	Sen. Garrou	**Summary by:**	Kory Goldsmith
Version:	PCS to Third Edition S881-CSRC-110		Committee Counsel

SUMMARY: The Senate Bill 881 would revise the penalties for individuals operating motor vehicles when their liability insurance policies have lapsed. The Proposed Committee Substitute makes the time period within which an insurer must notify DMV of certain changes in the status of a liability policy consistent (20 days) regardless of the type of change.

The bill would be effective January 1, 2007, and would apply to lapses occurring on or after that date.

CURRENT LAW: All vehicles intended to be operated on North Carolina highways must be registered with the DMV, and all registered vehicles are required to carry continuous liability insurance coverage. The purpose of this law is to provide protection to persons who may be injured or damaged by the negligent operation of a motor vehicle. Without financial responsibility, an owner loses the privilege to drive on North Carolina roads and must therefore surrender his registration plate and card.

G.S. 20-309(e) requires an insurer to notify DMV when it terminates a liability insurance policy and a lapse in coverage results (failure to do so is punishable by a civil penalty of $200 to be assessed by the Commissioner of Insurance). Upon receiving this notice, the DMV notifies the owner of the vehicle of the lapse, and the owner must respond within 10 days certifying to the DMV either:

- That the owner had financial responsibility effective on or before termination; or
- In case of a lapse, that the owner now has financial responsibility, the owner did not operate the vehicle during the lapse knowing that there was a lapse, and the vehicle was not involved in an accident during the lapse. The owner must also pay a $50 civil penalty for the lapse.

If the owner fails to certify that he has financial responsibility as described above, then the DMV is required to revoke the vehicle's registration for 30 days. The owner is required to surrender the registration plate and card to DMV upon revocation, and failure to do so is a Class 1 misdemeanor. After the 30 days, the owner may reregister the vehicle upon payment of a restoration fee of $50 and the appropriate fee for a new registration plate.

BILL ANALYSIS:

Section 1 – Insurer must notify DMV of actions on insurance policies.

Section 1 of the bill would rewrite and clarify the notice provisions formerly contained in G.S. 20-309(e) and G.S. 20-316.1 and place them in a new statutory section – G.S. 20-309.2. Current law requires insurers to notify DMV within 20 days upon termination, cancellation, or issuance of a new automobile liability insurance policy. The notice must be sent electronically if the insurer has $25 million or more in annual vehicle insurance premium volume.

The current law is somewhat unclear, however, with regard to notice of replacement policies. G.S. 20-309(e) states that an insurer must notify DMV of the issuance of a replacement policy, where no lapse in coverage occurred, by sending a certificate of insurance form. The statute goes on to state that an insurer must notify DMV of a new policy within 20 days unless the new coverage is a replacement

policy for a policy terminated by the same insurer, which would seem to suggest that either no notice is required for a replacement policy or that the notice need not be sent within 20 days. Current industry practice suggests that the "certificate of insurance" forms for replacement policies are usually sent within 20 days.

Section 1 of the bill would clarify the notice requirement by setting out the circumstances under which an insurer must notify DMV as follows:

1) Issuance of a new or replacement policy.
2) Termination of a policy, either by cancellation or failure to renew, that results in a lapse of coverage.
3) Renewal or reinstatement of a policy after the insurer has notified DMV of a cancellation or termination.

The only instance under which an insurance company is not required to notify DMV is when a policy is simply renewed (where there is no lapse in coverage).

The remainder of Section 1 incorporates the same substantive provisions that currently exist regarding notice, such as the time period, the form of notice, the trade secret protection provision for insured names, and the civil penalty assessed against insurers for violations.

Section 2 – Action by DMV upon notification of lapse.

Section 2 of the bill places in G.S. 20-311, the remaining provisions from G.S. 20-309(e) regarding action required by DMV upon notification by an insurer of a lapse in coverage and makes the following substantive changes to current law:

- It specifically requires DMV to notify the owner by letter of the lapse in coverage and requires the owner to respond within 10 days[1] explaining how the owner has met the duty to have continuous financial responsibility on the vehicle.
- It would increase, as well as create an increasing scale of, monetary penalties for not maintaining financial responsibility based on the number of lapses an owner has had in the previous 3 years. For the first lapse, the penalty would be $75, a second would be $150, and a third or subsequent lapse would be $250 (currently $50, regardless of number of lapses).[2]
- It would maintain the restoration fee to reregister the vehicle after a revocation at $50.
- It would require an owner to pay both the applicable civil penalty as well as the restoration fee upon reregistration. Under current law, an owner pays only the $50 restoration fee upon reregistration, but no civil penalty.
- It would make failure to surrender a registration plate and card to DMV after it has been revoked a Class 2 misdemeanor (currently Class 1 misdemeanor).

Sections 3, 4, and 5 – Conforming changes.

Sections 3, 4, and 5 make conforming changes to other statutes as the result of the repeal of G.S. 20-309(e), 20-312, and 20-316.1. and the reorganization of its provisions.

S0881e3-SMRC-CSRC-110 Trina Griffin and Brad Krehely substantially contributed to this summary.

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[1] The time period is the same under current law.

[2] In July 2005, the NC Supreme Court held in *North Carolina School Boards Assn. v. Moore* that these penalties, as well as the $200 penalty levied against an insurer that fails to provide the required notice, are required to be remitted to local school boards under Section 7 of Article IX of the NC Constitution. The court did not, however, address the restoration fee.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2005

Legislative Fiscal Note

BILL NUMBER: Senate Bill 881 (Third Edition)

SHORT TITLE: Lapse in Liability Insurance.

SPONSOR(S):

FISCAL IMPACT

	Yes (X)	No ( )	No Estimate Available ( )		
	FY 2005-06	**FY 2006-07**	**FY 2007-08**	**FY 2008-09**	**FY 2009-10**
REVENUES:					
Schools (Penalties)		**$2,500,000**	**$5,000,000**	**$5,000,000**	**$5,000,000**
EXPENDITURES:					
Highway Fund DMV IT	**$168,156**	**$434,700**			
POSITIONS (cumulative):					

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Division of Motor Vehicles (DMV)

EFFECTIVE DATE: January 1, 2007

BILL SUMMARY: Sections 1-3 of the Bill reorganize and rewrite the statutes governing financial responsibility for individuals operating motor vehicles and revise the penalties for noncompliance. The bill would increase monetary penalties (paid to local school boards) for not maintaining financial responsibility based on the number of lapses an owner has had in the previous three years.

ASSUMPTIONS AND METHODOLOGY: The bill would have significant fiscal impacts in two areas:

1. **Increases in civil penalties to local school districts.**
   Estimated impact: Increase of $5 million per year.
   Under current law an owner whose insurance lapses is subject to a civil penalty of $50 to retain the registration plate. Revenues from this penalty totaled about $10 million in fiscal year 2004-05. These revenues have accrued to the Highway Fund in the past but as a result of the recent NC Supreme Court ruling in *North Carolina School Boards Association v. Moore* penalties now go to the local school boards. This bill increases the penalties from $50 to $75

for the first lapse, $150 for the second lapse within three years, and $250 for subsequent lapses. A very rough estimate is that the 50% increase for the first lapse would yield a 50% increase in civil penalties, or $5 million per year.

2. **Costs to Highway Fund for DMV computer changes.**
   Estimated impact: $602,856
   DMV estimates that to carry out the provisions of the bill would require changes to three of its computer systems at a total cost of $602,856.

LITES (Liability Insurance Tracking and Enforcement System)
This system will require major changes at a high technical level of effort. DMV estimates 3,000 hours of IT effort and notes that the developers who would be involved are highly specialized and are billed out at $150 per hour, rather than the customary $80 per hour charge for IT contractors on other DMV systems. (Additional detail on the DMV IT requirements are included in Technical Considerations, below.) The total cost for the LITES changes is $450,000 for programming plus $27,000 for state IT overhead, for a total of $477,000. **DMV indicates that these would be major changes to a system that is unstable and suggests consideration be given to rewriting the entire LITES program. The current DMV estimate for a full rewrite is $20 million.**

STARS (State Titling and Registration System)
Changes to STARS will require 1,000 hours at $80 per hour, or $80,000, plus state IT overhead of $7,200 for a total of $87,200.

SADLS (State Automated Driver License System)
Changes to SADLS will be required for an additional interface with STARS and LITES. These changes will require 443 hours at $80 per hour, or $35,440, plus state IT overhead of $3,216, for a total of $38,656.

SOURCES OF DATA: Division of Motor Vehicles

TECHNICAL CONSIDERATIONS:

Additional Detail from DMV on IT Requirements

STARS AND LITES
LITES (Liability Insurance Tracking and Enforcement System) and STARS (State Titling And Registration System) will require modifications to implement the Bill. The following major changes will be required:
- *Modification of the STARS application to remove the maximum 30-day unlicensed period for non-accident Revocations because the unlicensed period can be indefinite.*
- *Modification of the LITES application to generate Revocation letters without the 30-day period for non-accident Revocations, and including statements concerning penalties and registration renewal.*
- *Modification of the LITES application to generate Revocation letters with the 30-day period for lapses involving accidents, and including statements concerning penalties and registration renewal.*
- *Modification of FR3 (Self-Certification) processing in the LITES mainframe and Internet applications, and STARS application, to compute the different penalty amounts based on number of lapses.*
- *Modification of FR3 processing in the LITES mainframe and Internet applications, and the STARS application, to allow owners to enter FR-3s on lapses that have reached Revocation.*

- *Modification of the FS5/7 (Insurance Lapse Notification) process in the LITES mainframe system to send customers FS5/7 letters stating the correct penalty.*
- *Modification of the STARS application to handle LITES penalty collection correctly.*
- *Modification of the STARS title transfer process to close the lapse when the vehicle is transferred to a family member with valid insurance.*
- *Modification of the STARS fee calculation process for the new fee structure.*
- *Modification of the LITES Hearing Decision process to display civil penalty decision correctly.*
- *Modification of the LITES mainframe system to allow only Accident Prima Facie lapses to be created. False Certification, False Self-Certification (false FR-3), and Self-certification Random Sampling Prima Facie lapses will be discontinued.*

***Technical Level of Effort** – High*

Detailed Cost Justifications for LITES:

Activity	***Estimated Hours***		
Analysis	*300*		
Design	*300*		
Programming/Testing	*1300*		
System Testing	*300*		
Client Testing	*500*		
Implementation	*150*		
Post Implementation	*150*		
Total	*3000*	*x $150/hr =*	*$450,000*

SIPS Charges = (15% of Programming & testing & implementation hours) x $80 = .15 x 2250 hrs x 80 hour =$27,000
Bill rate for LITES is based on contracting Sapiens developers.
Total Estimate (including Programming & SIPS Charges) = $477,000

Detailed Cost Justifications for STARS:

Activity	***Estimated Hours***		
Analysis	*150*		
Design	*100*		
Programming/Testing	*300*		
System Testing	*50*		
Client Testing	*200*		
Implementation	*50*		
Post Implementation	*150*		
Total	*1000*	*x $80/hr =*	*$80,000*

ITS Charges = (15% of Programming & testing & implementation hours) x $80 = .15 x 600 hrs x 80 hour =$7,200
Total Estimate (including Programming & ITS Charges) = $87,200

SADLS
Interface necessary with STARS and LITES to obtain proper information to reflect on MVR application

Technical Level of Effort – Medium

Activity	*Estimated Hours*
HLR / Analysis	*60*
RDD / SOW	*40*
Design / Spec	*75*
Programming / Unit	*120*
System test	*40*
Regression test	*20*
Client test	*60*
Implementation	*8*
Post implementation	*20*
	===
	*443 hrs * 80/hr = $ 35,440*

*ITS Charges = (15% of Programming & testing & implementation hours) * $80 = .15 * 268 * $80 = $3,216*

Total Estimate (including Programming & ITS charges) = $ 38,656

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Bob Weiss

APPROVED BY: James D. Johnson, Director
Fiscal Research Division

Official
Fiscal Research Division
Publication

DATE: August 10, 2005

Signed Copy Located in the NCGA Principal Clerk's Offices

ATTACHMENT III

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 881

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

S881-ARC-61 [v.1]

Date _____,2006

Comm. Sub. [YES]
Amends Title [NO]
S881-CSRC-110[v.2]

Representative _____

moves to amend the bill on page 5, line 11, by deleting the number "2007," and substituting "2008,".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 27, 2006

The House Committee on Insurance met at 11:00 AM on Tuesday, June 27, 2006 in Room 1228. The following Representatives in attendance were: Chairman H. Holliman, Vice Chairs: Ed Jones and M. Setzer. Members: D. Almond, H Brubaker, W. Current, R. Grady, J. Howard, L. Johnson, D. Ross, D. Saunders F. Steen, and R. Sutton.

Chairman Holliman welcomed visitors, House pages, Sgt-At-Arms and Visitors. See Attachment I.

Rep. Holliman asked for a motion to approve the minutes for the June 22, 2006 committee meeting. Rep. Saunders made the motion, motion carried.

Sen Dalton was called on to speak on SB 277 – Motor Vehicle Self-Insurers. Sen Dalton explained Section 5 on page 8 of the bill. See Attachment II.

Chairman Holliman asked for a motion to accept the PCS. Rep. Saunders made the motion, motion passed.

Barbara M. Burke, Chief Deputy Commissioner, NCDOI was asked to speak on the legislation. She explained how the bill addresses disaster preparedness and response situations. Ms. Burke explained the sections in the bill summary and answered questions from the committee members. See Attachment III.

Rep. Jones offered an amendment to amend page 9 lines 22-23. The motion passed unanimously. See Attachment IV.

Rep. Ross moved for a favorable report to the PCS as amended unfavorable to the original bill. The motion carried.

The meeting adjourned at 11:35

Representative L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

HOUSE INSURANCE COMMITTEE

June 27, 2006
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

Approve Committee Minutes for June 22, 2006 meeting.

SB 277 Motor Vehicle Self-Insurers – Sen Dalton

Carol Bowers (Rep. Holliman)

From: Carol Bowers (Rep. Holliman)
Sent: Tuesday, June 20, 2006 12:42 PM
Subject: MEETING NOTICE June 22, 2006.doc

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: THURSDAY, JUNE 22, 2006

TIME: 11:00 AM

LOCATION: 1228 LB

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

SB 277 – Motor Vehicle Self-Insurers – Sen. Dalton
SB 881 – Lapse in Liability Insurance – Sen Garrou

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 12:35 PM on June 20, 2005.

_X__Principal Clerk
_X__Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

ATTACHMENT I

House Pages

INSURANCE

Name Of Committee: _____ Date: 6-27-06

1. Name: Amanda Fox
   County: Buncombe
   Sponsor: Wilma Sherrill
2. Name: Robert Guillot
   County: Hoke
   Sponsor: Doug Yongue
3. Name: Ryan Griffin
   County: Contract
   Sponsor: Jim Foster
4. Name: Suzanne Sowda
   County: Wake
   Sponsor: Jim Crawford
5. Name: Andrew Kenny
   County: Cabarrus
   Sponsor: Barnhardt

Sgt-At-Arms

1. Name: Martha Gadison
2. Name: Charles Williams
3. Name: _____
4. Name: _____
5. Name: _____

F

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — June 27, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Woodson	NC Farm Bureau
[signature]	JD, AL, PA
[signature]	NC Ins
[signature]	NCAHP
Marlane Foster	NCAHP
Robert PASchal	Young, Moore
Susan Valsami	Nationwide
Joe Stewart	IFNC
Todd Barlow	NCATL
Marcus Downs	NC State Health Plan
Johanna Reese	DOT

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — June 27, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Nicki Payne	CFC 920 Barnardsville Hwy. #58 Weaverville, NC 28787
David Stoller	State Farm
Marni Pallin	1139 Jupiter Rd Weaverville NC 28787
Trudy Pallin	1139 Jupiter Rd Weaverville NC 28787
Riley B. Sluder	BUNC. CO.
IRIS H. SLUDER	BUNC. CO.
Jon Blackburn	NC Association of County Commissioners
Lu Hoch	JCCH
Charlie Diehl	NC Trucking Association
Cameron Courtenay	Daily Bulletin
CP Mott	NCAT

17

VISITOR REGISTRATION SHEET

HOUSE COMMITTTE ON INSURANCE — June 27, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	BCBSNC
[signature]	NCAHP
Holly Brian	NCATL
Vicky Young	NCDOT
[signature]	MAC Insurance
[signature]	DOI
Charles Francis	Attorney
Alex Miller	Covenant to NC's Children
FRANK W. FOLGER	HELMS MULLISS WICKER

ATTACHMENT 11

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

S D

SENATE BILL 277
Commerce Committee Substitute Adopted 5/31/05
PROPOSED HOUSE COMMITTEE SUBSTITUTE S277-CSRG-39 [v.2]

6/26/2006 4:17:36 PM

Short Title: Motor Vehicle Self-Insurers. (Public)

Sponsors:

Referred to:

March 2, 2005

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR A VOLUNTARY MEDIATION PROGRAM FOR RESIDENTIAL PROPERTY INSURANCE CLAIMS CAUSED BY DISASTERS, TO REQUIRE SELLERS OF PROPERTY INSURANCE TO DISCLOSE MAJOR PERILS THAT ARE NOT COVERED, TO PROVIDE FOR THE TOLLING OF TIME PERIODS IN PROPERTY INSURANCE POLICIES IN DISASTER SITUATIONS, TO PROVIDE FOR THE TOLLING OF TIME PERIODS IF THE OPERATIONS OF THE DEPARTMENT OF INSURANCE ARE INTERRUPTED BY FORCE MAJEURE, AND TO AUTHORIZE MOTOR VEHICLE SELF-INSURANCE FOR CERTAIN RELIGIOUS ORGANIZATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 44 of Chapter 58 of the General Statutes is amended by renaming the title of Article 44 to "Property Insurance Policies," by designating G.S. 58-44-1 through G.S. 58-44-55 of Article 44 as Part 1, entitled "Policy Provisions," and by adding the following new Part 2:

"Part 2.

"Mediation of Emergency or Disaster-Related Property Insurance Claims.

"§ 58-44-70. Purpose and scope.

(a) This Part creates a non-adversarial alternative dispute resolution procedure for a facilitated claim resolution conference prompted by the critical need for effective, fair, and timely handling of insurance claims arising out of damages to residential property as the result of a disaster. This Part applies only if a state of disaster has been proclaimed for the State or for an area within the State by the Governor under G.S. 166A-6; or if the President of the United States has issued a major disaster declaration for the State or for an area within the State under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §5121, *et seq.*, as amended.

(b) The procedure established by this Part is available to all first party claimants who have insurance claims resulting from damage to residential property occurring in this State. This Part does not apply to commercial insurance, motor vehicle insurance, or to liability coverage contained in property insurance policies.

(c) The Commissioner may designate a person, either within the Department of outside of the Department, as the Administrator or other functionary to carry out any of the Commissioner's duties under this Part.

"§ 58-44-75. Definitions.

As used in this Part:

(1) Administrator – The Commissioner or the Commissioner's designee; and the term is used interchangeably with regard to the Commissioner's duties under this Part.

(2) Disaster – As defined in G.S. 166A-4(1).

(3) Disputed claim – Any matter on which there is a dispute as to the cause of loss or amount of loss, for which the insurer has denied payment, in part or whole, with respect to claims arising from a disaster. Unless the parties agree to mediate a disputed claim involving a lesser amount, a "disputed claim" involves the insured requesting $1,500.00 or more to settle the dispute, or the difference between the positions of the parties is $1,500.00 or more. "Disputed claim" does not include a dispute with respect to which the insurer has reported allegations of fraud, based on a referral to the insurer's special investigative unit, to the Commissioner. A disputed claim does not include one in which there has been a denial of coverage for the loss because of exclusions in the policy, terms in the policy, conditions in the policy, or nonexistence of the policy at the time of the loss.

(4) Mediation – As defined in G.S. 7A-38.1(b)(2).

(5) Mediator – A neutral person who acts to encourage and facilitate a resolution of a claim.

(6) Party or parties – The insured and his or her insurer, including a surplus lines insurer and the underwriting associations in Articles 45 and 46 of this Chapter, when applicable.

"§ 58-44-80. Notification of right to mediate.

(a) Insurers shall notify their insureds in this State who have claimed damage to their residential properties as a result of a disaster of their right to mediate disputed claims. This requirement applies to all disputed claims, including instances where checks have been issued by the insurer to the insured.

(b) The insurer shall mail a notice of the right to mediate disputed claims to an insured within five days after the time the insured or the Administrator notifies the insurer of a dispute regarding the insured's claim. The following apply:

(1) If the insurer has not been notified of a disputed claim before the time an insurer notifies the insured that a claim has been denied in whole or in part, the insurer shall mail a notice of the right to mediate to the insured in the same mailing as the notice of denial.

(2) The insurer is not required to send a notice of the right to mediate if a claim is denied because the amount of the claim is less than the insured's deductible.

(3) The mailing that contains the notice of the right to mediate shall include any consumer brochure on mediation developed by the Commissioner.

(4) Notification shall be in writing and shall be legible, conspicuous, and printed in at least 12-point type.

(5) The first paragraph of the notice shall contain the following statement: "The General Assembly of North Carolina has enacted a law to facilitate fair and timely handling of residential property insurance claims arising out of disasters. The law gives you the right to attend a mediation conference with your insurer in order to settle any dispute you have with your insurer about your claim. An independent mediator, who has no connection with your insurer, will be in charge of the mediation conference.

(c) The notice shall also:

(1) Include detailed instructions on how the insured is to request mediation, including name, address, and phone and fax numbers for requesting mediation through the Administrator.

(2) Include the insurer's address and phone number for requesting additional information.

(3) State that the Administrator will select the mediator.

"**§ 58-44-85. Request for mediation.**

(a) If an insured requests mediation before receipt of the notice of the right to mediate or if the date of the notice cannot be established, the insurer shall be notified by the Administrator of the existence of the dispute before the Administrator processes the insured's request for mediation. An insured must request mediation within 60 days after the denial of the claim; failure to request mediation within this time period shall only bar the right to demand mediation, it shall not prejudice any other legal right or remedy of the insured nor prohibit the insurer from voluntarily accepting the request for mediation.

(b) If an insurer receives a request for mediation, the insurer shall electronically transmit the request to the Administrator within three business days after receipt of the request. If the Department receives any requests, it shall electronically transmit those requests to the Administrator within three business days after receipt. The Administrator shall notify the insurer within 48 hours after receipt of a request that has been filed with the Department.

(c) In the insured's request for mediation, the insured shall provide the following information, if known:

(1) Name, address, and daytime telephone number of the insured and location of the property if different from the address given.

(2) The claim and policy number for the insured.

(3) A brief description of the nature of the dispute.

(4) The name of the insurer and the name, address, and phone number of the contact person for scheduling mediation.

(5) Information with respect to any other policies of insurance that may provide coverage of the insured property for named perils such as flood, earthquake, or windstorm.

"**§ 58-44-90. Mediation fees.**

(a) The fees of the Mediator and of the Administrator as established by the Commissioner shall be borne by the insurer. All other mediation costs, fees, or expenses shall be borne by the party incurring such costs, fees, or expenses unless otherwise provided in a settlement agreement.

(b) The Commissioner may establish fee schedules, through emergency rules, for fees to be paid to the Administrator, the mediator, and for timely and untimely mediation cancellations.

"**§ 58-44-95. Scheduling of mediation; qualification of mediator.**

(a) The Administrator shall select a mediator and schedule the mediation conference.

(b) In order to be approved, a mediator must be certified by the Dispute Resolution Commission under G.S. 7A-38.2; or, if not, shall be approved at the discretion of the Administrator only if the parties agree on the selected mediator and the proposed mediator is a licensed attorney in North Carolina in good standing with the North Carolina State Bar. A mediator shall not make an award or render a judgment as to the merits of the action.

"**§ 58-44-100. Conduct of the mediation conference.**

(a) The Commissioner may adopt rules, in addition to the provisions of this section and that are not in conflict with G.S. 7A-38.1 or the Rules Implementing Statewide Mediated Settlement Conferences in Superior Court Civil Actions adopted by the Supreme Court of North Carolina pursuant to G.S. 7A-38.1 and G.S. 7A-38.2, for the conduct of mediation conferences under this Part. The rules adopted by the Commissioner shall include a requirement of the mediator to advise the parties of the mediation process and their rights and duties in the process.

(b) All parties shall negotiate in good faith. A decision by an insurer to stand by a coverage determination shall not be considered a failure to negotiate in good faith. A party shall be determined to have not negotiated in good faith if the party or a person participating on the party's behalf, becomes unduly argumentative or adversarial or continuously disrupts or otherwise inhibits the negotiations, as determined by the mediator.

(c) The mediator shall terminate the negotiations if the mediator determines that either party is not negotiating in good faith, either party is unable or unwilling to participate meaningfully in the process, or upon mutual agreement of the parties.

(d) The party responsible for causing termination shall be responsible for paying the mediator's fee and the administrative fee for any rescheduled mediation.

(e) The representative of the insurer attending the conference shall:

(1) Bring, in paper or electronic medium, a copy of the policy and the entire claims file to the conference.

(2) Know the facts and circumstances of the claim and be knowledgeable of the provisions of the policy.

(f) An insurer will be deemed to have failed to appear if the insurer's representative lacks authority to settle within the limits of the policy.

(g) The mediator shall be in charge of the conference and will establish and describe the procedures to be followed. The mediator shall conduct the conference in accordance with the standards of professional conduct for mediation adopted by the American Arbitration Association, the American Bar Association, the Society of Professionals in Dispute Resolution; and, where not inconsistent, with the Rules Implementing Statewide Mediated Settlement Conferences in Superior Court Civil Actions adopted by the Supreme Court of North Carolina pursuant to G.S. 7A-38.1 and G.S. 7A-38.2.

(h) All statements made and documents produced at a settlement conference shall be deemed settlement negotiations in anticipation of litigation. The provisions of G.S. 7A-38.1(j), (l), and (m) apply and are incorporated into this Part by reference.

(i) A party may move to disqualify a mediator for good cause at any time. The request shall be directed to the Administrator if the grounds are known before the mediation conference. Good cause consists of conflict of interest between a party and the mediator, inability of the mediator to handle the conference competently, or other reasons that would reasonably be expected to impair the conference.

"**§ 58-44-105. Post mediation.**

(a) Within five days after the conclusion of the conference, the mediator shall file with the Administrator a mediator's status report, on a form prescribed by the Administrator, indicating whether or not the parties reached a settlement.

(b) Mediation is non-binding unless all the parties specifically agree otherwise in writing.

(c) If the parties reach a settlement, the mediator shall include a copy of the settlement agreement with the status report. Within three business days after the conclusion of the conference, the insurer shall disburse the settlement funds in accordance with the terms of the settlement agreement. The insured has three business days after receipt of the settlement funds within which to notify the Commissioner and the insurer of the insured's decision to rescind the settlement agreement, as long as the insured has not received the settlement funds by electronic means or has not cashed or deposited any check or draft disbursed to the insured in payment of the settlement funds.

(d) If a settlement agreement is reached and is not rescinded, it shall act as a release of all specific claims that were presented in the conference. Any subsequent claim under the policy shall be presented as a separate claim.

"**§ 58-44-110. Non-participation in mediation program.**

If the insured decides not to participate in this program or if the parties are unsuccessful at resolving the claim, the insured may choose to proceed under the appraisal process set forth in the insurance policy, by litigation, or by any other dispute resolution procedure available under North Carolina law.

"**§ 58-44-115. Commissioner's review.**

If the insured rescinds a settlement agreement in accordance with G.S. 58-44-105(c), the Commissioner may review the settlement agreement to determine if the agreement was fair to the parties to the agreement. If the Commissioner, upon review and within 10 business days after receiving notice of the rescission, deems that it was fair to the parties, the insured, upon notice from the Commissioner, may withdraw the rescission within five business days after receipt of notice from the Commissioner and reinstate the settlement agreement as if no rescission had taken place. The Commissioner's review and findings shall not be offered or accepted as evidence in any subsequent proceedings.

"**§ 58-44-120. Relation to Administrative Procedure Act.**

The applicable provisions of Chapter 150B of the General Statutes shall govern issues relating to mediation that are not addressed in this Part. The provisions of this Part shall govern in the event of any conflict with Chapter 150B of the General Statutes."

SECTION 2. Article 44 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-44-60. Notice to property insurance policyholder about flood, earthquake, mudslide, mudflow, and landslide insurance coverage.**

(a) Every insurer that sells property insurance policies that do not provide coverage for the perils of flood, earthquake, mudslide, mudflow, or landslide shall, upon the issuance and renewal of each policy, identify to the policyholder which of these perils are not covered under the policy. The insurer shall print the following warning, citing which peril is not covered, in Times New Roman 16 point font or other equivalent font and include it in the policy on a separate page immediately before the declarations page:

"WARNING: THIS PROPERTY INSURANCE POLICY DOES NOT PROTECT YOU AGAINST LOSSES FROM [FLOODS], [EARTHQUAKES], [MUDSLIDES], [MUDFLOWS], [LANDSLIDES]. YOU SHOULD CONTACT YOUR INSURANCE COMPANY OR AGENT TO DISCUSS YOUR OPTIONS FOR OBTAINING COVERAGE FOR THESE LOSSES. THIS IS NOT A COMPLETE LISTING OF ALL OF THE CAUSES OF LOSSES NOT COVERED UNDER YOUR POLICY. YOU SHOULD READ YOUR ENTIRE POLICY TO UNDERSTAND WHAT IS COVERED AND WHAT IS NOT COVERED."

(b) As used in this section, "insurer" includes an entity that sells property insurance under Articles 21, 45, or 46 of this Chapter."

SECTION 3. Article 2 of Chapter 58 of the General Statutes is amended by adding two new sections to read:

"**§ 58-2-46. State of disaster; automatic stay of proof of loss requirements; premium and debt deferrals; loss adjustments for separate windstorm policies.**

Whenever a state of disaster is proclaimed for the State or for an area within the State under G.S. 166A-6; or whenever the President of the United States has issued a major disaster declaration for the State or for an area within the State under the Stafford Act, 42 U.S.C. §5121, *et seq.*, as amended:

(1) The application of any provision in an insurance policy insuring real property and its contents that are located within the geographic area designated in the proclamation or declaration, which provision requires an insured to file a proof of loss within a certain period of time after the occurrence of the loss, shall be stayed for the time period not exceeding the expiration of the disaster proclamation or declaration and all renewals of the proclamation or 45 days, whichever is later.

(2) As used in this subdivision, "insurance company" includes a service corporation, HMO, MEWA, surplus lines insurer, and the underwriting associations under Articles 45 and 46 of this Chapter. All insurance companies, premium finance companies, collection agencies, and other persons subject to this Chapter shall give their customers who reside within the geographic area designated in the proclamation or declaration the option of deferring premium or debt payments that are due during the time period covered by the proclamation or declaration. This deferral period shall be 30 days from the last day the premium or debt payment may be made under the terms of the policy or contract. This deferral period shall also apply to any statute, rule, or other policy or contract provision that imposes a time limit on an insurer, insured, claimant, or customer to perform any act during the time period covered by the proclamation or declaration, including the transmittal of information, with respect to insurance policies or contracts, premium finance agreements, or debt instruments when the insurer, insured, claimant or customer resides or is located in the geographic area designated in the proclamation or declaration. Likewise, the deferral period shall apply to any time limitations imposed on insurers under the terms of a policy or contract or provisions of law related to individuals who reside within the geographic area designated in the proclamation or declaration. The Commissioner may extend any deferral period in this subdivision, depending on the nature and severity of the proclaimed or declared disaster. No additional rate or contract filing shall be necessary to effect any deferral period.

(3) With respect to health benefit plans, after a deferral period has expired, all premiums in arrears shall be payable to the insurer. If premiums in arrears are not paid, coverage shall lapse as of the date premiums were paid up, and pre-existing conditions shall apply as permitted under this Chapter; and the insured shall be responsible for all medical expenses incurred since the effective date of the lapse in coverage.

(4) In addition to the requirements of GS 58-45-35(e), for separate windstorm policies that are written by an insurer other that the Underwriting Association, losses shall be adjusted by the insurer that issued the property insurance and not by the insurer that issued the windstorm policy. The insurer that issued the windstorm policy shall

reimburse the insurer that issued the property insurance for reasonable expenses incurred by that insurer in adjusting the windstorm losses.

"**§ 58-2-47. Incident affecting operations of the Department; stay of deadlines and deemer provisions.**

Regardless of whether a state of disaster has been proclaimed under G.S. 166A-6 or declared under the Stafford Act, whenever an incident beyond the Department's reasonable control, including an act of God, insurrection, strike, fire, power outage, or systematic technological failure, substantially affects the daily business operations of the Department, the Commissioner may issue an order, effective immediately, to stay the application of any deadlines and deemer provisions imposed by law or rule upon the Commissioner or Department or upon persons subject to the Commissioner's jurisdiction, which deadlines and deemer provisions would otherwise operate during the time period for which the operations of the Department have been substantially affected. The order shall remain in effect for a period not exceeding 30 days. The order may be renewed by the Commissioner for successive periods not exceeding 30 days each for as long as the operations of the Department remain substantially affected, up to a period of one year from the effective date of the initial order."

SECTION 4. G.S. 58-2-25(a) reads as rewritten:

"(a) The Commissioner shall appoint or employ such other deputies, actuaries, economists, financial analysts, financial examiners, licensed attorneys, rate and policy analysts, accountants, fire and rescue training instructors, market conduct analysts, insurance complaint analysts, investigators, engineers, building inspectors, risk managers, clerks and other employees that the Commissioner considers to be necessary for the proper execution of the work of the Department, at the compensation that is fixed and provided by the Department of Administration. If the Commissioner considers it to be necessary for the proper execution of the work of the Department to contract with persons, except to fill authorized employee positions, all of those contracts, except those provided for in Articles 36 and 37 and Part 2 of Article 44 of this Chapter, shall be made pursuant to the provisions of Article 3C of Chapter 143 of the General Statutes."

SECTION 5. Article 9A of Chapter 20 of the General Statutes is amended by adding a new section to read:

"**§ 20-279.33A. Religious organizations; self-insurance.**

(a) Notwithstanding any other provision of this Article or Article 13 of this Chapter, any recognized religious organization having established tenets or teachings and that has been in existence at all times since December 31, 1950, may qualify as a self-insurer by obtaining a certificate of self-insurance from the Commissioner as provided in subsection (c) of this section if the Commissioner determines that all of the following conditions are met:

(1) Members of the religious organization operate five or more vehicles that are registered in this State and are either owned or leased by them.

(2) Members of the religious organization hold a common belief in mutual financial assistance in time of need to the extent that they share in financial obligations of other members who would otherwise be unable to meet their obligations.

(3) The religious organization has met all of its insurance obligations for the five years preceding its application.

(4) The religious organization is financially solvent and not subject to any actions in bankruptcy, trusteeship, receivership, or any other court proceeding in which the financial solvency of the religious organization is in question.

(5) Neither the religious organization nor any of its participating members has any judgments arising out of the operation, maintenance, or use of a motor vehicle taken against them that have remained unsatisfied for more than 30 days after becoming final.

(6) There are no other factors that cause the Commissioner to believe that the religious organization and its participating members are not of sufficient financial ability to pay judgments against them.

(7) The religious organization and its participating members meet other requirements that the Commissioner by administrative rule prescribes.

(b) The Commissioner may, in the Commissioner's discretion, upon the application of a religious organization, issue a certificate of self-insurance when the Commissioner is satisfied that the religious organization is possessed and will continue to be possessed of an ability to pay any judgments that might be rendered against the religious organization. The certificate shall serve as evidence of insurance for the purposes of G.S. 20-7(c1), G.S. 20-13.2(e), G.S. 20-16.1, G.S. 20-19(k), and G.S. 20-179.3(l).

(c) The Commissioner may, at any time after the issuance of a certificate of self-insurance under this subsection, cancel the certificate by giving 30 days' written notice of cancellation to the religious organization whenever there is reason to believe that the religious organization to whom the certificate was issued is no longer qualified as a self-insurer under this section."

SECTION 6. If any section or provision of this act is declared unconstitutional, preempted, or otherwise 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, preempted, or otherwise invalid.

SECTION 7. Sections 2 of this act becomes effective January 1, 2007 and applies to policies issued or renewed on or after that date. Section 5 of this act becomes effective January 1, 2007. The remainder of this act is effective when it becomes law.

ATTACHMENT 1/1

SENATE BILL 277:
Motor Vehicle Self-Insurers

BILL ANALYSIS

Committee:	House Insurance	**Date:**	June 27, 2006
Introduced by:	Sen. Dalton	**Summary by:**	Tim Hovis
Version:	PCS to Second Edition S277-PCSRG		Committee Counsel

SUMMARY: ***Section 1*** *of the bill establishes a non-adversarial, alternative dispute resolution procedure for the voluntary mediation of residential property insurance claims resulting from disasters.* ***Section 2*** *requires an insurer to provide to an insured notice concerning whether the policy covers damages resulting from flood, earthquake, mudslide, mudflow, or landslide.* ***Section 3*** *of the bill would extend time periods for filing property damage claims as long as a state of disaster is in effect. This section also authorizes the Commissioner of Insurance to stay any deadlines imposed by law on the Department or any person under the Commissioner's regulation if the operations of the Department are substantially affected by an unexpected or uncontrollable event.* ***Section 4*** *makes technical changes allowing the Commissioner to contract with a person to administer the mediation program without the approval of the Department of Administration.* ***Section 5*** *amends the existing law relating to self-insurers for automobile insurance to recognize certain religious organizations as a new category of self-insurers. To qualify, the group must have been in existence since December 31, 1950 and meet certain financial and other criteria.*

***BILL ANALYSIS:**

SECTION 1: This section would establish a program for mediation of emergency or disaster-related residential property insurance claims that are in dispute. A summary of each of the proposed statutory provisions follows.

- G.S. 58-44-70: Describes the purpose and scope of the program. The program operates only if the Governor or the President has declared a state of disaster for all or part of the State. It applies only to residential property insurance claims by policyholders. It also allows the Commissioner to designate a person (an Administrator) to oversee the program.

- G.S. 58-44-75: Provides definitions for the purpose of the program. It defines "disputed claim" to make it clear as to what claims may be mediated and what claims will not be mediated. Unless the parties agree to mediate a disputed claim of a lesser amount, a disputed claim involves the insured requesting $1500.00 or more to settle the dispute, or a claim in which the difference between the positions of the parties is $1500.00 or more. A disputed claim does not include a claim involving allegations of fraud or denial of coverage because of policy provisions. This section makes clear that the program applies to residential property insurance policies including those written by surplus lines insurers and the Beach and FAIR Plans.

- G.S. 58-44-80: Requires insurers to notify their policyholders of their right to mediate disputed claims when a state of disaster has been declared. Prescribes the procedures for giving notice and what must be included in the notice. The insurer must mail a notice of right to mediate a claim within five days of the insured or Administrator notifying the insurer of a dispute. If the insurer has

not been notified of a disputed claim before the claim has been denied, the insurer must mail a notice of right to mediate to the insured with the notice of denial. Also, an insurer is not required to send a notice of right to mediate if a claim is denied because it is less than the insured's deductible.

- G.S. 58-44-85: Prescribes the procedures that must be followed by the insured and insurer when an insured requests mediation. An insured must request mediation within 60 days after denial of a claim. Failure to request mediation does not bar any other legal right or remedy. This section also describes the information the insured must provide in the insured's request.

- G.S. 58-44-90: Provides that all fees of the Mediator and Administrator must be paid by the insurer and authorizes the Commissioner to adopt emergency rules that establish fee schedules for the program. All other mediation costs, fees, or expenses are borne by the party incurring the costs.

- G.S. 58-44-95: Provides that the Administrator selects a mediator and prescribes the qualifications for persons to be mediators in the program.

- G.S. 58-44-100: Authorizes the Commissioner to adopt rules for the conduct of mediation conferences. The rules must not conflict with established mediation statutes or with the North Carolina Supreme Court mediation rules. This section also prescribes procedures for conducting the mediation conference and sets forth the rights and duties of the insured and insurer during the conference. All parties must negotiate in good faith and the party responsible for causing termination is responsible for mediator's fee and the administrative scheduling fee. By incorporating certain mediation statute provisions by reference, provides immunity for the mediator, this section also makes the mediation negotiations inadmissible in any other legal proceeding, and assures that the right to jury trial is not restricted by the mediation.

- G.S. 58-44-105: Prescribes procedures to be followed by the insurer, insured, and mediator after the conclusion of the conference. Gives the insured a "cooling off" period of three business days after receiving the settlement funds to rescind the settlement agreement, provided that the settlement funds have not been placed into the insured's bank account either by the insured or the insurer (e.g., electronic transfer).

- G.S. 58-44-110: Provides that if the insured decides not to mediate or if the mediation does not produce an agreement, the insured may proceed under the appraisal provision in the policy. Under that provision, which is used only to settle a dispute over the amount of loss, the insured and insurer each select a referee and the referees select a third person; and the three individuals decide how much the insurer must pay the insured.

- G.S. 58-44-115: Authorizes the Commissioner to review any settlement agreement that is rescinded by an insured and determine if the agreement was fair to the insured and insurer. If the Commissioner determines that the agreement was fair to the parties, the insured may withdraw the rescission, thereby reinstating the agreement as if rescission had not occurred. The review and findings by the Commissioner may not be used as evidence in any subsequent proceedings.

- G.S. 58-44-120: Provides that the N.C. Administrative Procedure Act applies to any mediation issues that are not covered by this act, but that this act applies if there is any conflict between this act and the Administrative Procedure Act.

SECTION 2: This section would provide for notice from the insurer to a property insurance policyholder about whether the policy being issued or renewed insures against flood, earthquake, mudslide, mudflow, or landslide. This section would also require an admonition to the policyholder to check with the company or agent on obtaining coverage for those perils and to read the policy to understand what other losses are not covered.

SECTION 3: As explained below, this section would (i) provide relief to policyholders and others during a state of disaster and (ii) relieve persons and the Department from deadlines if the operations of the Department are interrupted by unexpected or uncontrollable event.

G.S. 58-2-46:

- Extends time periods within which insured must file property damage claims for as long as the state of disaster is in effect.

- Requires all insurance companies HMOs, premium finance companies, and debt collection agencies to give persons the opportunity to defer premium or debt payments during the state of disaster. The deferral would also apply to policy or contract provisions or provisions of law that impose time limits on an insurer, insured, claimant, or customer during the state of disaster.

- Provides that after the end of the deferral period, any health benefit plan premiums in arrears are payable to the insurer; and if not paid, coverage will be terminated and the insured will be liable for medical expenses incurred since the effective date of the lapse.

- Provides that if property is insured by property policy and a separate windstorm policy, losses shall be adjusted by the company that issued the property policy and not by the entity that issued the windstorm policy; and the latter must reimburse the former for reasonable adjusting expenses. This procedure is already in place for policies written under the Beach Plan.

G.S. 58-2-47:

Regardless of whether a state of disaster exists, if the operations of the Department are substantially affected by an unexpected or uncontrollable event (examples are cited in the statute), the Commissioner may issue an order to stay the applications of any deadlines and deemer provisions that are imposed by law on the Department or any persons under the Commissioner's regulation and that would operate during the period in which the Department cannot function. This period would initially be thirty days, but could be extended by subsequent orders for thirty more days as long as the operations of the Department are substantially affected. Deemer provisions provide that if the Department does not disapprove a rate filing or a policy form filing within a set period of time, the filing is "deemed" to be approved by the Department.

SECTION 4: Amends G.S. 58-2-25(a) to allow the Commissioner to contract with a person to administer the mediation program in Section 1 of this bill without having to obtain approval from the

Department of Administration. This is needed to allow the Commissioner to act quickly in selecting an administrator once a state of disaster has been declared.

SECTION 5: Contains the substance of the Senate Commerce Committee Substitute for S.B. 277. Amends the Motor Vehicle Financial Responsibility Act by authorizing the Commissioner of Motor Vehicles to allow certain religious organizations to self-insure for motor vehicle liability insurance. The organization would have to meet certain financial and other criteria and satisfy the Commissioner that it would be a viable self-insurer.

EFFECTIVE DATE: Sections 2 and 5 of the act would become effective January 1, 2007. The rest of the act would become effective when signed by the Governor.

**The analysis above was substantially contributed to by Mr. Bill Hale, North Carolina Department of Insurance.*

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

ATTACHMENT IV

EDITION No. _____

H. B. No. _____ DATE 6/27/06

S. B. No. 277 - PCS Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
) Jones
Sen.)

moves to amend the bill on page 9, line s 22-23

( ) WHICH CHANGES THE TITLE

by inserting between those lines the following:

"(c) A group issued a certificate of self-insurance under this ~~subsection~~ section shall notify the Commissioner in writing if any person ceases to be a member of the group. The group shall notify the Commissioner within 10 days of the person's removal or departure from the group."; and by relettering the remaining subsections accordingly.

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

GA-33-A

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

MINUTES
HOUSE COMMITTEE ON INSURANCE
July 6, 2006

The House Committee on Insurance met at 11:00 AM on Tuesday, July 6, 2006 in Room 1228. The following Representatives in attendance were: Chairman H. Holliman, Vice Chairs: B. Faison, and Ed Jones. Members: L. Allen, D. Almond, W. Current, R. Grady, J. Howard, L. Johnson, D. Ross, D. Saunders, and R. Sutton.

Chairman Holliman welcomed visitors, House pages, Sgt-At-Arms and Visitors. See Attachment I.

Rep. Saunders made a motion for the committee not to concur with HB 657 – Revise Insurance Rate Deviations. The motion carried. Attachment II.

Rep. Howard made a motion to accept the PCS for HB ESC/Employers' Protest Filing Period. The motion carried. David Clegg, Employment Security Commission, was asked to clarify changes in the deadlines for the filing period. After much discussion, Rep. Jones made a motion for favorable report to the PCS unfavorable to the original bill. The motion carried. Attachment III.

Rep. Gibson was asked to speak on HB 1388 – Debt Collection Licensing Changes. He called on Karen Cochrane-Brown, Staff Attorney to explain the bill authorizes the Commissioner of Insurance to issue permits to alien and foreign companies from outside the US. See Attachment IV. Rep. Sutton made a motion the committee concur. The motion passed.

The meeting adjourned at 11: 40 AM

Representative L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

HOUSE INSURANCE COMMITTEE

July 6, 2006
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

HB 657 - REVISE INSURANCE RATE DEVIATIONS –
REP. HOLLIMAN

HB 1388 - DEBT COLLECTION LICENSING CHANGES. –
REP. GIBSON

HB 2885 - ESC/EMPLOYERS' PROTEST FILING PERIOD. -
REP. WAINWRIGHT

Carol Bowers (Rep. Holliman)

From: Carol Bowers (Rep. Holliman)
Sent: Wednesday, July 05, 2006 9:01 AM
Subject: MEETING NOTICE July 6, 2006.doc

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **THURSDAY, JULY 6 , 2006**

TIME: **11:00 AM**

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 657 - REVISE INSURANCE RATE DEVIATIONS - REP. HOLLIMAN
HB 1388 - DEBT COLLECTION LICENSING CHANGES. - REP. GIBSON
HB 2885 - ESC/EMPLOYERS' PROTEST FILING PERIOD. - REP. WAINWRIGHT

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 8:55 AM on July 5, 2005.

_X__Principal Clerk
_X__Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Holliman (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 2885 A BILL TO BE ENTITLED AN ACT RELATING TO THE FILING PERIOD FOR EMPLOYERS TO PROTEST UNEMPLOYMENT INSURANCE CLAIMS.

☒ With a favorable report as to the committee substitute bill, unfavorable as to the original bill.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House/Senate) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

Senate

By Representative Holliman (Chair) for the Committee on INSURANCE.

☒Committee Substitute for

HB 1388 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO ISSUE PERMITS TO ALIEN DEBT COLLECTORS.

☒ With recommendation that the House concur.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Holliman (Chair) for the Committee on INSURANCE.

Senate

☒Committee Substitute for

HB 657 A BILL TO BE ENTITLED AN ACT TO REVISE THE LAW GOVERNING INSURANCE RATE DEVIATIONS.

☒ With recommendation that the House do not concur.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

_____ On motion of Representative_____, Committee Amendment No.(s) ___ is/are adopted by EV (_____).

ATTACHMENT 1

House Pages

Name Of Committee: Insurance Date: 7-6-06

Also Page:
Jonathan Daniels
Johnston
Daughtry

1. Name: Kathryn Penry
   County: Wake
   Sponsor: Weiss
2. Name: Michael
   County: Orange
   Sponsor: Insko
3. Name: Christine Abernathy
   County: Mecklenburg
   Sponsor: Carney
4. Name: Suzannah Kimbrel
   County: Mecklenburg
   Sponsor: Black
5. Name: Tarie Dominguez
   County: Mecklenburg
   Sponsor: James Black

Sgt-At-Arms

1. Name: Nell Casper
2. Name: Toussaint Avent
3. Name:
4. Name:
5. Name:

VISITOR REGISTRATION SHEET

Name of Committee _____ Date _____

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Morales Davis	DOT
Karen Johnson	Smith Anderson
[illegible]	ESC
[illegible]	ESC
David Stutts	State Farm
[illegible]	NFIS
Steve Woodson	NC Farm Bureau
Robert Paschal	Young Moore
Susan Valenti	Nationwide
David Barnes	Poyner + Spruill
[illegible]	NMRS
[illegible]	BCBSNC
[illegible]	
Joseph Pace	Brooks Pierce

VISITOR REGISTRATION SHEET

Name of Committee _____ Date _____

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
J Covington	USFS
Jim Long	NCDOT
Wayne Woodrum	DoD
Jeff Mixon	Civitas
Joe Stewart	IFNC
Marlowe Foster	NCAHP
Harry Taylor	"
Bill Scoggin	KCLH
Grant Gray	NCCA
Ken Thompson	NCDOT

ATTACHMENT 11

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H 3

HOUSE BILL 657*
Committee Substitute Favorable 5/25/05
Senate Rules and Operations of the Senate Committee Substitute Adopted 6/12/06

Short Title: Revise Insurance Rate Deviations. (Public)

Sponsors:

Referred to:

March 16, 2005

A BILL TO BE ENTITLED

AN ACT TO REVISE THE LAW GOVERNING INSURANCE RATE DEVIATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-36-30(a) reads as rewritten:

"(a) 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 that does not conform to the rates, rating plans, classifications, schedules, rules and standards made and filed by the ~~Bureau.~~ Bureau, as approved by the Commissioner. An insurer may deviate from ~~the rates promulgated by the Bureau~~ such rates, rating plans, classifications, schedules, rules, and standards if the insurer has filed the proposed deviation with the Bureau and the Commissioner, if the resulting premium by coverage does not exceed the premium that would have been determined using the rates, rating plans, classifications, schedules, rules, and standards promulgated by the Bureau and if the proposed deviation is based on sound actuarial ~~principles, and if the proposed deviation is approved by the Commissioner. Amendments to deviations are subject to the same requirements as initial filings. 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.~~ principles."

SECTION 2. This act is effective when it becomes law.

HOUSE BILL 657:
Revise Insurance Rate Deviations

BILL ANALYSIS

Committee:	House Insurance	**Date:**	July 5, 2006
Introduced by:	Rep. Holliman	**Summary by:**	Tim Hovis
Version:	Third Edition		Committee Counsel

SUMMARY: *House Bill 657 amends G.S. 58-36-30, Deviations, North Carolina Rate Bureau. Under subsection (a) of the statute an insurer may deviate from the rates, rating plans, classifications, schedules, rules and standards filed by the North Carolina Rate Bureau.*

House Bill 657amends the statute to specifically require approval by the Commissioner of existing rates, plans, classifications, schedules, rules and standards. (This is current law.) Under existing law, deviation is allowed if the following conditions are met: (i) the insurer has filed the deviation with the Bureau; (ii) the proposed deviation is based on sound actuarial principles; and (iii) the deviation is approved by the Commissioner. ***The bill adds an additional requirement that the resulting premium by coverage not exceed the premium that would have been determined by the Bureau and deletes existing law requiring that the deviation be approved by the Commissioner.***

The bill also deletes existing law requiring that amendments to deviations are subject to the same requirements as initial filings. This deletes the requirements that amendments to deviations must be filed with the Rate Bureau and the Commissioner. The bill also deletes existing law allowing termination of a deviation only if it as been in effect for a period of six months and only with notice to the Commissioner no later than 15 days before the effective date of the termination.

EFFECTIVE DATE: *This act is effective when it becomes law.*

H0657e3-SMRG

ATTACHMENT III

HOUSE BILL 1388:
Debt Collection Licensing Changes

BILL ANALYSIS

Committee:	House Insurance	**Date:**	July 5, 2006
Introduced by:	Reps. Gibson, Cole	**Summary by:**	Karen Cochrane-Brown
Version:	Third Edition		Staff Attorney

SUMMARY: The Senate Committee Substitute for House Bill 1388 authorizes the Commissioner of Insurance to issue permits to debt collection businesses that are incorporated outside of the United States under certain circumstances.

CURRENT LAW:

Under current law, debt collection agencies are required to obtain a permit from the Commissioner of Insurance before operating within the State. Operating a collection agency business without a permit is a Class I felony.

Before obtaining a permit, a collection agency must file a bond with the Commissioner in the amount of $10,000 for the initial permit, and no less than $10,000 nor more than $75,000 for any renewal permit, based on the total amount of collections paid to the collection agency.

Although the current law allows the Commissioner to issue a permit to a foreign corporation, which is a corporation incorporated or organized in another state, the law does not authorize the Commissioner to issue a permit to a non-US corporation.

BILL ANALYSIS:

This bill authorizes the Commissioner to issue a collection agency permit to an alien, or non-US, corporation if the corporation is owned or majority controlled by a parent entity that is incorporated or organized in the United States, and the alien corporation can only service accounts held by an affiliate or subsidiary of the parent entity. The bill also requires that:

- The Department of Insurance be given notice if the alien corporation is sold.
- The alien corporation must file a bond of double the amount of a US corporation.
- The alien corporation must make records available to the Commissioner in North Carolina.
- The parent entity must agree to cure any violation committed by the alien corporation.
- Service of process on the parent entity is sufficient service of process on the alien corporation.
- The alien corporation must maintain a trust account with a bank located in the US or in a bank approved by the Commissioner.

EFFECTIVE DATE: This act becomes effective October 1, 2006.

H1388e2-SMRO-CSRO-59v3

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H 3

HOUSE BILL 1388

Committee Substitute Favorable 6/1/05

Senate Commerce Committee Substitute Adopted 6/28/06

Short Title: Debt Collection Licensing Changes. (Public)

Sponsors:

Referred to:

April 21, 2005

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO ISSUE PERMITS TO ALIEN DEBT COLLECTORS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-70-5 reads as rewritten:

"**§ 58-70-5. Application to Commissioner for permit.**

Any person, firm, corporation or association desiring to secure a permit as provided by G.S. 58-70-1, shall make application to the Commissioner of Insurance for each location at which such person, firm, corporation or association desires to carry on the collection agency business as hereinafter defined. Such applicant shall be entitled to a permit upon submission to the Commissioner of Insurance of the following:

(a) The name, trade name if any, street address, and telephone number of the applicant, including any home office address and telephone number, if different;

(b) If the applicant is a corporation,

(1) A certified copy of the board of director's resolution authorizing the submission of the application;

(2) An authenticated copy of the Articles of Incorporation and all amendments thereto;

(3) An authenticated copy of the bylaws or other governing instruments;

(4) If the applicant is a foreign corporation, a copy of the certificate of authority to transact business in this State issued by the North Carolina Secretary of State;

(b1) In addition to the information required by subsection (b) of this section, if the applicant is an alien corporation, the corporation must be owned or majority controlled ultimately by a parent entity incorporated or organized under the laws of the United States or any jurisdiction within the United States, and the alien corporation may only service accounts held by an affiliate or subsidiary of the same parent entity. For purposes of this subsection, "control" is defined by G.S. 58-19-5(2). Should the alien

corporation be sold to an entity unrelated to the parent entity, notice shall be provided to the Department of the pending sale 30 days in advance of the sale. Provision of Form 8-K, properly filed with the Securities and Exchange Commission, shall be deemed compliance with the notice requirement of this subsection. In the event of a sale, the new parent entity shall provide evidence to the Department within 30 days of the sale of its and the alien corporation's compliance with the requirements of this section. In the event that the new parent entity does not provide the evidence within 30 days after the sale, the alien corporation's permit shall be automatically suspended until the Department is provided the evidence of compliance which is satisfactory to the Commissioner;

(c) If the applicant is a partnership, an authenticated copy of the then current partnership agreement;

(d) If the trade name is used, certificates showing that the trade name has been filed as required by G.S. 66-68;

(e) A surety bond as required by ~~G.S. 58-70-20;~~ G.S. 58-70-20. In the case of an alien corporation, the surety bond requirements shall be double the amount set by G.S. 58-70-20;

(f) A completed statement by each stockholder owning ten percent (10%) or more of the applicant's outstanding voting stock and each partner, director, and officer actively engaged in the collection agency business, containing: the name of the collection agency, the name and address of the individual completing the form, the positions held by the individual, each conviction of any criminal offense and any criminal charges pending other than minor traffic violations of the individual, and the name and address of three people not related to the individual who can attest to the individual's reputation for honesty and fair dealings;

(g) A statement sworn to by an appropriate corporate officer, partner, or individual proprietor giving a description of the collection method to be employed in North Carolina;

(h) A statement certifying that there are no unsatisfied judgments against the applicant;

(i) A list of all telephone numbers assigned to, or to be used by the applicant in the operation of the collection agency;

(j) The appropriate permit fee as required by G.S. 58-70-35;

(k) A balance sheet as of the last day of the month prior to the date of submission of the application, certified true and correct by a corporate officer, partner, or proprietor, setting forth the current assets, fixed assets, current liabilities and positive net worth of the applicant;

(l) The address of the location at which the applicant will make those records of its collection agency business described in G.S. 58-70-25 available for inspection by the Commissioner of Insurance.

(m) A statement certifying that no officer, individual proprietor or partner of the applicant has been convicted of a felony involving moral turpitude, or any violation of any State or federal debt collection law.

(n) If the collection agency's office or records, as described in G.S. 58-70-25, are located outside of North Carolina, a statement sworn to by an appropriate corporate officer, partner, or individual proprietor consenting to and authorizing the reimbursement, to the Commissioner by the collection agency, of expenses incurred by the Commissioner in conducting routine examinations, audits, and in investigating written complaints against the collection agency or its employees. All reimbursements shall be paid to the Commissioner no more than 30 days after the date of billing. In the case of an alien corporation, the sworn statement must provide that the corporation will make available to the Commissioner for his inspection, in North Carolina, those records described in G.S. 58-70-25, at the expense of the corporation;

(o) If the applicant is a foreign corporation, a statement authorizing the Commissioner to be its agent for service of process, which shall be administered pursuant to the provisions of G.S. 58-16-30.

(p) In the case of an alien corporation, when the corporation is in violation of this Article, the parent entity must agree to cure the violation by the alien corporation.

(q) For purposes of this Article, the following definitions apply:

(1) "Alien corporation" means a company incorporated or organized under the laws of any jurisdiction outside of the United States.

(2) "Foreign corporation" means a company incorporated or organized under the laws of the United States or of any jurisdiction within the United States other than this State."

SECTION 2. G.S. 58-70-40 is amended by adding a new subsection to read:

"(d) In the case of an alien corporation that has been issued a permit under this Article, in an action brought by the Commissioner, service of process upon the parent entity is sufficient service of process on the alien corporation."

SECTION 3. G.S. 58-70-65(c) reads as rewritten:

"(c) Each permit holder located outside this State shall deposit in a separate trust account, designated for its North Carolina creditors, funds to pay all monies due or owing all collection creditors or forwarders located within this State. In the case of alien corporations that are permit holders, the trust account must be established with a bank located in the United States or in any bank approved by the Commissioner."

SECTION 4. This act becomes effective October 1, 2006.

ATTACHMENT IV

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H D

HOUSE BILL 2885
PROPOSED COMMITTEE SUBSTITUTE H2885-CSRC-114 [v.2]

7/5/2006 3:26:16 PM

Short Title: ESC/Employers' Protest Filing Period. (Public)

Sponsors:

Referred to:

June 19, 2006

A BILL TO BE ENTITLED

AN ACT RELATING TO THE FILING PERIOD FOR EMPLOYERS TO PROTEST UNEMPLOYMENT INSURANCE CLAIMS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 96-15(b)(2) reads as rewritten:

"(2) Adjudication. – When a protest is made by the claimant to the initial or monetary determination, or a question or issue is raised or presented as to the eligibility of a claimant under G.S. 96-13, or whether any disqualification should be imposed under G.S. 96-14, or benefits denied or adjusted pursuant to G.S. 96-18, the matter shall be referred to an adjudicator. The adjudicator may consider any matter, document or statement deemed to be pertinent to the issues, including telephone conversations, and after such consideration shall render a conclusion as to the claimant's benefit entitlements. The adjudicator shall notify the claimant and all other interested parties of the conclusion reached. The conclusion of the adjudicator shall be deemed the final decision of the Commission unless within 15 days after the date of notification or mailing of the conclusion, whichever is earlier, a written appeal is filed pursuant to such regulations as the Commission may adopt. The Commission shall be deemed an interested party for such purposes and may remove to itself or transfer to an appeals referee the proceedings involving any claim pending before an adjudicator.

Provided, any interested employer shall be allowed 10 ~~15~~ days from the earlier of mailing or delivery of the notice of the filing of a claim against the employer's account to protest the claim and have the claim referred to an adjudicator for a decision on the question or issue raised. Provided further, no question or issue may be raised or presented by the Commission as to the eligibility of a claimant under

G.S. 96-13, or whether any disqualification should be imposed under G.S. 96-14, after 45 days from the first day of the first week after the question or issue occurs with respect to which week an individual filed a claim for benefits. None of the provisions of this subsection shall have the force and effect nor shall the same be construed or interested as repealing any of the provisions of G.S. 96-18."

SECTION 2. This act becomes effective October 1, 2006, and applies to claims filed on or after that date.

IV

HOUSE BILL 2885:
ESC/Employers' Protest Filing Period

BILL ANALYSIS

Committee:	House Insurance	**Date:**	July 5, 2006
Introduced by:	Rep. Wainwright	**Summary by:**	Kory Goldsmith
Version:	PCS to First Edition H2885-CSRC-114		Committee Counsel

SUMMARY: HB2885 would reduce, from 15 to 10, the number of days that an employer has to protest a claim for unemployment insurance.

The bill is eligible for consideration via passage of an authorizing resolution (attached).

The PCS corrects a citation.

The PCS also changes the effective date to October 1, 2006, and makes it applicable to claims filed on or after that date.

CURRENT LAW: When a person files a claim for unemployment benefits with the North Carolina Employment Security Commission (ESC), the person must provide certain information regarding the employment and the circumstances resulting in the termination of employment. The ESC then sends a notice of claim to the employer and requests similar information from the employer. The ESC then compares the two versions and makes an initial determination regarding whether to pay benefits, and if so, the date benefits will commence, the weekly benefit amount payable, and the potential maximum duration of the benefits. An employer that wants to protest a claim and have it referred to an adjudicator has 15 days to respond to the claim as measured from the earlier of mailing or delivery of the notice of the filing. G.S. 96-15(b)(2).

BILL ANALYSIS: HB 2885 reduces the amount of time, from 15 to 10 days as measured from the earlier of mailing or delivery of the notice of the filing, during which an employer may protest a claim for benefits and have the matter referred to an adjudicator.

BACKGROUND: Federal rules adopted by the U.S. Secretary of Labor require that the ESC must make first payments to eligible claimants on intrastate claims within 14 days of the first compensable week-ending date 87% of the time. 20 CFR 640.5. Failure to meet this requirement ultimately can result in the withholding of federal funds to implement the Federal Unemployment Tax Act.

During 2003, North Carolina averaged 86.2% of payments made within 14 days and in 2004, it averaged 85.4% of claims paid within 14 days. Because North Carolina has not achieved the required 87% average, the U.S. Department of Labor has recommended that North Carolina reduce the number of days that are allowed for employers to respond to a notice of claim for unemployment.

A Federal Requirement Certification has been prepared in conjunction with this bill.

H2885e1-SMRC-CSRC-114

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005
RATIFIED BILL

RESOLUTION 2006-6
HOUSE JOINT RESOLUTION 1982

A JOINT RESOLUTION AUTHORIZING THE 2005 GENERAL ASSEMBLY, 2006 REGULAR SESSION, TO CONSIDER "A BILL TO BE ENTITLED AN ACT RELATING TO THE FILING PERIOD FOR EMPLOYERS TO PROTEST UNEMPLOYMENT INSURANCE CLAIMS."

Be it resolved by the House of Representatives, the Senate concurring:

SECTION 1. The 2005 General Assembly, Regular Session 2006, may consider "A BILL TO BE ENTITLED AN ACT RELATING TO THE FILING PERIOD FOR EMPLOYERS TO PROTEST UNEMPLOYMENT INSURANCE CLAIMS."

SECTION 2. This resolution is effective upon ratification.

In the General Assembly read three times and ratified this the 15th day of June, 2006.

Beverly E. Perdue
President of the Senate

Richard T. Morgan
Speaker Pro Tempore of the House of Representatives

IV

FEDERAL REQUIREMENT CERTIFICATION

Authorized by G.S. 120-36.8

Session 2005

HB2885

ESC/Employers' Protest Filing Period

Bill Primary Sponsor(s):	Rep. Wainwright	H2885-CSRC-114
Relevant Federal Law:	*Section 303(a)(1) of the Social Security Act; 20 CFR 640.5*	
☒ Required by or Necessary for Compliance with Federal Law		☐ Exceeds Federal Law
☐ Federal Funds Conditioned upon Passage of Law		☐ Implements Federal Law

SUMMARY OF BILL PROVISIONS ALLEGEDLY REQUIRED BY FEDERAL LEGISLATION

Section 303(a)(1) of the Social Security Act [42 U.S.C. 503(a)(1)] requires that a state's unemployment compensation law include provisions for methods of administration that are reasonably calculated to insure the full payment of unemployment compensation to eligible claimants when due. The United States Secretary of Labor has adopted rules which interpret this provision with regard to promptness in the payment of benefits to eligible claimants. 20 CFR 640.1 et seq. - Standard for Benefits Promptness. In particular and regarding intrastate claims, the North Carolina Employment Security Commission (ESC) must make first payments to eligible claimants within 14 days of the first compensable week-ending date 87% of the time. 20 CFR 640.5. Failure to meet this requirement ultimately can result in the withholding of federal funds to implement the Federal Unemployment Tax Act.

During 2003, North Carolina averaged 86.2% of payments made within 14 days and in 2004, it averaged 85.4% of claims paid within 14 days. Because North Carolina has not achieved the required 87% average, the U.S. Department of Labor has recommended that North Carolina reduce the number of days that are allowed for employers to respond to a notice of claim for unemployment. Currently, the time limit is 15 days from the earlier of mailing or delivery of the notice of the filing. G.S. 96-15(b)(2). The U.S. Department of Labor has recommended that the time limit be reduced to not more than 10 days.

Preliminary

COMPLIANCE CONSIDERATIONS

The proposed change to G.S. 96-15(b)(2) comes as a recommendation by the U.S. Department of Labor to assist North Carolina in meeting a required performance standard. The proposed statutory change (reducing from 15 to 10 days during which an employer may protest an unemployment claim) is not specifically required by federal law. However, as a practical matter, this reduction is probably necessary for North Carolina to meet the required federal performance standard.

TECHNICAL OR MECHANICAL CONSIDERATIONS

The 1st Edition of the bill contains an incorrect statutory citation. This has been corrected in the Proposed Committee Substitute. The PCS also makes the act effective October 1, 2006, and applicable to claims filed on or after that date.

REVIEW AND APPROVAL

Prepared By: _____ **Date:** _____

Kory Goldsmith
Co-Counsel, House Insurance Committee

Approved By: _____ **Date:** _____

Terrence D. Sullivan
Director of Research

MINUTES
HOUSE COMMITTEE ON INSURANCE
July 13, 2006

The House Committee on Insurance met at 11:00 AM on Thursday, July 13, 2006 in Room 1228. The following Representatives in attendance were: Chairman H. Holliman, Vice Chairs: Ed. Jones and M. Setzer. Members: L. Allen, H. Brubaker, W. Current, R. Grady, J. Howard, L. Johnson, D. Ross, D. Saunders, R. Sutton and T. Wright.

Chairman Holliman welcomed visitors, House pages, Sgt-At-Arms and Visitors. See Attachment I.

Rep. Johnson moved for the committee to accept the PCS for HB 1895 – Establish High – Risk Pool. The motion carried. Bill sponsor, Rep. Insko was asked to explain an amendment for HB 1895 – Establish High-Risk Pool. She explained the technical changes that were necessary to clarify some of the language. Attachment II.

Mark Trogdon, Fiscal Research explained who oversees the pool. Barbara M. Burke, DOI explained to the committee how and when the seed money was applied for and how the deadline affected the application. George Stokes, Executive Administrator, of State Health Plan spoke in support and the importance of the legislation and how the health plans roll in the High Risk Pool.

Rep. Wright moved to amend the bill requiring the State Health Plan Executive Administrator to report to two legislative committees. The amendment was accepted and rolled into the PCS. Attachment III.

Rep. Ross moved for a favorable report to the PCS, as amended and unfavorable to the PCS #2.

Rep. Holliman thanked everyone for their time and the meeting adjourned at 11:40 AM

Representative L. Hugh Holliman, Chairman

Carol Bowers, Committee Clerk

HOUSE INSURANCE COMMITTEE

July 13, 2006
11:00 AM
Room 1228 LB

Rep. Hugh Holliman, Chairman

Vice-Chairs:

Rep. Bill Faison
Rep. Edward Jones
Rep. Edd Nye
Rep. Mitchell Setzer

AGENDA

HB 1895 – Establish High –Risk Pool

Carol Bowers (Rep. Holliman)

From: Carol Bowers (Rep. Holliman)
Sent: Thursday, July 13, 2006 8:46 AM
Subject: RESCHEDULED MEETING FOR HOUSE INSURANCE

RESCHEDULED

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **THURSDAY, JULY 13, 2006**

TIME: **11:00 am**

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 1895 - Establish High Risk Pool

(We will go over technical changes of the bill necessitated by moving the pool under the state health plan.)

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at on

x ___Principal Clerk
x ___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

7/13/2006

Carol Bowers (Rep. Holliman)

From: Carol Bowers (Rep. Holliman)
Sent: Wednesday, July 12, 2006 11:55 AM
Subject: CALLED MEETING FOR HOUSE INSURANCE

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2005-2006 SESSION

You are hereby notified that the Committee on **INSURANCE** will meet as follows:

DAY & DATE: **Wednesday , JULY 12 , 2006**

TIME: **when session recesses**

LOCATION: **1228 LB**

The following bills will be considered (Bill # & Short Title & Bill Sponsor):

HB 1895 - Establish High Risk Pool

(We will go over technical changes of the bill necessitated by moving the pool under the state health plan.)

Respectfully,
Representative Holliman
Chair

I hereby certify this notice was filed by the committee assistant at the following offices at on

x ___Principal Clerk
x ___Reading Clerk - House Chamber

Carol Bowers (Committee Assistant)

2005 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Holliman (Chair) for the Committee on INSURANCE.

☒Committee Substitute # 2 for
HB 1895 A BILL TO BE ENTITLED AN ACT TO ESTABLISH THE NORTH CAROLINA HEALTH INSURANCE RISK POOL AND TO APPROPRIATE FUNDS THEREFOR.

☒ With a favorable report as to Committee substitute bill 3, which changes the title, unfavorable as to Committee Substitute Bill 2.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House/Senate) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

ATTACHMENT I

House Pages

Name Of Committee: Insurance Date: July 18, 2006

1. Name: Spencer Gentry
   County: Buncombe
   Sponsor: Bruce Goforth
2. Name: Cody Hall
   County: Stokes
   Sponsor: Mrs Holloway
3. Name: Brittney Harbin
   County: Gaston
   Sponsor: Cannon
4. Name: _____
   County: _____
   Sponsor: _____
5. Name: _____
   County: _____
   Sponsor: _____

Sgt-At-Arms

1. Name: Mark Cone
2. Name: Charles Williams
3. Name: _____
4. Name: _____
5. Name: _____

VISITOR REGISTRATION SHEET

Insurance — 7-13-06

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY
Harry Taylor	NCLHA
Susan Adams	NW
Joe Stewart	IFNC
Eric Scoggin	KGLH
Joyce Bacon	Bacon & Assoc
Chris Valauri	Valauri Group
Barbara Morales Burke	DOT
Ed Turlington	BP
Barbara Carsten	BSCBS
Hugh Tilson	NCHA
Dana Simpson	Smith Anderson
Kathleen Edwards	UNC-CH Daily Bulletin
	NMRS
	Dynamic Insurance
Brad Pollard	BCBSNC
	Raleigh E. Chamber
	NFIB
Don Beason	
	Nursing
Mario Davis	NC State Health Plan
George Stokes	NC State Health Plan
John Bowdish	Astra Zeneca
	NMSS
Frank Folger	Holmes Mullis Wicker

VISITOR REGISTRATION SHEET

Insurance — 7-13-06

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY
[signature]	GA, AL, FA

ATTACHMENT 11

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H D

HOUSE BILL 1895
Committee Substitute Favorable 6/12/06
Committee Substitute #2 Favorable 7/10/06
PROPOSED COMMITTEE SUBSTITUTE H1895-PCS60862-RD-57

Short Title: Establish High-Risk Pool. (Public)

Sponsors:

Referred to:

May 11, 2006

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE NORTH CAROLINA HEALTH INSURANCE RISK POOL.

The General Assembly of North Carolina enacts:

SECTION 1.1. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 7. North Carolina Health Insurance Risk Pool.

"**§ 58-50-245. Definitions.**

For the purposes of this Part:

(1) "Administrator" means the Pool Administrator selected by the Executive Director in accordance with this Part.

(2) "Benefit plan" means coverage offered by the Pool to eligible individuals.

(3) "Board" means the Board of Directors of the Pool.

(4) "Commissioner" means the Commissioner of Insurance.

(5) "Covered person" means any individual resident of this State, excluding dependents, who is eligible to receive health benefits from any insurer.

(6) "Church plan" has the meaning given that term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(7) "Creditable coverage" has the same meaning as prescribed in G.S. 58-68-30(c)(1).

(8) "Dependent" means a resident spouse or unmarried child under the age of 19 years, a child who is a full-time student under the age of 23 years and who is financially dependent upon the parent, a child who is over 18 years of age and for whom a person may be obligated to pay child

support, or a child of any age who is disabled and dependent upon the parent.

(9) "Executive Director" means the Executive Administrator of the Teachers' and State Employees' Comprehensive Major Medical Plan.

(10) "Family member" means a parent, grandparent, brother, sister, or child of a dependent residing with the insured.

(11) "Federally defined eligible individual" has the same meaning as "eligible individual" as prescribed in G.S. 58-68-60(b).

(12) "Governmental plan" has the same meaning as prescribed in G.S. 58-68-60(h)(2).

(13) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, including items and services paid for as medical care to employees or their dependents, as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(14) "Health insurance coverage" shall have the same meaning as prescribed in G.S. 58-68-25(a)(5). Health insurance coverage does not include benefits described in G.S. 58-68-25(b).

(15) "Insurance arrangement" means a plan, program, contract, or other arrangement through which health care services are provided by an employer to its officers or employees but does not include health care services covered through an insurer.

(16) "Insured" means an individual who is eligible to receive benefits from the Pool. The term "insured" includes dependents and family members, as applicable.

(17) "Insurer" means any entity that provides health insurance coverage in this State. For the purposes of this Part, insurer includes:

a. An insurance company;

b. A hospital or medical service corporation;

c. A health maintenance organization;

d. A multiple employer welfare arrangement;

e. A third-party administrator or claims processor;

f. An administrative service organization;

g. Any other nongovernmental entity providing a health benefit plan subject to State insurance regulation; and

(18) "Medical care" means amounts paid for:

a. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

b. Transportation primarily for and essential to medical care referred to in sub-subdivision a. of this subdivision; and

c. Insurance covering medical care referred to in sub-subdivisions a. and b. of this subdivision.

(19) "Plan of Operation" means the articles, bylaws, and operating rules and procedures adopted by the Board in accordance with this Part.
(20) "Pool" means the North Carolina Health Insurance Risk Pool.
(21) "Resident" means an individual who is in the country legally and who:
a. Has been legally domiciled in this State for a period of at least 30 days, except that for a federally defined eligible individual, there shall not be a 30-day requirement;
b. Is legally domiciled in this State on the date of application to the Pool and who is eligible for enrollment in the Pool as a result of the Health Insurance Portability and Accountability Act of 1996; or
c. Is legally domiciled in this State on the date of application to the Pool and is eligible for the credit for health insurance costs under section 35 of the Internal Revenue Code of 1986.
(22) "Significant break in coverage" means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.
(23) "State Health Plan" means the Teachers' and State Employees' Comprehensive Major Medical Plan as set forth in Parts 1, 2, and 3 of Article 3 of Chapter 135 of the General Statutes.
(24) "Trade Adjustment Assistance Program" (TAA) means Title II of the Trade Act of 2002, P.L. 107-210.

"**§ 58-50-250. Risk Pool established; board of directors; plan of operation.**

(a) High-Risk Pool Established. – There is hereby created within the Teachers' and State Employees' Comprehensive Major Medical Plan the North Carolina Health Insurance Risk Pool. The Pool shall operate under the supervision and control of the Board of Directors of the Pool.

(b) Board Appointment; Membership. – The Board of the North Carolina Health Insurance Risk Pool shall consist of the Commissioner of Insurance, who shall serve as an ex officio nonvoting member of the Board, and 11 members appointed as follows:
(1) One member who represents an insurer, as appointed by the Governor.
(2) Two members of the general public who are not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, and can reasonably be expected to qualify for coverage in the Pool. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member. The two members of the general public shall be appointed as follows:
a. One member upon the recommendation of the President Pro Tempore of the Senate.
b. One member upon the recommendation of the Speaker of the House of Representatives.
(3) Eight members appointed by the Commissioner, as follows:

a. One insurer who sells individual health insurance policies.
b. One insurer who covers the largest number of persons in the State.
c. One who is licensed to sell health insurance in this State.
d. Two who represent the medical provider community, one as recommended by the North Carolina Medical Society and one as recommended by the North Carolina Hospital Association.
e. One who represents business, as recommended by the North Carolina Citizens for Business and Industry.
f. One who represents small business, as recommended by the National Federation of Independent Business.
g. One who is either a health policy researcher or a health economist with experience relating to the operation of high-risk insurance pools.

(c) Board; Terms of Appointment; Vacancies; Compensation. – The initial Board members shall be appointed as follows: three of the members to serve a term of three years; four of the members to serve a term of one year; and four of the members to serve a term of two years. Subsequent Board members shall serve for terms of three years. A Board member's term shall continue until the member's successor is appointed. The Commissioner shall appoint a chair to serve for the initial two years of the Plan's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms. The Commissioner shall fill vacancies in membership and may remove members from the Board for cause. Board members shall not be compensated in their capacity as Board members but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties.

(d) Plan of Operation. – The Executive Director shall submit to the Board a Plan of Operation for the Pool and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Plan of Operation. The Plan of Operation shall become effective upon approval by the majority of the Board consistent with the date on which the coverage under this Part must be made available. The Executive Director shall submit a suitable Plan of Operation within 180 days after the appointment of the Board. The Plan of Operation shall:

(1) Establish procedures for operation of the Pool.
(2) Establish procedures for selecting a Pool Administrator in accordance with G.S. 58-50-255.
(3) Establish procedures to create a fund for administrative expenses, which shall be managed by the Board.
(4) Establish procedures for the collection, handling, disbursing, accounting, assessing, and auditing of assets, monies, and claims of the Pool and the Pool Administrator.
(5) Develop and implement a program to publicize the existence of the Pool, the eligibility requirements, procedures for enrollment, and availability of State premium subsidies, and to maintain public awareness of the Pool.

(6) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the Executive Director in accordance with G.S. 58-50-295.

(7) Establish procedures for identifying and confirming income levels of applicants for Pool coverage who are eligible to receive a State premium subsidy, if a State premium subsidy is available.

(8) Provide for other matters as may be necessary and proper for the execution of the Executive Director's powers, duties, and obligations under this Part.

(e) The Pool shall have the general powers and authority granted under the laws of this State to health insurers and the specific authority to do all of the following:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Part, including the authority, with the approval of the Executive Director in collaboration with the Board, to enter into contracts with similar plans of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions.

(2) Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the Pool.

(3) Take legal action as necessary to:

a. Avoid the payment of improper claims against the Pool or the coverage provided by or through the Plan.

b. Recover any amounts erroneously or improperly paid by the Plan.

c. Recover any amounts paid by the Pool as a result of mistake of fact or law.

d. Recover other amounts due the Pool.

(4) Establish rates and rate schedules in accordance with this Part.

(5) Issue policies of insurance in accordance with the requirements of this Part.

(6) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the Pool, policy, and other contract design, and any other function within the Pool's authority.

(7) Borrow money to effect the purposes of the Pool. Any notes or other evidence of indebtedness of the Pool not in default are legal investments for insurers and may be carried as admitted assets.

(8) Establish policies, conditions, and procedures for reinsuring risks of participating insurers desiring to issue Pool coverage in their own name. Provision of reinsurance shall not subject the Pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

(9) Employ and fix the compensation of employees.

(10) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public.
(11) Provide for reinsurance of risks incurred by the Pool.
(12) Issue additional types of health insurance policies to provide optional coverage, including Medicare supplemental insurance coverage.
(13) Provide for and employ cost containment measures and requirements including preadmission screening, second surgical opinion, concurrent utilization review, disease management, individual case management, and other commonly used benefit plan design features for the purpose of making health insurance coverage offered by the Pool more cost-effective.
(14) Design, utilize, contract, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.
(15) Adopt bylaws, policies, and procedures as may be necessary or convenient for the implementation of this Part and the operation of the Pool.
(16) Assess all insurers and the State Health Plan in accordance with G.S. 58-50-290.

(f) The Executive Director, with the approval of the Board, shall operate the Pool in a manner so that the estimated cost of providing health insurance coverage during any fiscal year is not anticipated to exceed the total income the Pool expects to receive from policy premiums and other revenue available to the Pool. The Board may impose a cap on enrollment or may suspend enrollment for an indefinite period if the Board finds that estimated costs are anticipated to exceed income, except that any enrollment cap or suspension shall not apply to federally defined eligible individuals who are eligible to enroll in the Pool pursuant to G.S. 58-50-265(5).

(g) The Executive Director shall make an annual report to the Speaker of the House of Representatives and to the President Pro Tempore of the Senate. The report shall summarize the activities of the Pool in the preceding calendar year, including the net written and earned premiums, benefit plan enrollment, the expense of administration, and the paid and incurred losses.

(h) Neither the Board nor the employees of the Pool are liable for any obligations of the Pool. There shall be no liability on the part of and no cause of action of any nature shall arise against the Pool or its agents or employees, the Board, the Executive Director, the Commissioner, or his representatives for any action taken by them in good faith in the performance of their powers and duties under this Part. The Pool and the Teachers' and State Employees' Comprehensive Major Medical Plan may provide in their bylaws or rules for indemnification of, and legal representation for, their members and employees.

(i) The members of the Board shall comply with the provisions of G.S. 14-234 prohibiting conflicts of interest.

"**§ 58-50-255. Administrator.**

(a) The Executive Director, in collaboration with the Board, shall select through a competitive bidding process one or more authorized insurers or a third-party administrator to administer the Pool. The Executive Director shall evaluate bids submitted based on criteria established by the Board. The criteria shall allow for the comparison of information about each bidding administrator and selection of a Pool Administrator based on at least the following:

(1) Proven ability to handle health insurance coverage to individuals.

(2) Efficiency and timeliness of the claim processing procedures.

(3) Estimated total charges for administering the Pool.

(4) Ability to apply effective cost containment programs and procedures and to administer the Pool in a cost-efficient manner.

(5) Financial condition and stability.

(b) The Administrator shall serve for a period specified in the contract between the Pool and the Administrator subject to removal for cause and subject to any terms, conditions, and limitations of the contract between the Pool and the Administrator. At least one year before the expiration of each period of service by an Administrator, the Executive Director shall invite eligible entities, including the current Administrator, unless the current Administrator was removed for cause, to submit bids to serve as the Administrator. Selection of the Administrator for the succeeding period shall be made at least six months before the end of the current period.

(c) The Administrator shall perform such functions relating to the Pool as may be assigned to it, including:

(1) Verification of eligibility.

(2) Payment of claims.

(3) Establishment of a premium billing procedure for collection of premiums from individuals covered under the Pool.

(4) Other necessary functions to assure timely payment of benefits to covered persons under the Pool.

(d) The Administrator shall submit regular reports to the Executive Director and the Board regarding the operation of the Pool. The contract between the Pool and the Administrator shall specify the frequency, content, and form of the report.

(e) Following the close of each calendar year, the Administrator shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the Executive Director and the Board on a form prescribed by the Executive Director.

(f) The Administrator shall be paid as provided in the contract between the Pool and the Administrator.

"**§ 58-50-260. Risk Pool rates and policy forms.**

(a) The Pool shall adopt and modify, as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of the Pool. Rates and rate schedules may be adjusted for appropriate factors such as age, sex, and geographic variation in claim cost and shall take into consideration appropriate rating factors in accordance with established actuarial and underwriting practices.

(b) The Pool shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for the coverage. Pool rates shall be one hundred fifty percent (150%) of rates established as applicable for individual standard rates.

(c) The Executive Director, with the approval of the Board and the Commissioner, shall have the authority to develop incentive programs with premium discounts.

(d) Provider reimbursement rates under Pool coverage shall be limited to the rates allowed for providers under the Medicare Program.

(e) The Pool shall submit all rates and rate schedules and amendments thereto to the Commissioner for approval, and the Commissioner shall approve the rates and rate schedules before the Pool may use them. The Commissioner, in evaluating the rates and rate schedules, shall consider the factors provided in this section. The Pool shall provide all individuals enrolled in the Pool with at least 45 days' notice of any change in Pool rates or rate schedules.

(f) The Pool shall submit all policy forms to the Commissioner for approval, and the Commissioner shall approve the forms before the Pool may use them. Except for any provisions that are specifically treated otherwise under this Part, the provisions of this Chapter that apply to benefit plans and policy forms of health insurers generally shall apply to the benefit plans offered and policy forms used by the Pool.

"**§ 58-50-265. Eligibility for Pool coverage.**

(a) Any individual who is and continues to be a resident of this State is eligible for Pool coverage if evidence is provided of:

(1) A notice of rejection or refusal to issue substantially similar health insurance coverage for health reasons by an insurer. A rejection or refusal by an insurer offering only stop-loss, excess loss, or reinsurance coverage with respect to the applicant is not sufficient evidence of eligibility;

(2) An offer to issue health insurance coverage only with a conditional rider that limits coverage for the individual's high-risk medical condition;

(3) A refusal by an insurer to issue health insurance coverage except at a rate exceeding the Pool rate;

(4) A diagnosis of the individual with one of the medical or health conditions listed by the Board in accordance with this section. An individual diagnosed with one or more of these conditions is eligible for Pool coverage without applying for other health insurance coverage;

(5) In the case of a federally defined eligible individual, the individual's maintenance of health insurance coverage, of which the most recent coverage was through an employer-sponsored plan, for the previous 18

months with no gap in coverage greater than 63 days and exhaustion of any available COBRA or State continuation benefits; or

(6) An individual who is legally domiciled in this State and is eligible for the credit for health insurance costs under the Trade Adjustment Assistance Reform Act of 2002, section 35 of the Internal Revenue Code of 1986.

(b) The Board, upon approval of the Executive Director, shall adopt a list of medical or health conditions for which a person shall be eligible for Pool coverage without applying for health insurance pursuant to subsection (a) of this section. The Board may amend the list as the Board considers appropriate.

(c) Each dependent of an individual who is eligible for Pool coverage shall also be eligible for Pool coverage.

(d) An individual is not eligible for coverage under the Pool if:

(1) The individual has or obtains health insurance coverage substantially similar to or more comprehensive than a Pool policy, or would be eligible to have coverage if the person elected to obtain it, except that:

a. An individual may maintain other coverage for the period of time the individual is satisfying any preexisting condition waiting period under a Pool policy; and

b. An individual may maintain Pool coverage for the period of time the individual is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the Pool policy.

(2) The individual is determined to be eligible for enrollment in the State Medical Assistance Plan.

(3) The individual has previously terminated Pool coverage unless 12 months have lapsed since the termination, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual or to an applicant eligible for or receiving benefits under the Trade Adjustment Assistance Program.

(4) The individual is an inmate or resident of a public institution, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual.

(5) The individual's premiums are paid for or reimbursed under any government-sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider. This subdivision shall not apply for individuals receiving benefits under the Trade Adjustment Assistance Program or to individuals receiving premium subsidies made available by the State based on individual income levels.

(6) The individual has in effect on the date Pool coverage takes effect health insurance coverage from an insurer or insurance arrangement.

(e) Coverage under the Pool shall cease:

(1) On the date an individual is no longer a resident of this State.
(2) On the date an individual requests coverage to end.
(3) Upon the death of the covered individual.
(4) On the date State law requires cancellation of the Pool policy.
(5) At the option of the Pool, 30 days after the Pool makes any inquiry concerning the individual's eligibility or residence to which the individual does not reply.
(6) Because the individual has failed to make the payments required under this Part.

(f) Except as provided in subsection (e) of this section, an individual who ceases to meet the eligibility requirements of this section may be terminated at the end of the Pool period for which the necessary premiums have been paid.

"**§ 58-50-270. Unfair referral to Pool.**

It is an unfair trade practice under Article 63 of this Chapter for an insurer, insurance producer, as defined in G.S. 58-33-10(7), or third-party administrator to refer an individual employee to the Pool or arrange for an individual employee to apply to the Pool for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment or for the purpose of separating an individual covered by health insurance offered in the individual market.

"**§ 58-50-275. Minimum Pool benefits.**

(a) The Pool shall offer at least two types of health insurance coverage for individuals eligible under G.S. 58-50-265, including preferred provider organizations with different levels of deductibles and cost-sharing, and at least one choice of a health savings account. The covered services and benefit levels may vary between the types of coverage, but at least two types of coverage must, at a minimum, cover the benefits and services outlined in the National Association of Insurance Commissioners' (NAIC) Model Health Pool for Uninsurable Individuals Act and be consistent with comprehensive coverage generally available to persons who are eligible for health insurance other than Medicare. All health insurance products offered by the Pool shall include disease or case management services.

(b) Health insurance products offered by the Pool shall include not less than one million dollars ($1,000,000) lifetime limit and an annual limit of up to five thousand dollars ($5,000) on out-of-pocket expenses. The Board, upon recommendation of the Executive Director, shall adjust limitations at least once every five years to reflect changes in the medical component of the Consumer Price Index.

"**§ 58-50-280. Preexisting conditions.**

(a) Except as otherwise provided by law, Pool coverage shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage as to any condition for which medical advice, care, or treatment was recommended or received as to such conditions during the 12-month period immediately preceding the effective date of coverage, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual.

(b) Subject to subsection (a) of this section, the preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage that was involuntarily terminated, provided that:

(1) Application for Pool coverage is made not later than 63 days following the involuntary termination, and in such case coverage in the Pool shall be effective from the date on which the prior coverage was terminated; and

(2) The applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to Pool coverage.

"**§ 58-50-285. Nonduplication of benefits.**

(a) The Pool shall be payor of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under coverage shall be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or no-fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any State or federal law or program.

(b) The Pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the Pool may be reduced or refused as a setoff against any amount recoverable under this subsection.

"**§ 58-50-290. Assessments.**

(a) For the purposes of providing the funds necessary to carry out the powers and duties of the Pool, the Pool shall assess all insurers and the State Health Plan at such time and for such amounts as the Board finds necessary. Assessments shall be due in not less than 30 days after prior written notice to the insurers and shall accrue interest at twelve percent (12%) per annum on and after the due date.

(b) Except with respect to special assessments authorized under this section, the Pool shall assess each insurer and the State Health Plan in an amount not to exceed two dollars ($2.00) per covered individual insured or reinsured by each insurer or the State Health Plan per month. The assessment shall be based on actual and expected losses, actuarially appropriate reserves, and administrative expenses in excess of expected and collected premiums and federal loss reimbursements, if any, received by the Pool. Each insurer and the State Health Plan shall not be assessed an amount exceeding eight dollars ($8.00) per family policy for each family insured or reinsured per month.

In addition to the assessment, the Pool may impose on each insurer and the State Health Plan a special assessment only when enrollment in the Pool has been capped or suspended. A special assessment may be made to cover only the additional losses of the Pool that are expected to result from the continued entry into the Pool by federally defined eligible individuals during the time that enrollment is closed to all other individuals eligible under G.S. 58-50-265. The special assessment shall be based on actual and expected losses, actuarially appropriate reserves, and administrative expenses in excess of expected and collected premiums for the federally defined eligible

individuals who enrolled or are expected to enroll while the suspension of enrollment is in effect.

(b1) Except with respect to special assessments authorized under this section, the Pool shall assess each insurer and the State Health Plan an amount not to exceed the following limitations for each covered individual insured per month:

(1) Seventy cents (70¢) for the 2007-2008 fiscal year.

(2) One dollar ($1.00) for the 2008-2009 fiscal year.

(3) One dollar and thirty cents ($1.30) for the 2009-2010 fiscal year.

(4) One dollar and seventy cents ($1.70) for the 2010-2011 fiscal year.

(5) Two dollars ($2.00) for the 2011-2012 fiscal year and all years thereafter.

(c) The Pool shall make reasonable efforts designed to ensure that each covered individual is counted only once with respect to any assessment. For that purpose, the Pool shall require each insurer that obtains excess or stop-loss insurance to include in its count of covered individuals all individuals whose coverage is insured (including by way of excess or stop-loss coverage) in whole or in part, except that lives covered under the Pool and reinsured or administered by a third-party administrator shall not be included in the count. The Pool shall allow a reinsurer to exclude from its number of covered individuals those individuals who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop-loss insurer for the purposes of determining its assessment under this section.

(d) The Pool may verify each insurer's assessment based on annual statements and other reports deemed to be necessary by the Pool. The Pool may use any reasonable method of estimating the number of covered individuals of an insurer if the specific number is unknown.

(e) If assessments and other receipts by the Pool exceed the actual losses and administrative expenses of the Pool, the excess shall be held at interest and used by the Pool to offset future losses or to reduce Pool premiums. Future losses include reserves for claims incurred but not reported.

(f) The Commissioner may suspend or revoke, after notice and hearing, the license to transact insurance in this State of any insurer that fails to pay an assessment. As an alternative, the Commissioner may levy a forfeiture on any insurer that fails to pay an assessment when due. The forfeiture may not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100.00) per month.

"**§ 58-50-295. Complaint procedures.**

An applicant or participant in coverage from the Pool is entitled to have complaints against the Pool reviewed by a grievance committee appointed by the Executive Director. Members of the Board shall not serve on the grievance committee. The grievance process shall comply with G.S. 58-50-62. The grievance committee shall report to the Board after completion of the review of each complaint. The Executive Director shall retain all written complaints regarding the Pool at least until the third anniversary of the date the Pool received the complaint. An applicant or participant may file for external review of the applicant's grievance after having exhausted the Pool's

internal grievance procedure. External review, including eligibility determinations, shall be conducted in accordance with Part 4 of this Article.

"**§ 58-50-300. Audit.**

An audit of the Pool shall be conducted annually under the oversight of the State Auditor. The cost of the audit shall be reimbursed to the State Auditor from the Special Reserve for the North Carolina Health Insurance Risk Pool.

"**§ 58-50-305. Taxation.**

The Pool established under this Part is exempt from any and all taxes.

"**§ 58-50-310. Rules.**

The Executive Director, in collaboration with the Board, may adopt rules, including temporary rules, to implement this Part. The Executive Director, in collaboration with the Board, and the Commissioner may adopt rules to carry out their respective powers and duties under this Part.

"**§ 58-50-315. Collective action.**

The establishment of rates, forms, or procedures, and any other joint or collective action required by this Part may not be the basis of any legal action or criminal or civil liability or penalty against the Pool or any insurer."

SECTION 1.2. On or before January 1, 2007, the Executive Director shall notify the Centers for Medicare and Medicaid Services that the State has established the North Carolina Health Insurance Risk Pool and shall request that the North Carolina Health Insurance Risk Pool be approved as an acceptable "alternative mechanism" under the federal Health Insurance Portability and Accountability Act in accordance with 45 C.F.R. § 148.128(e).

SECTION 1.3. The Board of Directors of the North Carolina Health Insurance Risk Pool, as appointed under Section 1.1 of this act, shall monitor methods of financing the Pool to ensure a stable funding source and allow for its continued operation. This monitoring shall include supplementary sources of funding, such as funds obtained from public and private not-for-profit foundations, insurer assessments including special assessments, or other appropriate and available State or non-State funds. The Board shall also review on a regular basis:

(1) The number of individuals in this State who are uninsured as of a date certain because of high-risk conditions.

(2) The number of uninsured individuals who would qualify for coverage under the Pool based on G.S. 58-50-265 and its Plan of Operation.

(3) The cost of coverage under each of the health insurance plans developed by the Board, including administrative costs.

(4) The extent to which assessments meet or exceed amounts necessary for coverage and Board operations.

(5) The status of a request by the State to the Centers for Medicare and Medicaid Services for approval of the North Carolina Health Insurance Risk Pool to be considered an acceptable "alternative mechanism" under the federal Health Insurance Portability and Accountability Act in accordance with 45 C.F.R. § 148.128(e).

The Board shall report its findings and recommendations to the General Assembly on March 1, 2007, and annually thereafter.

SECTION 1.4. The North Carolina Health Insurance Risk Pool Administrator shall study methods for encouraging healthy behaviors and report its findings to the Board and to the General Assembly not later than one year after initial implementation of the Pool.

SECTION 1.5. Notwithstanding G.S. 58-50-280(a), individuals enrolling in the North Carolina Health Insurance Risk Pool within six months of the date that enrollment into the Pool first begins shall be subject to a six-month preexisting condition waiting period.

SECTION 2. There is established in the Teachers' and State Employees' Comprehensive Major Medical Plan the Reserve for the North Carolina Health Insurance Risk Pool ("Reserve"). The sum of one million dollars ($1,000,000) is transferred from the Public Employee Health Benefit Fund ("Fund") to the Reserve for the 2006-2007 fiscal year. These funds may be used to support reasonable expenses for personnel to carry out the Board's responsibilities under the North Carolina Health Insurance Risk Pool and shall be allocated for the reasonable expenses of the Board in conducting its duties under Section 1 of this act that are incurred on or before July 1, 2008. The Reserve is subject to the Executive Budget Act, except that Article 3C of Chapter 143 of the General Statutes does not apply to G.S. 58-50-250(e).

Transfer of the funds from the Fund to the Reserve is contingent upon successful application for and award of federal grant funds to implement the North Carolina Health Insurance Risk Pool. Federal funds received for this purpose shall be deposited to the Reserve. Upon receipt of the federal funds, the Board shall, from Reserve funds, reimburse the Fund in the amount of one million dollars ($1,000,000). It is the intent of the General Assembly that in the event the State is not awarded the federal funds anticipated, the Fund shall be held harmless.

SECTION 3. Section 2 of this act becomes effective July 1, 2006. The remainder of this act is effective when it becomes law. G.S. 58-50-290(b1), as enacted by Section 1.1 of this act, is repealed January 1, 2013. Enrollment in the North Carolina Health Insurance Risk Pool shall commence no later than January 1, 2008.

ATTACHMENT III

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1895

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

H1895-ARD-58 [v.2]

Date _____,2006

Comm. Sub. [YES]
Amends Title [NO]
Third Edition

Representative Wright

moves to amend the bill on page 6, line 30, by rewriting the line to read:
"House of Representatives, the President Pro Tempore of the Senate, the Joint Legislative Health Care Oversight Committee, and the Committee on Employee Hospital and Medical Benefits. The report";
and on page 14, lines 10-11, by inserting between the lines the following:
"**SECTION 1.6.** G.S. 135-38(e) reads as written:
'(e) The Executive Administrator shall routinely report to the Committee and shall provide the Committee with any information or assistance requested by the Committee as relates to the North Carolina Health Insurance Risk Pool, as established under Part 7 of Article 50 of Chapter 58 of the General Statutes.';
SECTION 1.7. G.S. 120-70.111(a) reads as rewritten:
'(a) The Joint Legislative Health Care Oversight Committee shall review, on a continuing basis, the provision of health care and health care coverage to the citizens of this State, in order to make ongoing recommendations to the General Assembly on ways to improve health care for North Carolinians. To this end, the Committee shall study the delivery, availability, and cost of health care in North Carolina. The Committee shall also review, on a continuing basis, the implementation of the State Health Insurance Program for Children established under Part 8 of Article 2 of Chapter 108A of the General Statutes. As part of its review, the Committee shall advise and consult with the Department of Health and Human Services as provided under G.S. 108A-70.21. The Committee shall review, on a continuing basis, the implementation of the North Carolina Health Insurance Risk Pool established under Part 7 of Article 50 of Chapter 58 of the General Statutes. As part of its review, the Committee shall advise and consult with the Executive Director of the North Carolina Health Insurance Risk Pool as

NORTH CAROLINA GENERAL ASSEMBLY
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H1895-ARD-58 [v.2]

provided under G.S. 58-50-250. The Committee may also study other matters related to health care and health care coverage in this State.'".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____