2009-2010

HOUSE INSURANCE

MINUTES

HOUSE COMMITTEE ON

INSURANCE

2009 SESSION

CHAIRS

REP. BRUCE GOFORTH

REP. MICHAEL WRAY

COMMITTEE ASSISTANTS

ANN JORDAN

MARY CAPPS

STAFF

TIM HOVIS
KORY GOLDSMITH
BILL PATTERSON
BEN POPKIN

NORTH CAROLINA GENERAL ASSEMBLY

INSURANCE COMMITTEE
2009-2010 SESSION

Rep. Bruce Goforth
Chair

Rep. Michael H. Wray
Chair

Rep. Margaret Dickson
Vice-Chair

Rep. Jerry Dockham
Vice-Chair

Rep. Mitchell Setzer
Vice-Chair

Rep. Jeff Barnhart

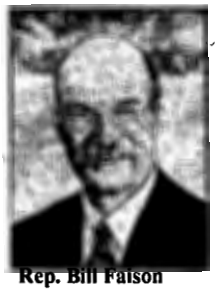
Rep. John Blust

Rep. R. Van Braxton

Rep. Harold Brubaker

Rep. Nelson Cole

Rep. Bill Current



Rep. Bill Faison

Rep. Pryor Gibson

Rep. Hugh Holliman

Rep. Julia Howard

Rep. Sandra Spaulding
Hughes

Rep. David Lewis

Rep. Garland Pierce

Rep. William Wainwright

HOUSE COMMITTEE ON INSURANCE

MEMBER	ASSISTANT	PHONE	OFFICE	SEAT
Chair Bruce Goforth	Ann Jordan	733-5746	1220	21
Chair Michael Wray	Mary Capps	733-5662	405	60
V-C Margaret Dickson	Brenda Lee	733-5776	2217	42
V-C Jerry Dockham	Regina Irwin	715-2526	1213	39
V-C Mitchell Setzer	Margaret Herring	733-4948	1204	49
Rep. Jeff Barnhart	Pamela Ahlin	715-2009	608	52
Rep. John Blust	Betty Childress	733-5781	1109	110
Rep. Van Braxton	Ada Finch	715-3017	2219	46
Rep. Harold Brubaker	Cindy Coley	715-4946	1229	2
Rep. Nelson Cole	Linda Layton	733-5779	1218	45
Rep. Bill Current	Wendy Miller	733-5809	418A	106
Rep. Bill Faison	Lavada Vitalis	715-3019	611	84
Rep. Pryor Gibson	Susanna Davis	715-3007	419A	96
Rep. Hugh Holliman	Carol Bowers	715-0873	2301	55
Rep. Julia Howard	Renee Weaver	733-5904	1106	3
Rep. Sandra S. Hughes	Marilyn Suitt	733-5754	537	89
Rep. David Lewis	Grace Rogers	715-3015	533	64
Rep. Garland Pierce	Mildred Alston	733-5803	301C	7
Rep. William Wainwright	Blinda Edwards	733-5995	301F	8

ATTENDANCE

House Committee on Insurance

(Name of Committee)

DATES	03-12-09	03-19-09	03-24-09	03-26-09	04-02-09 A	04-02-09 P	04-09-09	04-16-09	04-21-09	04-28-09	04-30-09	05-05-09	05-07-09	05-11-09	05-13-09
GOFORTH, Bruce CHAIR	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
WRAY, Michael H. CHAIR	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
DICKSON, Margaret VICE-CHAIR	X	X	X	X	X	X	X	X	ex	X	ex	ex	X		
DOCKHAM, Jerry VICE-CHAIR	X	X	X	X	X	X			X	X		X		X	
SETZER, Mitchell VICE-CHAIR	X	X	X	X	X	X	X	X	X	X	X	X	X		
BARNHART, Jeff	X	X		X	X	X		X	X		X	X	X	X	
BLUST, John	X	X	X	X	X	X	X		X	X	X	X	X	X	
BRAXTON, R. Van	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
BRUBAKER, Harold	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
COLE, Nelson	X	X	X	X	X	X	X	X	X	X	X	X	X		
CURRENT, Bill	ex	X	X	X	X	X	X	X	X	X	X	X	X	X	
FAISON, Bill	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
GIBSON, Pryor		X	X	X	X	X			X	X	X	X	X	X	
HOLLIMAN, Hugh	X		X	X	X	X	X		X	X		X	X	X	
HOWARD, Julia	X	X	X	X	X		X	X	X	X	X	X	X	X	
HUGHES, Sandra Spaulding	X			X	X	X	X	X	X	X	X	X	X	X	
LEWIS, David								X	X	X	X	X	X	X	
PIERCE, Garland	X	X	X	X	X	X		X	X	X	X	X	X	X	
WAINWRIGHT, William	X	X	X	X	X	X		X	X	X		X	X	X	
Kory Goldsmith, Staff	X	X	X	X	X	X	X	X		X	X	X	X	X	
Tim Hovis, Staff	X	X	X	X	X	X	X	X	X		X		X		
Bill Patterson, Staff	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Ben Popkin, Staff	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Mary Capps, Committee Assistant	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Ann Jordan, Committee Assistant	X	X	X	X	X	X	X	X	X	X	X	X	X	X	

ATTENDANCE

House Committee on Insurance

(Name of Committee)

DATES	05-28-09	06-02-09	06-18-09	06-23-09	06-25-09	06-30-09	07-02-09	07-07-09	07-09-09	07-14-09	07-16-09	08-04-09			
GOFORTH, Bruce CHAIR	X	X	X	X	X	X	X	X	X	X	X				
WRAY, Michael H. CHAIR	X	X	X	X	X	X	X	X	X	X	X	X			
DICKSON, Margaret VICE-CHAIR	X	X	X	X	X	X	X		X	X		X			
DOCKHAM, Jerry VICE-CHAIR	X	X	X	X	X	X	X	X	X	X	X				
SETZER, Mitchell VICE-CHAIR	X	X	X	X			X	X	X	X	X	X			
BARNHART, Jeff	X	X	X	X	X	X	X	X	X		X				
BLUST, John	X		X		X	X	X	X	X	X	X	X			
BRAXTON, R. Van	X		X	X	X	X	X	X	X	X	X	X			
BRUBAKER, Harold	X	X	X	X	X	X	X	X	X		X	X			
COLE, Nelson	X	X	X	X	X	X	X		X	X	X	X			
CURRENT, Bill	X	X	X	X	X	X	X	X	X	X	X				
FAISON, Bill	X	X	X	X	X	X	X	X	X	X	X	X			
GIBSON, Pryor	X		X	X		X									
HOLLIMAN, Hugh			X	X	X	X			X	X		X			
HOWARD, Julia	X	X	X	X	X	X	X	X	X	X		X			
HUGHES, Sandra Spaulding	X	X	X	X	X	X	X	X	X	X	X	X			
LEWIS, David				X	X		X		X		X				
PIERCE, Garland	X	X	ex	X	X	X	X		X	X	X	X			
WAINWRIGHT, William			X	X						X					
Kory Goldsmith, Staff	X	X	X		X		X		X		X	X			
Tim Hovis, Staff	X	X	X	X	X	X	X	X	X	X	X				
Bill Patterson, Staff	X	X	X	X	X	X	X	X	X	X	X	X			
Ben Popkin, Staff	X	X	X	X	X	X		X	X	X	X	X			
Mary Capps, Committee Assistant	X	X	X	X	X	X	X	X	X	X	X	X			
Ann Jordan, Committee Assistant	X	X	X	X	X	X	X		X	X	X	X			

MINUTES

HOUSE COMMITTEE ON INSURANCE

March 12, 2009

The House Committee on Insurance met at 11:00 AM on Thursday, March 12, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael H. Wray; Vice Chairs: M. Dickson, J. Dockham and M. Setzer. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Cole, Faison, Holliman, Howard, Hughes, Pierce and Wainwright.

Chairman Wray called the meeting to order, welcomed visitors and introduced staff. He recognized Sgt-At Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachment #1)

Chairman Wray recognized Chairman Goforth who moved for adoption of a PSC for HB 212 – Health Insurance Pool Pilot Program for the purpose of discussion. Chairman Goforth discussed HB 212 as a pilot program in Ashville. The Chamber of Commerce has been working on this bill for a year with a roundtable that has done an outstanding job working with Ben Popkin and our staff to generate this bill. Mr. Ben Popkin was called upon to explain the PSC which included a range of technical changes as suggested by the Department of Insurance. It would authorize the creation and operation of health insurance demonstration projects for large and small employers in the State and would direct project participants and the Department of Insurance to conduct post-project analyses of the impact of the projects on the cost and availability of health insurance in the project areas and the State as a whole. He reviewed Sections 1 through 5(d).

Chairman Goforth introduced Dr. John Ashley, a specialist in Preventive Medicine and Public Health and a former staff member of Mission Hospital, who spoke in support of the bill. (Attachment 2) Chairman Wray introduced Mr. Ken Lewis, First Carolina Care, a licensed North Carolina Insurer based in Pinehurst, North Carolina (Attachment 3). He addressed the debt spiral, protections that are lost in the bill and the slippery slope we would go down. Our core purpose is to cover the uninsured by making coverage more assessable and affordable, and he spoke in opposition to the bill. The Chair recognized Mr. John Friesen, Vice President, Blue Cross Blue Shield North Carolina. He shared concerns that the legislation would be a problem for small business in North Carolina. Chairman Goforth said the bill will go to Commerce, Small Business and Entrepreneurship for further study if passed out of committee.

Chairman Wray stated we need to vote on the bill and recognized Representative Faison for a motion. He moved that the PCS for HB 212 be given a favorable report, unfavorable as to original bill and with a serial referral to the Commerce, Small Business and Entrepreneurship Committee, and the motion passed.

Chairman Wray adjourned the meeting at 11:47 AM.

Representative Michael H. Wray, Chairman

Mary Capps – Committee Assistant

HOUSE BILL 212

Short Title:	Health Insurance Pool Pilot Program.	(Public)
Sponsors:	Representatives Goforth, Fisher, Rapp, Whilden (Primary Sponsors); K. Alexander, Bell, Bryant, England, Faison, Hurley, Insko, Lucas, McElraft, Tarleton, Wainwright, R. Warren, and Wray.	
Referred to:	Insurance, if favorable, Commerce, Small Business, and Entrepreneurship.	

February 18, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE ESTABLISHMENT OF HEALTH INSURANCE PILOT DEMONSTRATION PROJECTS IN INTERESTED COUNTIES TO PROVIDE A MODEL FOR AFFORDABLE EMPLOYER-BASED HEALTH INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. Notwithstanding any other provision of law to the contrary, health insurance demonstration projects ("Demonstration Projects") for large and small employees may be established by eligible sponsors ("Eligible Demonstration Project Sponsors"). Specific Demonstration Projects, the goal of which is to reduce the number of uninsured North Carolinians and to reduce the cost of health insurance for all purchasers of health insurance in the Demonstration Project areas, may begin not later than April 1, 2010, and may continue through December 31, 2014. Entities which are eligible under subdivisions (b)(1) and (b)(1a) of G.S. 58-51-80 to have issued a policy of group health insurance are Eligible Demonstration Project Sponsors. A Demonstration Project must comply with the following:

(1) The products for any pooling of groups are fully insured by an insurer authorized to issue coverage in North Carolina.

(2) The insurance is issued through a group master contract with a bona fide association as defined in G.S. 58-68-25 or a trust or other legal entity that, pursuant to G.S. 58-51-80, is capable of entering into a group master contract.

(3) The pooling arrangement requires that all small employers desiring to join be accepted and that all eligible employees of each employer who elect coverage through the participating employers be included in the pool.

(4) Each employer participating in the pooling arrangement and its employees are offered the same benefit plan.

SECTION 2. A Demonstration Project authorized under Section 1 of this act may contain the following components:

(1) Use of matching funds from State, federal, and private sources to subsidize private health insurance premiums paid by eligible small employers and low-wage employees participating in the Demonstration Project.

(2) Offering of a health benefits package with defined tiers of benefits and premium payment mechanisms as optional alternatives to the standard large group health benefits package to be applied to eligible small employers in achieving affordable health insurance premiums for employees and employers.

SECTION 3. The premium rates charged to individuals covered under employers participating in the group master contract are not subject to G.S. 58-50-130(b) when the rates are based on a community rate that reflects the experience of all the employers participating in the pool. Such community rate may be adjusted in order to determine premiums for each employee based only on the following factors: the benefit plan option selected by the participating employer or individual employee, family composition, age, and gender.

SECTION 4. The large risk pool authorized in this act shall not be established and a group master insurance contract shall not be executed with an insurer unless and until reviewed and approved by the Department of Insurance. Department approval shall be given if the Department determines that the pool satisfies the requirement of Section 1 of this act and that the group master contract, certificates of coverage, and premium rates of the insurer desiring to issue the coverage satisfy all applicable requirements of Chapter 58 of the General Statutes.

SECTION 5.(a) The Demonstration Project Sponsor of each Demonstration Project shall prepare an evaluation of their Demonstration Project. A report on each evaluation shall be submitted to the Department of Insurance and to the Joint Legislative Health Care Oversight Committee not later than February 1, 2014. The reports shall include a recommendation as to whether the Demonstration Project authority should be extended, made permanent, or expire on its scheduled expiration date. The Department of Insurance shall evaluate the Demonstration Project authority, taking into account the impact that the Demonstration Projects have on the overall insurance market. A report on the Department's evaluation shall be submitted to the Joint Legislative Health Care Oversight Committee not later than March 1, 2014. The report shall include a recommendation as to whether the Demonstration Project authority should be extended, made permanent, or expire on its scheduled expiration date.

The Department of Insurance and the Demonstration Project Sponsors may submit interim reports to the Joint Legislative Health Care Oversight Committee. If the Commissioner of Insurance determines that a specific Demonstration Project or the Demonstration Project authority is not in the public's interest or is detrimental to the small group or large group health insurance markets, the Commissioner may recommend early termination of a specific Demonstration Project or the Demonstration Project authority to the Joint Legislative Health Care Oversight Committee.

SECTION 5.(b) The evaluation performed by the Department of Insurance shall analyze the impact that the Demonstration Projects have on the small and large group insurance markets, both statewide and in the demonstration areas. The analysis shall include, but not be limited to, consideration of the impact that the Demonstration Projects have had on the following:

(1) Incurred loss ratios.
(2) Administrative costs.
(3) Annual premiums.
(4) Total number of covered groups and covered lives.
(5) Age and gender composition of covered lives.

SECTION 5.(c) The Department of Insurance may adopt rules concerning the collection of pertinent data from all insurers covering small and large employer groups in the State, whether through a Demonstration Project or through the traditional small and large group markets, to conduct the evaluation authorized by this act. Data collected pursuant to this section shall be the minimum that the Department deems necessary to perform its evaluation, and data collection shall not occur more frequently than on an annual basis during the life of the Demonstration Project authority.

SECTION 5.(d) The evaluation performed by each Demonstration Project Sponsor shall address the following:

(1) The impact on the number of uninsured persons in the Demonstration Project area and the cost and source of their care.

(2) The impact of any unique, local structures for disease management and health promotion on the health and costs for enrollees through small employers.

(3) Approaches to achieve prudent and appropriate use of high technology health care resources to the population enrolled in the Demonstration Project among large and small employers.

(4) Integration of primary care for the increased insured population with the ongoing programs of care for the remaining uninsured to enhance access to care and improve quality and continuity of care.

(5) The impact on the cost of care to uninsured and insured populations in the Demonstration Project communities.

SECTION 6. This act is effective when it becomes law and expires December 31, 2014.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 212
PROPOSED COMMITTEE SUBSTITUTE H212-CSRD-6 [v.2]

3/11/2009 4:14:38 PM

Short Title: Health Insurance Pool Pilot Program. (Public)

Sponsors:

Referred to:

February 18, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE ESTABLISHMENT OF HEALTH INSURANCE PILOT DEMONSTRATION PROJECTS IN INTERESTED COUNTIES TO PROVIDE A MODEL FOR AFFORDABLE EMPLOYER-BASED HEALTH INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. Notwithstanding any other provision of law to the contrary, health insurance demonstration projects ("Demonstration Projects") for large and small employers may be established by eligible sponsors ("Eligible Demonstration Project Sponsors"). Specific Demonstration Projects, the goal of which is to reduce the number of uninsured North Carolinians and to reduce the cost of health insurance for all purchasers of health insurance in the Demonstration Project areas, may begin not later than April 1, 2010, and may continue through December 31, 2014. Entities which are eligible under subdivisions (b)(1) or (b)(1a) of G.S. 58-51-80, subdivision (e) of G.S. 58-65-60, or subdivision (a) of G.S. 58-67-85, to have issued a policy of group health insurance are Eligible Demonstration Project Sponsors. A Demonstration Project must comply with the following:

(1) The products for any pooling of groups are fully insured by an insurer authorized to issue health insurance coverage in North Carolina.

(2) The insurance is issued through a group master contract with a bona fide association as defined in G.S. 58-68-25 or a trust or other legal entity that, pursuant to G.S. 58-51-80, G.S. 58-65-60, or G.S. 58-67-85, is capable of entering into a group master contract.

(3) The pooling arrangement requires that all small employers desiring to join and meeting the eligibility requirements for the group be accepted and that all eligible employees of each employer who elect coverage through the participating employers be included in the pool.

(4) Each employer participating in the pooling arrangement and its employees are offered the same benefit plans.

SECTION 2. A Demonstration Project authorized under Section 1 of this act may contain the following components:

(1) Use of matching funds from State, federal, and private sources to subsidize private health insurance premiums paid by eligible small employers and low-wage employees participating in the Demonstration Project.

(2) Offering of a health benefits package with defined tiers of benefits and premium payment mechanisms as optional alternatives to the standard large

group health benefits package to be applied to eligible small employers in achieving affordable health insurance premiums for employees and employers.

SECTION 3. The premium rates charged to individuals covered under employers participating in the group master contract are not subject to G.S. 58-50-130(b) when the rates are based on a community rate that reflects the experience of all the employers participating in the pool. Such community rate may be adjusted in order to determine premiums for each employee based only on the following factors: the benefit plan option selected by the participating employer or individual employee, family composition, age, and gender.

SECTION 4. The large risk pool authorized in this act shall not be established and a group master insurance contract shall not be executed with an insurer unless and until reviewed and approved by the Department of Insurance. Department approval shall be given if the Department determines that the pool satisfies the requirement of Section 1 of this act and that the group master contract, certificates of coverage, and premium rates of the insurer desiring to issue the coverage satisfy all applicable requirements of Chapter 58 of the General Statutes.

SECTION 5.(a) The Demonstration Project Sponsor of each Demonstration Project shall prepare an evaluation of their Demonstration Project. A report on each evaluation shall be submitted to the Department of Insurance and to the Joint Legislative Health Care Oversight Committee not later than February 1, 2014. The reports shall include a recommendation as to whether the Demonstration Project authority should be extended, made permanent, or expire on its scheduled expiration date. The Department of Insurance shall evaluate the Demonstration Project authority, taking into account the impact that the Demonstration Projects have on the overall insurance market. A report on the Department's evaluation shall be submitted to the Joint Legislative Health Care Oversight Committee not later than May 1, 2014. The report shall include a recommendation as to whether the Demonstration Project authority should be extended, made permanent, or expire on its scheduled expiration date.

The Department of Insurance and the Demonstration Project Sponsors may submit interim reports to the Joint Legislative Health Care Oversight Committee. If the Commissioner of Insurance determines that a specific Demonstration Project or the Demonstration Project authority is not in the public's interest or is detrimental to the small group or large group health insurance markets, the Commissioner may recommend early termination of a specific Demonstration Project or the Demonstration Project authority to the Joint Legislative Health Care Oversight Committee.

SECTION 5.(b) The evaluation performed by the Department of Insurance shall analyze the impact that the Demonstration Projects have on the small and large group insurance markets, both statewide and in the demonstration areas. The analysis shall include, but not be limited to, consideration of the impact that the Demonstration Projects have had on the following:

(1) Incurred loss ratios.
(2) Administrative costs.
(3) Annual premiums.
(4) Total number of covered groups and covered lives.
(5) Age and gender composition of covered lives.

SECTION 5.(c) The Department of Insurance may adopt rules concerning the collection of pertinent data from all insurers covering small and large employer groups in the State, whether through a Demonstration Project or through the traditional small and large group markets, to conduct the evaluation authorized by this act. Data collected pursuant to this section shall be the minimum that the Department deems necessary to perform its evaluation, and data

collection shall not occur more frequently than on an annual basis during the life of the Demonstration Project authority.

SECTION 5.(d) The evaluation performed by each Demonstration Project Sponsor shall address the following:

(1) The impact on the number of uninsured persons in the Demonstration Project area and the cost and source of their care.

(2) The impact of any unique, local structures for disease management and health promotion on the health and costs for enrollees through small employers.

(3) Approaches to achieve prudent and appropriate use of high technology health care resources to the population enrolled in the Demonstration Project among large and small employers.

(4) Integration of primary care for the increased insured population with the ongoing programs of care for the remaining uninsured to enhance access to care and improve quality and continuity of care.

(5) The impact on the cost of care to uninsured and insured populations in the Demonstration Project communities.

SECTION 6. This act is effective when it becomes law and expires December 31, 2014.

HOUSE BILL 212:
Health Insurance Pool Pilot Program

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Commerce, Small Business, and Entrepreneurship	**Date:**	March 11, 2009
Introduced by:	Reps. Goforth, Fisher, Rapp, Whilden	**Prepared by:**	Ben Popkin Committee Counsel
Analysis of:	PCS to First Edition H212-CSRD-6		

SUMMARY: The Proposed Committee Substitute to House Bill 212 would authorize the creation and operation of health insurance demonstration projects for large and small employers in the State and would direct project participants and the Department of Insurance to conduct post-project analyses of the impact of the projects on the cost and availability of health insurance in the project areas and the State as a whole.

CURRENT LAW: The Small Employer Group Health Coverage Reform Act (Part 5 of Article 50 of Chapter 58 of the General Statutes) creates a health insurance pool for small employers (up to 50 employees) in the State. As of 2007, 43,000 employers (492,000 total covered lives) received coverage under provisions of the Act.

BILL ANALYSIS: The Proposed Committee Substitute to House Bill 212 would do the following:

Section 1 – Would authorize the establishment of demonstration projects with the goal of reducing the number of uninsured in the State and reducing the cost of health insurance for all health insurance purchasers in the demonstration project areas. Only insurers, medical service corporations, and HMOs licensed by the Department of Insurance to offer health insurance coverage in the State may participate as demonstration project sponsors, and the projects may operate between April 1, 2010 and December 31, 2014. Demonstration projects must allow all eligible employers to join a project pool, and all eligible interested employees of participating employers be included in the pool. Each demonstration project must offer the same benefit plans to all employers and employees in the pool.

Section 2 – Would allow demonstration projects to 1) use matching funds to subsidize premiums paid by employers and low-wage employees, and 2) offer a health benefits package with defined tiers of benefits and premium payment mechanisms.

Section 3 – Would exempt premium rates charged to participants in the demonstration project from the rating provision of the Small Employer Group Health Coverage Reform Act when the rates are based on a community rate for all employers participating in the project pool. Adjustments to premium rates may be allowed only for the following factors: benefit plan option chosen, family composition, age, and gender.

Section 4 – Would require approval by the Department of Insurance before establishing the demonstration project pool or contracting with an insurer. For approval to be given, the Department must determine that the pool satisfies the terms of Section 1 of this act, and that the group master contract, certificates of coverage, and premium rates satisfy all applicable requirements of Chapter 58 of the General Statutes.

Section 5(a) – Would direct each demonstration project sponsor to evaluate their project and submit a report to the Department of Insurance and the Joint Legislative Health Care Oversight Committee by February 1, 2014 and include a recommendation of whether the project should be extended, made permanent, or allowed to expire. This section would also direct the Department to evaluate the project,

its impact on the overall insurance market, and recommend the project's continuation, permanence, or expiration, and report to the Joint Legislative Health Care Oversight Committee by May 1, 2014. Finally, this section would allow for submission of interim reports by the Department or the project sponsors and would authorize the Commissioner to recommend early termination of the projects if continuation would not be in the public's interest.

Section 5(b) – Would specify that the Department's report would include analysis of the impact of the projects on small and large group insurance markets and consideration of the project's impact on: incurred loss rations, administrative costs, annual premiums, total number of covered groups and lives, and the age and gender composition of covered lives.

Section 5(c) – Would authorize the Department to adopt rules for the collection of data from insurers to conduct its analysis of project impact, and would provide that data collected should be the minimum necessary and not collected more frequently than on an annual basis.

Section 5(d) – Would identify specific issues to be addressed in the project sponsors' evaluations (impact on cost of care to all in the demonstration project communities, impact on number of uninsured in the project area, etc.).

EFFECTIVE DATE: This act is effective when it becomes law and expires December 31, 2014.

H212-SMRD-18(CSRD-6) v1

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 212 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE ESTABLISHMENT OF HEALTH INSURANCE PILOT DEMONSTRATION PROJECTS IN INTERESTED COUNTIES TO PROVIDE A MODEL FOR AFFORDABLE EMPLOYER-BASED HEALTH INSURANCE.

☒ 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 COMMERCE, SMALL BUSINESS, AND ENTREPRENEURSHIP.

(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 Committee on Insurance — **Name of Committee**

3/12/09 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jake Cashion	Winston-Salem Chamber
[signature]	Misc
[signature]	CAA
Ken McHon	Ken McHon & Assoc.
Jon Allen	BEGINNINGS
Robert Paschal	Young Moore
Bill Scoggin	K & L Gates
[signature]	Pfizer
[signature]	MWC
[signature]	Smith Anderson
Elyse Ashby	

VISITOR REGISTRATION SHEET

House Committee on Insurance — 3/12/09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	NMRS
[signature]	JD, AL, PA
Ken Lewis	First Carolina Care
Debra MacClennan	BCBSNC
Laura Copeland	Asheville Area Chamber
Dr John Ashley	" "
Kris Brathaer	[illegible]
Ashley G Bell	American Cancer Society
Betsy Vetter	American Heart Assn
CHERIE CONLEY	AHA
Cam Cowey	BPMHL

VISITOR REGISTRATION SHEET

House Committee on Insurance — 3-12-09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mark Flemming	BCBSNC
Jim Blackburn	NC Association of County Commissioners
John Goodman	NC Chamber
Patrick Hannah	Liberty Mutual
Laura W. Bone	Bone + Associates
Jennifer Farmer	Duke, NCPA

VISITOR REGISTRATION SHEET

House Committee on Insurance — 3/12/09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jean Holliday	NCDOI
Rose Williams	NCDOT
Russ Dubisky	State Farm
Jim Stewart	NC Chamber

House Pages

Name Of Committee: INSURANCE Date: 3-12-09

1. Name: RACHEL DOUGLAS
   County: WAKE
   Sponsor: REP STAM
2. Name: ADONNA ROWLAND
   County: DURHAM
   Sponsor: REP. K. ALEXANDER
3. Name: _____
   County: _____
   Sponsor: _____
4. Name: _____
   County: _____
   Sponsor: _____
5. Name: _____
   County: _____
   Sponsor: _____

Sgt-At-Arms

1. Name: CHARLES WILLIAMS
2. Name: DUSTY RHODES
3. Name: ROBERT ROSSI
4. Name: EARL COKER
5. Name: _____

Mary Capps (Rep. Wray)

From: Ann Jordan (Rep. Goforth)
Sent: Friday, March 06, 2009 1:17 PM

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

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

DAY & DATE: **Thursday, March 12, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

HB 212 – Health Insurance Pool Pilot Program

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at **1:30 pm** on **March 6, 2009**.

___Principal Clerk
___Reading Clerk - House Chamber

(Committee Assistant)

MINUTES
HOUSE COMMITTEE ON INSURANCE
March 19, 2009

The House Committee on Insurance met at 11:00 AM on Thursday, March 19, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael Wray; Vice Chairs: M. Dickson, J. Dockham and M. Setzer. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Cole, Current, Faison, Gibson, Howard, Pierce, and Wainwright. .

Chairman Goforth called the meeting to order and welcomed visitors. He recognized Sgt-At Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachments)

Chairman Goforth recognized Rep. Tim Spear to explain HB 426 – Stay on Homeowner Insurance Actions. House Bill 426 would place a stay on surcharge increases for wind and hail portion of homeowners policies and separate homeowners' wind and hail policies issued by the NCIUA, also know as the Beach Plan. The bill also stays all residential and commercial deductible increases for policies issued by the NCIUA and NCJUA, also know as the FAIR Plan. Lastly, the bill stays all statewide owners coverage rate increases approved by the Commissioner of Insurance and prohibits the use of the rate increases by the NCIUA and NCJUA when determining base rates for homeowner's coverage. In summary, Rep. Spear said that the people cannot afford additional premiums given the current state of unemployment and the economy.

Mr. Tom Thompson with the Economic Development Office for Beaufort County was recognized to speak. He agreed that the rate increases would be harmful at this time. He felt that the insurance companies were basing their information on a hypothetical storm situation such as a Katrina hitting NC.

Ms. Willo Kelly, Government Affairs Officer with the Outer Banks Home Builders Association and spokesperson for "Twenty Counties – One Voice" spoke. Her comments were focused on information from Attachment #1 – In Support of HB 426 and Attachment #2 – Actual Loss Data. .

Chairman Goforth adjourned the meeting at 11:45 AM.

Bruce Goforth

Representative Bruce Goforth, Chairman

Ann Jordan

Ann Jordan – Committee Assistant

HOUSE INSURANCE COMMITTEE

March 19 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

HB 426 – Stay on Homeowner Insurance Actions
Representatives. Spear, Wainwright, Owens and McElraft

Adjourn

HOUSE BILL 426

Short Title:	Stay on Homeowners Insurance Actions.	(Public)
Sponsors:	Representatives Spear, Wainwright, Owens, McElraft (Primary Sponsors); Cleveland, Grady, Hughes, Justice, McComas, Mobley, Underhill, and Williams.	
Referred to:	Insurance, if favorable, Commerce, Small Business, and Entrepreneurship.	

March 5, 2009

A BILL TO BE ENTITLED

AN ACT TO IMPOSE A TEMPORARY STAY ON INCREASED SURCHARGES AND DEDUCTIBLES UNDER THE BEACH PLAN AND THE FAIR PLAN AND TO TEMPORARILY STAY PROPERTY INSURANCE RATE INCREASES FOR HOMEOWNERS POLICIES ACROSS THE STATE.

Whereas, the economy of the State is in historic decline, as evidenced by the projected $2.2 billion shortfall in revenue for the 2009-2010 fiscal year; and

Whereas, the unemployment rate for December 2008 by the Employment Security Commission was 8.7%, an increase of 85% over the rate in December 2007; and

Whereas, over 53,995 homes in North Carolina entered foreclosure in 2008, and an additional 2,221 homes entered foreclosure in January 2009; and

Whereas, the homeowners insurance rate increase approved by the Department of Insurance in December 2008 and scheduled to take effect in May 2009 increases rates by 22% in portions of Currituck, Hyde, Dare, and Pamlico Counties and increases rates by 29.8% in portions of Brunswick, New Hanover, Onslow, and Pender Counties; and

Whereas, over the last six years, the Department of Insurance estimates that homeowners insurance rates in the Beach Plan beach area have increased 90%, and rates in the Beach Plan coastal area have increased 65%; and

Whereas, seven of the counties included in the Beach Plan's beach and coastal areas are classified by the Department of Commerce as Tier One counties, meaning that they are among the 40 most economically distressed counties in the State and are eligible for the highest level of economic development incentives; and

Whereas, nine of the counties included in the Beach Plan's beach and coastal areas have poverty rates above the statewide average and median family income below the statewide average, according to U.S. Census Bureau 2007 estimates; and

Whereas, 57% of properties insured by the Beach Plan have an insured value for building and contents of $300,000 or less; and

Whereas, the citizens of North Carolina who are struggling to hold onto their homes and jobs should not be required to pay higher insurance rates during this economic crisis; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. The filing by the North Carolina Insurance Underwriting Association (NCIUA) approved by the Department of Insurance on November 21, 2008, and designated by the Department as PC121215 increasing from fifteen percent (15%) to twenty-five percent (25%) the factor or surcharge for homeowners coverage shall not take effect.

SECTION 2. The filing by the NCIUA approved by the Department on November 21, 2008, and designated by the Department as PC122445 increasing from five percent (5%) to fifteen percent (15%) the factor or surcharge for homeowners windstorm and hail only coverage shall not take effect.

SECTION 3. The residential deductible guideline submitted by the NCIUA, approved by the Department on November 21, 2008, and designated by the Department as PC122635 shall not take effect.

SECTION 4. The residential deductible guideline submitted by the North Carolina Joint Underwriting Association (NCJUA), approved by the Department on November 21, 2008, and designated by the Department as PC122682 shall not take effect.

SECTION 5. The commercial deductible guideline submitted by the NCIUA, approved by the Department on November 21, 2008, and designated by the Department as PC122637 shall not take effect.

SECTION 6. The commercial deductible guideline submitted by the NCJUA, approved by the Department on November 21, 2008, and designated by the Department as PC122683 shall not take effect.

SECTION 7. There shall be no surcharge or deductible increases or changes for coverages as specified in Sections 1 through 6 of this act on or after the effective date of this act.

SECTION 8. Rate increases resulting from the 2008 Rate Filing approved by the Commissioner of Insurance in the Consolidated Settlement Agreement and Consent Order dated December 18, 2008, shall not take effect, nor shall these rate increases be used by the NCIUA or the NCJUA when determining rates for coverage. In addition, there shall be no rate increases for coverage as specified in this section subsequent to the effective date of this act.

SECTION 9. Premiums or deductibles paid in violation of this act shall be refunded by insurers, the NCIUA, and the NCJUA, as applicable.

SECTION 10. Sections 1 through 9 of this act are effective when they become law and apply to policies issued or renewed on or after that date. The remainder of this act is effective when it becomes law. This act expires July 1, 2010.

HOUSE BILL 426:
Stay on Homeowners Insurance Actions

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Commerce, Small Business, and Entrepreneurship	**Date:**	March 18, 2009
Introduced by:	Reps. Spear, Wainwright, Owens, McElraft	**Prepared by:**	Tim Hovis Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***House Bill 426 would place a stay on surcharge increases for wind and hail portions of homeowners policies and separate homeowners' wind and hail policies issued by the North Carolina Insurance Underwriting Association (NCIUA), also known as the Beach Plan. The bill also stays all residential and commercial deductible increases for policies issued by the NCIUA and the North Carolina Joint Underwriting Association (NCJUA), also known as the FAIR Plan. Finally, the bill stays all statewide homeowners coverage rate increases approved by the Commissioner of Insurance and prohibits the use of these rate increases by the NCIUA and the NCJUA when determining base rates for homeowners coverage.***

House Bill 426 is effective when it becomes law and applies to policies issued or renewed on or after that date. The bill expires July 1, 2010.

BILL ANALYSIS: Below is a summary of current surcharges and deductibles under the Beach and FAIR Plans and increases to these surcharges and deductibles approved by the Commissioner of Insurance.

- **Section 1 of the bill**
  Surcharge on Homeowners Policies (wind portion)
  Increased from 15% to 25%
  Effective for policies issued or renewed on or after February 1, 2009

- **Section 2 of the bill**
  Surcharge on Wind Only Homeowners Policies
  Increased from 5% to 15%
  Effective for policies issued or renewed on or after February 1, 2009

- **Sections 3 and 4 of the bill**
  Residential Deductible Guidelines for Wind and Hail
  1. **Current residential deductible guidelines under the Beach Plan:**
     $500 flat deductible for less than $100,000 in coverage
     $1000 flat deductible for $149,999-$249,999
     $2,000 flat deductible for $250,000 and above
  2. **Current residential deductible guidelines under the FAIR Plan:**
     $500 flat deductible on all FAIR Plan residential properties
     (This deductible applies to all perils, not just wind and hail.)
  3. **Revised residential guidelines under both Beach and FAIR Plans:**
     $1,000 flat deductible for less than $50,000 in building coverage
     2% of building value for more than $50,000 in coverage
     (Bald Head Island—5%)
     (FAIR plan increases apply only to Territories 42 and 43.)

Revised deductibles are effective for policies issued on or after February 1, 2009 and for policies renewed on or after April 1, 2009.

All deductibles are per occurrence, not annual.

Deductible remains the same for all perils except wind and hail--$500 flat deductible for residential, $1,000 for commercial.

- **Sections 5 and 6 of the bill**
  Commercial Deductible Guidelines for Wind and Hail
  1. Current commercial deductible guidelines under Beach Plan
  $1000 flat deductible for less than $100,000 in coverage
  $2,500 flat deductible for less than $100,000-$249,999
  $5,000 flat deductible for $250,000 and above
  2. Current commercial deductible guidelines under FAIR Plan
  $500 flat deductible for less than $100,000 in coverage
  $1,000 flat deductible for $100,000-249,999
  $2,500 flat deductible for $250,000 and above
  3. Revised commercial deductible guidelines under both Beach and Fair Plans
  $1,000 flat deductible for less than $50,000 in building coverage
  2% of combined building value for more than $50,000 in coverage
  (FAIR Plan deductibles apply only to Group II, Seacoast Territories II and III.)

Revised deductibles are effective for policies issued on or after February 1, 2009 and for policies renewed on or after April 1, 2009.

Deductible remains the same for all perils except wind and hail: $1,000 flat deductible under Beach Plan and $500-$2500, depending on the amount of coverage, under the FAIR Plan.

- **Section 8**
  Statewide Rate Increases

The North Carolina Rate Bureau requested an average statewide homeowners rate increase of 19.5% in its filing to the Commissioner of Insurance. The Commissioner approved an average statewide rate increase of 4.05%. Attached to this summary is a chart showing percentage rate increases by territory as approved by the Commissioner.

BACKGROUND: The purpose of the Beach Plan is to serve as a market of last resort to make property insurance available to people who are unable to buy insurance through the standard or voluntary market. The Beach Plan functions as an insurance company by acting as an agent for insurers. All property and casualty insurers in the State are members of the Plan. By statute, the Plan covers two areas: (1) the barrier islands, referred to under the Plan as the beach area; and (2) 18 coastal counties, referred to as the coastal area. The Plan offers homeowners, dwelling, and wind only coverage in the beach area and homeowners and wind only coverage in the coastal area. Commercial coverage is also available under the Plan.

The Plan's members include all insurers authorized to write property insurance in North Carolina. All member companies share in the expenses, profits, and losses of the Plan. Each year that the Plan

generates revenues in excess of claims paid, the Plan may elect to return the excess funds to the member companies or hold those funds as "surplus." The surplus is used to cover Plan losses where claims filed are greater than the premium received. Should claims exceed the revenues from premiums, the amount of surplus, and any applicable reinsurance, member companies are assessed by the Plan to pay the claims. Assessments are calculated based on a member's market share and are reduced by credits given for writing coverage in the beach and coastal areas. Providing credits against assessments for coverage written in the beach and coastal area was intended to encourage insurers to write such policies and limit the growth of exposure to risk in the Beach Plan.

The NCIUA's Plan of Operation is adopted by its Board of Directors and submitted to the Commissioner of Insurance for approval. The Plan of Operation sets forth the administration of the Plan including the membership and manner of election of members to the Board of Directors.

The Plan also files with the Commissioner for his or her approval rates for separate policies of windstorm and hail, policy deductible plans to be paid by property owners, and the percentage differential or surcharge for coverage offered by the Plan. The surcharge is a percentage amount above the voluntary market rate approved by the Commissioner which all beach and coastal property owners must pay to purchase homeowners coverage through the Plan. The surcharge applies to homeowner's coverage and homeowner's wind and hail coverage only.

H426-SMRG-5(e1) v4

North Carolina Homeowners Rate Revision Breakdown by Territory
2009

Counties/Cities Located In This Territory	Territory	Current	Filed/NCRB	Filed %	Ordered	Ordered %
~~Carteret~~, Currituck, Dare & Hyde	5	$1,993	$2,636	32.1	$2,122	6.5
Brunswick, New Hanover, Onslow & Pender **(Carteret)**	6	$1,993	$3,010	50.9	$2,342	17.5
Durham & Raleigh	32	$631	$833	32.9	$663	5.0
Cumberland	34	$817	$939	15.6	$850	4.0
Winston-Salem & Greensboro	36	$545	$617	13	$562	3.0
Charlotte	38	$551	$576	3.9	$529	-4.0
Gaston, Mecklenburg & Union	39	$531	$540	1.2	$499	-6.0
Bladen, Columbus & Robeson	41	$945	$1,150	22.5	$1,059	12.0
Brunswick, New Hanover, Onslow & Pender **(Carteret)**	42	$1,245	$2,116	69.8	$1,616	29.8
~~Beaufort, Camden, Carteret, Chowan, Craven, Currituck, Dare, Hyde, Jones, Pamilco, Pasquotank, Perquimans, Tyrrell & Washington~~	43	$1,245	N/A	N/A	N/A	N/A
Currituck, Dare, Hyde, & Pamilco	**43 E**	$1,245	$2,564	106	$1,519	22.0
Beaufort, Camden, Chowan, Craven, Jones, Pasquotank, Perquimans, Tyrrell & Washington	**43 W**	$1,245	$1,596	28.2	$1,327	6.5
Anson, Montgomery & Richmond	44	$637	$774	22.2	$676	6.0

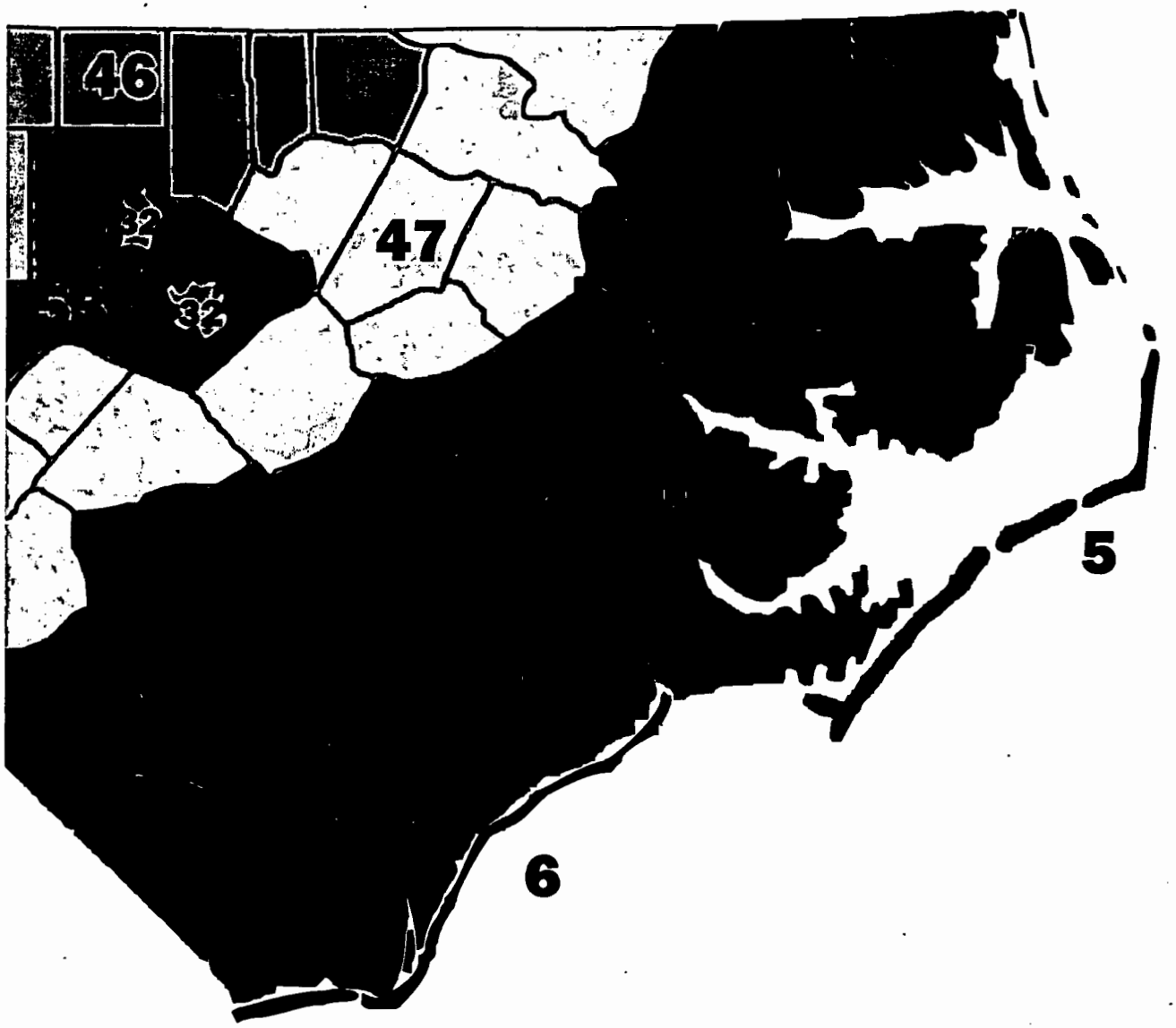
Examples are based on a frame home valued at $150,000 and insured under the HO-3 policy, Protection ises 1 - 6.

North Carolina Homeowners Rate Revision Breakdown by Territory
2009

Counties/Cities Located In This Territory	Territory	Current	Filed/NCRB	Filed %	Ordered	Ordered %
Bertie, Duplin, Gates, Greene, Hertford, Lenoir, Martin, Pitt, Sampson & Wayne	45	$797	$914	15.4	$853	7.0
Caswell, Granville, Person, Vance & Warren	46	$605	$660	9.7	$587	-3.0
Edgecombe, Franklin, Halifax, Harnett, Hoke, Johnston, Lee, Moore, Nash, Northhampton, Scotland & Wilson	47	$686	$773	13.2	$700	2.0
Chatham, Durham, Orange & Wake	53	$613	$693	13.8	$625	2.0
Alamance, Davidson, Forsyth, Guilford, Randolph & Yadkin	57	$550	$613	11.2	$560	2.0
Alexander, Alleghany, Ashe, Avery, Buncombe, Burke, Cabarrus, Caldwell, Catawba, Cherokee, Clay, Cleveland, Davie, Graham, Haywood, Henderson, Iredell, Jackson, Lincoln, Macon, Madison, McDowell, Mitchell, Polk, Rockingham, Rowan, Rutherford, Stanly, Stoke, Surry, Swain, Transylvania, Watauga, Wilkes & Yancey	60	$486	$532	9.2	$480	-1.2
Overall Statewide Average				19.5		

Examples are based on a frame home valued at $150,000 and insured under the HO-3 policy, Protection ses 1 - 6.

North Carolina Rate Bureau
Homeowners Territories
(Effective May 1, 2009)



In Support of HB 426

NC 20

ATTACHMENT #1

NC-20

NC 20 is a coalition of the 20 CAMA counties that was formed to advocate for coastal issues in matters of legislation and regulation by State government. In this particular endeavor, our efforts may benefit many other eastern counties which have also seen insurance rates rise without justification.

The Problem

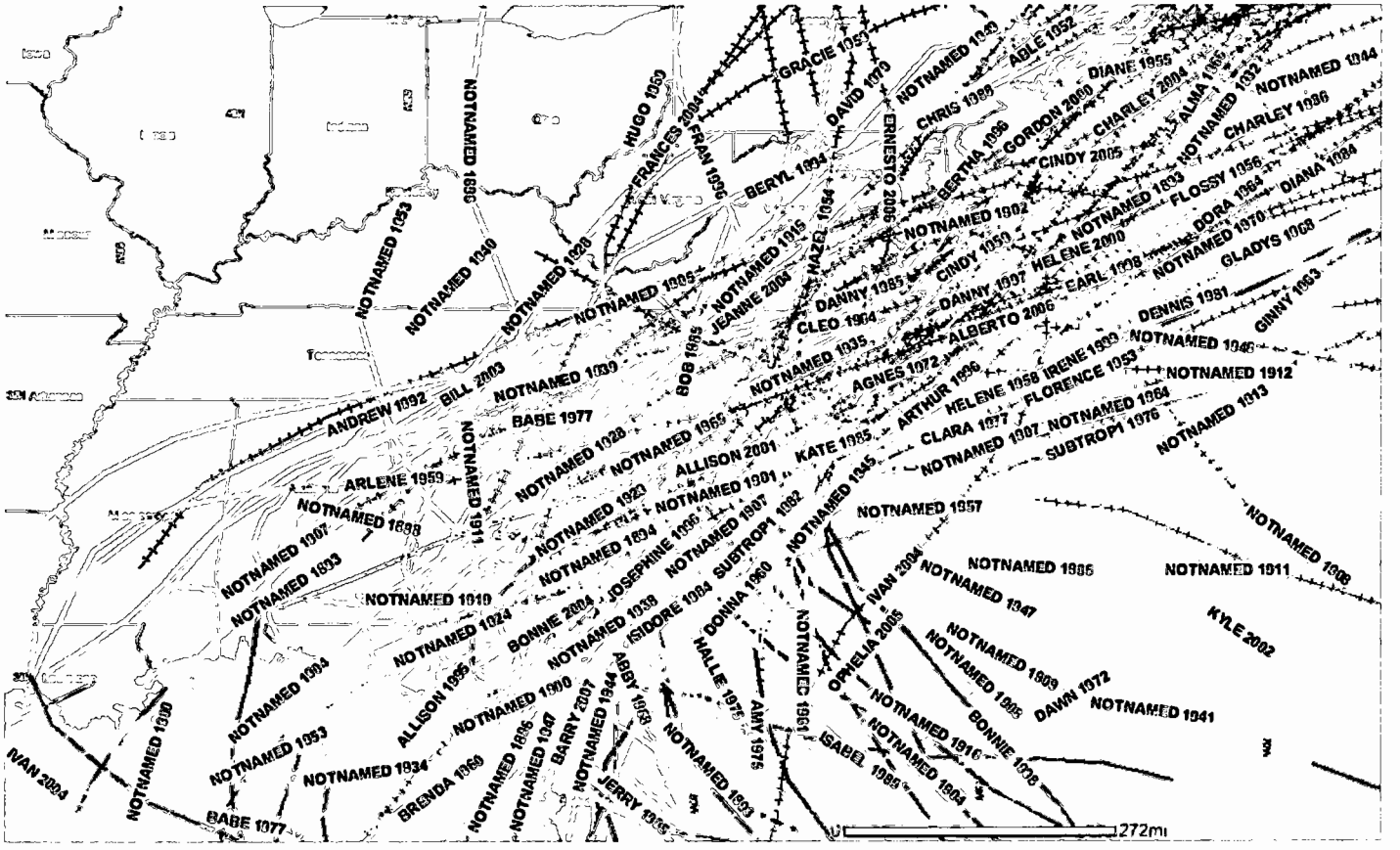
- The Insurance Commissioner has approved substantially higher insurance rates for many eastern counties at a time of economic distress unequaled in the life of most citizens today.
- Any increase in the cost to own or rent a home in today's economy increases the hardship of those who have lost their jobs, those on fixed incomes, or those who are trying avoid foreclosure.
- These rate and deductible increases affect financing and refinancing opportunities and the ability to reduce the extensive inventory of existing homes on the market.
- These rates were based on data that were not presented in a public forum and which were denied to NC 20 despite repeated, face-to-face requests to the Commissioner by NC 20.
- The increases approved defy any logical pattern of a thoughtful, actuarial approach.
- The specter being raised by the Commissioner is that a catastrophic hurricane (100 – 125 year storm) could deplete the resources of the Beach Plan; however, no such storm has occurred in the past 150 years.

The Myth in Detail

- Hurricanes only affect the coast.
- Damage on the coast is mostly caused by wind
- NC needs to be prepared for a catastrophic hurricane and the Beach Plan is underfunded
- Artificially low rates attract more homeowners into the Beach Plan
- If the Beach Plan does not improve its financial standings, taxpayers, consumers, insurers, and the state's economy will be endangered.

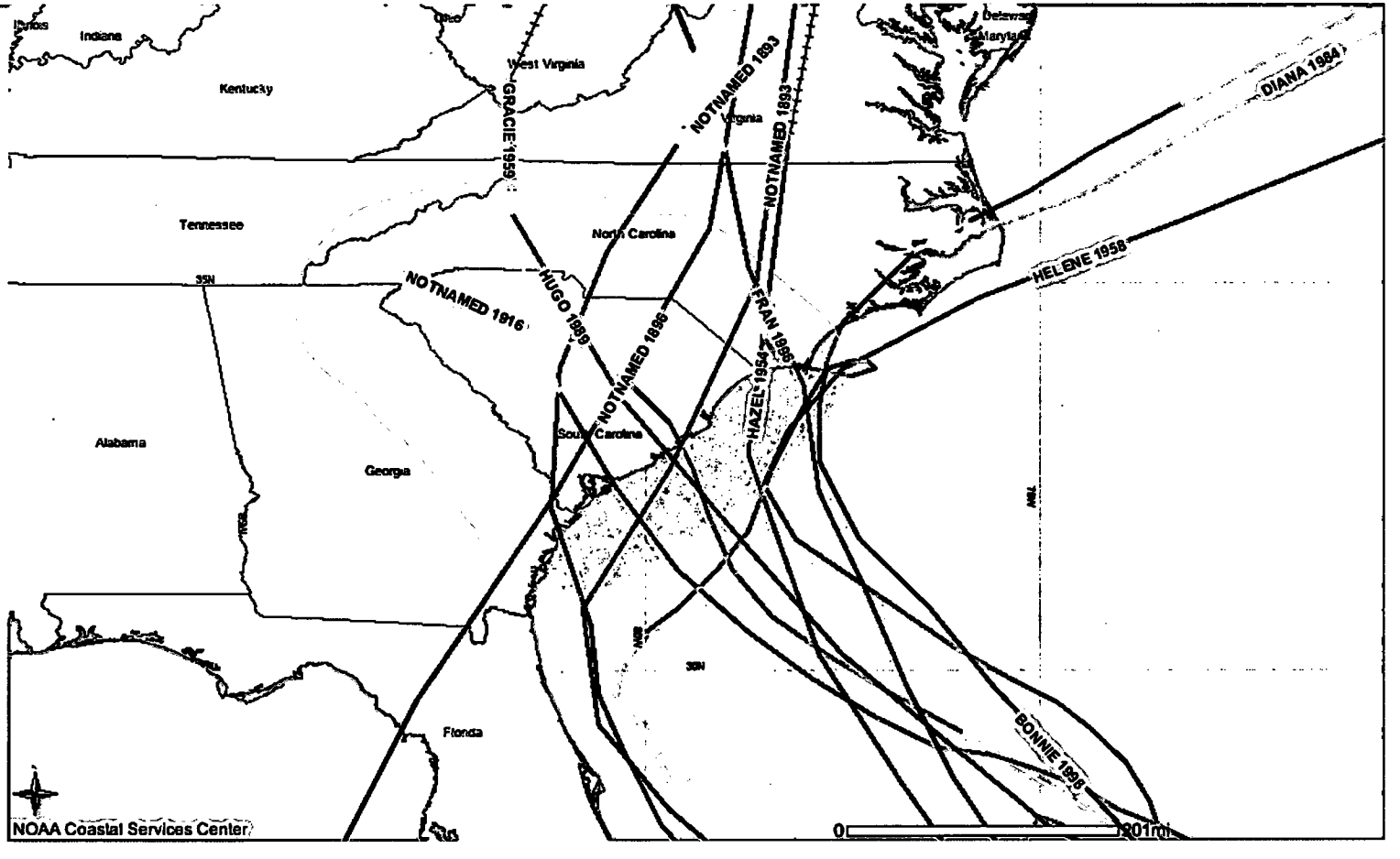
Myth: Hurricanes only affect the coast

1892 to 2007 Storm Tracks



Myth: The strongest hurricanes are on the coast

Category 3 to 5 storms
1892 to 2007



Myth: Damage on the coast is mostly caused by wind

Myth: NC needs to be prepared for a catastrophic hurricane

Hurricane Info 1851 - 2004

Florida	***North Carolina***
▪ 19 hurricanes category 3 or above	▪ 6 Hurricanes category 3 or above
▪ 3 category five storms	▪ 0 category five storms
▪ 6 category four storms	▪ 1 category four storm

(Source: NOAA)

Hugo's Charlotte Visit

- Almost two-hundred miles inland Hugo still had 100-mph wind gusts
- The major metropolitan area of Charlotte, North Carolina suffered extensive damage.
- Thousands of large trees fell into homes and business around Charlotte
- Glass was shattered in downtown skyscrapers.
- Torrential rains in Virginia flooded roads and cut power to 2 million people.
- By late on September 22nd, Hugo finally died over the cool forests of southern Canada.

Fran and Raleigh

- Like Hugo, Fran first visited coastal communities then roared inland.
- Raleigh experienced wind gust in excess of 90 miles per hour.
- Thousands of tree were downed causing major damage to homes and business.
- Electrical power was lost to thousands.
- Terrified residents sat in darkness, as fifty-foot, century old oaks crash through homes.
- One million square feet of the Crabtree valley

  Mall and Sheraton hotel was flooded up to the second level.

Myth: The Coastal area has the bulk of the wind claims

Data: See Appendix A

- From 1986 to 2005, during which there were nine hurricanes, the Coastal Counties had 26% of the incurred wind losses Statewide.
- Rates here, however, are 3 to 5 times that of Charlotte.
- Actual Rate Quote, Feb 17, 2009, $150,000 HO3 policy:
  - Charlotte - $482
  - Carteret Mainland - $1,526
  - Carteret Beach - $2,405

The Beach Plan Facts

- Since 2004, growth in exposure, 151%.
- Growth in premiums earned, 192%
- Growth in equity , 294%
- The Beach Plan had net income of over $475 million in just the past five years (2004-2008).
- In 2006, participating companies took over $41 million out of the surplus.
- In 2008, two years later, they claimed the Beach Plan was seriously underfunded.
- See Appendix B

Conclusion

1. Hurricanes are a statewide threat.
2. The premium burden and the deductibles on the coast in all plans is disproportionately high.
3. The Beach Plan had a total of $475 million in net income over the last 5 years.
4. In the event of a catastrophic loss, insurers would be assessed in proportion to their market share in North Carolina; therefore, the Beach Plan is not at risk of failure and taxpayers are never at risk.
5. NC 20 supports non-recoupable and recoupable losses Statewide.
6. There is no public input in insurance matters.
7. The recent increases, which can only be described as drastic, bear no resemblance to actuarial data or loss history. Modeling is a highly variable and subjective science.
8. There is no transparency in the rate making process.
9. Insurance companies only two years ago withdrew $41 million from the surplus.

North Carolina is suffering from perhaps the most devastating economic downturn in memory. The greatest increases are occurring in the poorest region of the State, and are by no means confined to the beach area. Please do all you can to prevent any more pain to the citizens of this State

A stay of increases is in order followed by the creation of a one-year study commission with appropriate public involvement

ATTACHMENT #2

"TWENTY COUNTIES..ONE VOICE"

Actual Loss Data - Entire State

Wind and Hail Incurred Losses 1986 - 2005

Data provided by the NC Department of Insurance

705 Page Road ▫ Washington, NC 28779 ▫www.nc-20.com ▫252-946-1435

"TWENTY COUNTIES...ONE VOICE"

NC Incurred Losses Due to Wind and Hail
1986 - 2005
Report Summary

Definition of Terms
Beach Area: The properties on the NC barrier islands adjacent to the Atlantic Ocean.
Coastal Area: The properties within the eighteen coastal counties of Beaufort, Brunswick, Camden, Carteret, Chowan, Craven, Currituck, Dare, Hyde, Jones, New Hanover, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Tyrrell and Washington not located on the barrier islands.

Dwelling EC: Dwelling Extended Coverage can be written on any residential property; includes wind, smoke, hail, etc.; predominately carried on second homes when ineligible for homeowner's policy.
HO Owners: Homeowner's coverage for primary residences only; can be losses under general homeowner's policies that cover wind or homeowners wind only.

This report shows actual incurred wind and hail losses in the state from 1986 thru 2005. This report does not separate out Beach Plan losses - but shows ALL losses in the Beach Area and the Coastal Area.

There were 10 hurricanes that hit NC during 1986 - 2005.

The total of the Beach Plan Area and Coastal Area represents total losses in the eighteen coastal counties. This total is **$756 million** over a 19-year time period. (Data for 1991 was unavailable)

Total statewide wind and hail losses during the same 19-year time period was **$2.9 billion.**

Cumulative coastal county losses during the 19-year time period of 1986-2005 were only 26% of the cumulative state wind and hail losses.

705 Page Road ▫ Washington, NC 28779 ▫www.nc-20.com ▫252-946-1435

North Carolina Residential Property
Adjusted Incurred Losses due to Wind and Hail - 1986-2005

blank cells indicate unavailable data

	Beach Area				Coastal Area		
	Dwelling EC Incurred Loss	HO Owners Incurred Loss	TOTAL Incurred Loss		Dwelling EC Incurred Loss	HO Owners Incurred Loss	TOTAL Incurred Loss
Charley - 1986		66,149	66,149			552,185	552,185
1987		207,729	207,729			718,069	718,069
1988		51,035	51,035			2,192,391	2,192,391
1989		727,076	727,076			2,829,771	2,829,771
1990		145,226	145,226			1,264,911	1,264,911
1991			-				-
1992	54,734	83,240	137,974	1992	179,944	1,775,010	1,954,954
Emily - 1993	11,020,794	6,386,050	17,406,844	1993	2,172,328	25,552,187	27,724,515
1994	209,938	139,876	349,814	1994	157,152	1,065,374	1,222,526
1995	246,083	171,808	417,891	1995	298,354	3,053,521	3,351,875
Fran, Bertha - 1996	101,465,118	32,629,711	134,094,829	1996	17,805,016	195,081,441	212,886,457
1997	470,681	183,824	654,505	1997	250,822	2,013,887	2,264,709
Bonnie - 1998	34,748,453	9,409,876	44,158,329	1998	3,859,749	47,345,528	51,205,277
Floyd - 1999	31,188,497	7,370,452	38,558,949	1999	4,407,817	45,502,761	49,910,578
2000	520,238	226,234	746,472	2000	235,281	3,613,213	3,848,494
2001	210,057	102,117	312,174	2001	385,791	1,313,546	1,699,337
2002	263,302	112,445	375,747	2002	444,987	1,326,311	1,771,298
Isabel - 2003	27,253,741	3,082,797	30,336,538	2003	20,003,920	83,071,521	103,075,441
Charley, Alex - 2004		1,869,511	1,869,511	2004		9,142,924	9,142,924
Ophelia - 2005		3,721,587	3,721,587	2005		13,419,776	13,419,776
			274,338,379				**491,035,488**

Total loss for the coastal counties: **765,373,867**

Total State				Statewide excl Beach and Coast			
	Dwelling EC Incurred Loss	HO Owners Incurred Loss	TOTAL Incurred Loss		Dwelling EC Incurred Loss	HO Owners Incurred Loss	TOTAL Incurred Loss
Charley - 1986		15,655,401	15,655,401	1986		15,037,067	15,037,067
1987		22,495,771	22,495,771	1987		21,569,973	21,569,973
1988		65,492,834	65,492,834	1988		63,249,408	63,249,408
1989		406,198,435	406,198,435	1989		402,641,588	402,641,588
1990		37,503,350	37,503,350	1990		36,093,213	36,093,213
1991			-	1991		-	-
1992	1,679,324	24,186,075	25,865,399	1992	1,444,646	22,327,825	23,772,471
Emily - 1993	17,115,568	94,875,027	111,990,595	1993	3,922,446	62,936,790	66,859,236
1994	2,598,090	26,662,873	29,260,963	1994	2,231,000	25,457,623	27,688,623
1995	3,489,841	53,051,068	56,540,909	1995	2,945,404	49,825,739	52,771,143
Fran, Bertha - 1996	158,289,245	813,376,837	971,666,082	1996	39,019,111	585,665,685	624,684,796
1997	3,067,948	34,988,278	38,056,226	1997	2,346,445	32,790,567	35,137,012
Bonnie - 1998	47,128,964	190,143,070	237,272,034	1998	8,520,762	133,387,666	141,908,428
Floyd - 1999	51,098,293	222,799,257	273,897,550	1999	15,501,979	169,926,044	185,428,023
2000	6,216,750	88,922,556	95,139,306	2000	5,461,231	85,083,109	90,544,340
2001	3,062,969	30,953,444	34,016,413	2001	2,467,121	29,537,781	32,004,902
2002	4,827,522	48,471,021	53,298,543	2002	4,119,233	47,032,265	51,151,498
Isabel - 2003	66,418,320	274,991,002	341,409,322	2003	19,160,659	188,836,684	207,997,343
Charley, Alex - 2004		107,485,841	107,485,841	2004	-	96,473,406	96,473,406
Ophelia - 2005		62,560,438	62,560,438	2005	-	45,419,075	45,419,075
			2,985,805,412				**2,220,431,545**

Cum. Coastal Counties' Wind Losses Compared to State Losses $765,373,867 / 2,985,805,412 = 26%

The other 82 counties incurred 74% of the total wind losses.

SOURCE: various Cause of Loss reports included in filings, as compiled by ISO

"TWENTY COUNTIES...ONE VOICE"

Beach Plan Financials
2004 - 2008

705 Page Road ▫ Washington, NC 28779 ▫www.nc-20.com ▫252-946-1435

Beach Plan Financials - Fiscal Year 2004 - 2008 (web data only goes back to 2004)

	2003	2004	2005	2006	2007	2008
Premiums Earned		**$87,341,137**	**$111,328,193**	**$150,607,305**	**$195,022,246**	**$255,294,739**
Reinsurance					$32,327,854	$78,097,116
Losses Incurred		$31,868,561	$70,546,474	$1,164,414	$9,757,690	$11,154,608
Net Underwriting Gain		$36,317,313	$14,263,848	$122,260,679	$113,902,820	$118,289,093
Net Income		$38,133,009	$20,596,817	$136,454,790	$135,362,539	$145,117,727
Assessments		**$4,004,538**				
Distributions/Profit Sharing				**$41,427,003**		
Change in Equity (profit)		**$42,208,382**	**$20,470,522**	**$95,035,712**	**$135,019,350**	**$145,206,993**
Members' Equity	$92,267,791	$134,476,173	$154,946,695	$249,982,407	$385,001,757	$530,208,750
Exposure		**$28,905,006,918**	**$41,304,716,800**	**$53,011,170,240**	**$64,056,581,691**	**$72,454,379,274**
Premiums to Exposure		0.0030	0.0027	0.0028	0.0030	0.0035

Growth in exposure since 2004: 151%
Growth in premiums earned: 192%
Growth in Member's Equity since 2004: 294%

This data was compiled by NC-20 from Beach Plan financial statements listed on www.ncjua-nciua.org.
Due to space limitations, not all lineitems are listed. The following are definitions:
Net Underwriting Gain: Premiums earned less reinsurance, losses incurred, loss expense, operating expenses, taxes
Net Income: Net Gain plus investment income, miscellaneous income
Change in Equity: Net Income: - distributions or + assessments, +/- adjustments, +/- change in assets not admitted, - pension liability
Members Equity: The prior period members' equity plus positive change in equity (surplus/profit). Beach Plan Board member companies agreed not to make any further distributions from the equity fund after 2006.

"TWENTY COUNTIES...ONE VOICE"

Beach Plan Financial Statement
Fiscal Year 2007-2008
September 30, 2008

Summary and Analysis

705 Page Road ▫ Washington, NC 28779 ▫www.nc-20.com ▫252-946-1435

"TWENTY COUNTIES...ONE VOICE"

NCIUA Financial Statement
2007- 2008 Fiscal Year - September 30, 2008
Analysis

Total Policyholders:	174,247
Residential:	164,568
Commercial:	9,679
Total Exposure:	$72,454,379,274
Total *Residential* Exposure:	$63,340,641,817
Total *Commercial* Exposure:	$ 9,113,737,457
Total **Residential** Wind Exposure in Beach and Coastal Area: (HO Wind Beach; HO Wind Coastal; Dwelling Beach Wind; Dwelling Coast Wind)	$52,259,032,890
Percentage of Wind Exposure in Beach Plan to Total Exposure:	**72%**
Residential Exposure Breakdown:	
Beach Area - Properties on the Barrier Islands:	$12,972,893,785
Percentage of Beach Area to Total Residential Exposure:	**25%**
Coastal Area - Properties elsewhere in the 18 coastal counties:	$39,286,139,105
Percentage of Coastal Area to Total Residential Exposure:	**75%**

Total Exposure data is **"based upon total Building and Personal Property Amounts."**

- Beach Plan *Personal Property* coverage is automatically calculated at an over-inflated amount of **70%** of the building coverage in all Homeowners Wind policies. $150,000 policy + $105,000 in personal property coverage.
- The Personal Property amount is included in the financial statement summary exposure totals for HO Wind Beach and HO Wind Coastal - $12,248,267,573 + $37,392,120,464 = **$49,640,388,037.**
- Therefore of the Total Residential Wind Exposure for HO Wind Beach and HO Coastal - **approximately $29 billion** is actually building exposure and **$20 billion is for personal property coverage.**

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NORTH CAROLINA INSURANCE UNDERWRITING ASSOCIATION
BEACH PLAN
AS OF SEPTEMBER 30, 2008

AGGREGATE LIABILITY BY COUNTIES

RESIDENTIAL AGGREGATE LIABILITY

COUNTY	DWELLING BEACH LIABILITY *	DWELLING BEACH COUNT	HOMEOWNER BEACH LIABILITY*	HOMEOWNER BEACH COUNT	HOMEOWNER COASTAL LIABILITY *	HOMEOWNER COASTAL COUNT	HO WIND BEACH LIABILITY*	HO WIND BEACH COUNT	HO WIND COASTAL LIABILITY *	HO WIND COASTAL COUNT	DWELLING BEACH WIND LIABILITY *	DWELLING BEACH WIND COUNT	DWELLING COASTAL WIND LIABILITY*	DWELLING COASTAL WIND COUNT	TOTAL RESIDENTIAL BEACH LIABILITY *	TOTAL RESIDENTIAL COUNT
BEAUFORT	0	0	0	0	75,906,370	164	0	0	727,431,598	1,983	0	0	65,369,309	726	868,707,277	2,873
BRUNSWICK	1,520,508,967	7,161	234,414,902	321	693,483,186	1,204	2,095,918,903	3,696	6,808,304,245	14,830	81,769,201	358	275,998,533	2,677	11,708,377,937	30,247
CAMDEN	0	0	0	0	26,775,660	50	0	0	331,124,680	775	0	0	15,948,260	146	373,848,600	971
CARTERET	547,185,324	4,324	170,772,110	234	305,258,229	541	2,001,192,093	3,535	4,520,893,450	10,973	128,612,459	522	227,380,502	1,841	7,901,094,167	21,970
CHOWAN	0	0	0	0	19,277,500	43	0	0	348,119,629	888	0	0	32,812,714	337	400,009,843	1,268
CRAVEN	0	0	0	0	351,958,411	737	0	0	1,694,799,681	5,057	0	0	117,743,491	990	2,364,501,583	6,784
CURRITUCK	886,128,034	2,250	6,989,600	11	90,784,230	184	1,530,500,778	1,639	1,165,643,569	2,647	67,774,740	178	54,268,970	420	3,802,089,921	7,309
DARE	2,407,492,086	10,305	428,266,040	586	53,980,200	80	4,239,058,056	7,064	740,158,463	1,387	308,585,685	1,198	24,261,690	130	8,201,782,220	20,750
HYDE	67,855,825	381	3,399,400	5	8,037,720	25	42,531,611	86	43,632,651	142	7,674,667	42	10,855,687	157	183,987,561	838
JONES	0	0	0	0	16,920,098	47	0	0	121,487,771	367	0	0	12,899,310	159	151,307,177	573
NEW HANOVER	551,725,288	2,416	251,023,102	383	938,172,654	1,724	1,474,100,939	2,245	12,079,752,374	25,046	90,468,675	350	410,398,135	2,529	15,795,641,147	34,693
ONSLOW	143,838,924	909	50,408,680	72	593,704,329	1,307	371,737,920	709	4,573,772,482	13,932	19,593,905	64	326,071,418	2,858	8,079,125,658	19,851
PAMLICO	0	0	0	0	16,808,545	37	0	0	579,945,466	1,355	0	0	49,532,824	424	846,288,835	1,816
PASQUOTANK	0	0	0	0	109,405,267	212	0	0	699,619,705	1,992	0	0	67,698,492	640	876,723,464	2,844
PENDER	242,268,440	1,319	46,417,750	62	182,284,918	339	493,227,273	986	2,184,977,625	5,308	20,166,880	95	144,562,162	1,463	3,313,903,048	9,572
PERQUIMANS	0	0	0	0	22,023,540	50	0	0	388,535,454	856	0	0	30,788,151	320	439,347,145	1,226
TYRRELL	0	0	0	0	4,673,720	10	0	0	49,543,681	154	0	0	10,155,403	132	84,372,804	296
WASHINGTON	0	0	0	0	13,483,900	37	0	0	138,577,940	423	0	0	17,473,590	227	169,535,430	687
TOTAL	6,367,000,868	29,065	1,191,689,584	1,674	3,522,918,475	6,771	12,246,267,573	19,980	37,392,120,464	88,115	724,626,212	2,807	1,894,018,641	16,176	63,340,641,817	164,568

COMMERCIAL AGGREGATE LIABILITY

COUNTY	COMMERCIAL BEACH LIABILITY *	COMMERCIAL BEACH COUNT	COMMERCIAL BEACH WIND LIABILITY*	COMMERCIAL BEACH WIND COUNT	COMMERCIAL COASTAL WIND LIABILITY *	COMMERCIAL COASTAL WIND COUNT	TOTAL COMMERCIAL BEACH LIABILITY *	TOTAL COMMERCIAL COUNT
BEAUFORT	0	0	0	0	143,648,569	227	143,648,569	227
BRUNSWICK	87,008,434	80	325,501,895	194	912,092,257	939	1,324,602,586	1,213
CAMDEN	0	0	0	0	31,026,987	47	31,026,987	47
CARTERET	52,718,500	115	686,468,928	377	878,515,951	1,053	1,617,703,379	1,545
CHOWAN	0	0	0	0	109,644,805	112	109,644,805	112
CRAVEN	0	0	0	0	448,777,719	591	448,777,719	591
CURRITUCK	4,871,070	23	84,207,923	105	153,844,795	251	242,723,788	379
DARE	132,000,554	250	984,573,203	920	198,515,421	186	1,315,089,178	1,356
HYDE	10,627,800	29	39,113,683	49	22,566,410	33	72,307,893	111
JONES	0	0	0	0	13,318,712	44	13,318,712	44
NEW HANOVER	173,677,787	232	525,769,846	357	1,731,909,872	1,627	2,431,357,505	2,216
ONSLOW	24,141,800	15	51,790,340	30	671,361,747	907	747,293,887	952
PAMLICO	0	0	0	0	85,651,155	129	85,651,155	129
PASQUOTANK	0	0	0	0	160,765,028	209	160,765,028	209
PENDER	20,996,160	35	78,756,677	74	161,831,749	265	261,584,586	374
PERQUIMANS	0	0	0	0	35,568,697	72	35,568,697	72
TYRRELL	0	0	0	0	22,128,542	32	22,128,542	32
WASHINGTON	0	0	0	0	50,546,441	70	50,546,441	70
TOTAL	506,042,105	779	2,776,182,495	2,106	5,831,512,857	6,794	9,113,737,457	9,679

TOTAL BEACH

COUNTY	TOTAL BEACH LIABILITY *	TOTAL BEACH COUNT
BEAUFORT	1,012,353,846	3,100
BRUNSWICK	13,032,980,523	31,480
CAMDEN	404,875,587	1,018
CARTERET	9,518,797,546	23,515
CHOWAN	509,654,648	1,380
CRAVEN	2,813,279,302	7,375
CURRITUCK	4,044,813,709	7,688
DARE	9,516,871,398	22,108
HYDE	256,295,454	949
JONES	184,625,889	617
NEW HANOVER	18,226,998,652	36,909
ONSLOW	6,826,419,545	20,803
PAMLICO	731,937,990	1,945
PASQUOTANK	1,037,488,492	3,053
PENDER	3,575,487,634	9,946
PERQUIMANS	474,915,842	1,298
TYRRELL	86,501,346	328
WASHINGTON	220,081,871	757
TOTAL	72,454,379,274	174,247

* Based upon the total Building and Personal Property amounts. Dwelling "other coverages, " which are additional amounts of insurance based upon Coverage A and Commercial policy extensions, are not factored into this amount.

Att 2

Consumer Federation of America
1620 I Street, N.W., Suite 200 * Washington, DC 20006

For Immediate Release:
Thursday, January 10, 2008

Contact: J. Robert Hunter, 703-528-0062
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INSURERS MAINTAIN RECORD PROFITS IN 2007 BY OVERPRICING POLICIES AND UNDERPAYING CLAIMS

--Anti-Consumer Practices Also Lead to Bloated Surplus and Reserve Levels--

State and national consumer organizations joined the Consumer Federation of America (CFA) today to release a new study concluding that the property/casualty insurance industry continued in 2007 to systematically overcharge consumers and reduce the value of home and automobile insurance policies, leading to profits, reserves, and surplus that are at or near record levels. The study estimates that insurer overcharges over the last four years amount to an average of $870 per household.

The report provides extensive data demonstrating that property/casualty insurance companies are paying out lower claims in relationship to the premiums they charge consumers than at any time in decades. The pure loss ratio, the actual amount of each premium dollar insurers pay back to policyholders in benefits, was only 54.6 cents in 2007. Over the past 20 years, the amount paid back as benefits has dramatically declined from over 70 cents per premium dollar, indicating a huge loss in the value of insurance to consumers.

"Consumers ultimately pay the price for the unjustified profits, padded reserves, and excessive capitalization that exist right now in the insurance industry," said J. Robert Hunter, the Director of Insurance for the Consumer Federation of America (CFA) and author of the study. Hunter is an actuary, former state insurance commissioner, and former federal insurance administrator.

"The insurance industry reaped record profits in 2004 and 2005, despite significant hurricane activity," said Hunter. "Profits in 2006 rose to unprecedented heights and 2007 may set a fourth consecutive profit record," he said. "Unfortunately, a major reason why insurers have reported record-high profits and low losses in recent years is that they have been methodically overcharging consumers, cutting back on coverage, underpaying claims, and getting taxpayers to pick up some of the tab for risks the insurers should cover," said Hunter.

In the last several years, insurers sharply increased premiums for homeowners and commercial insurance and reduced or eliminated coverage for tens of thousands of Americans in coastal areas. Insurers have succeeded in convincing Congress to continue taxpayer subsidies for terrorism losses and are seeking additional subsidies for catastrophe insurance.

Using a number of common measures of financial health, the study finds that balance sheets for property/casualty insurers are in better condition overall than at any time in history.

Record High Profits/ Low Losses

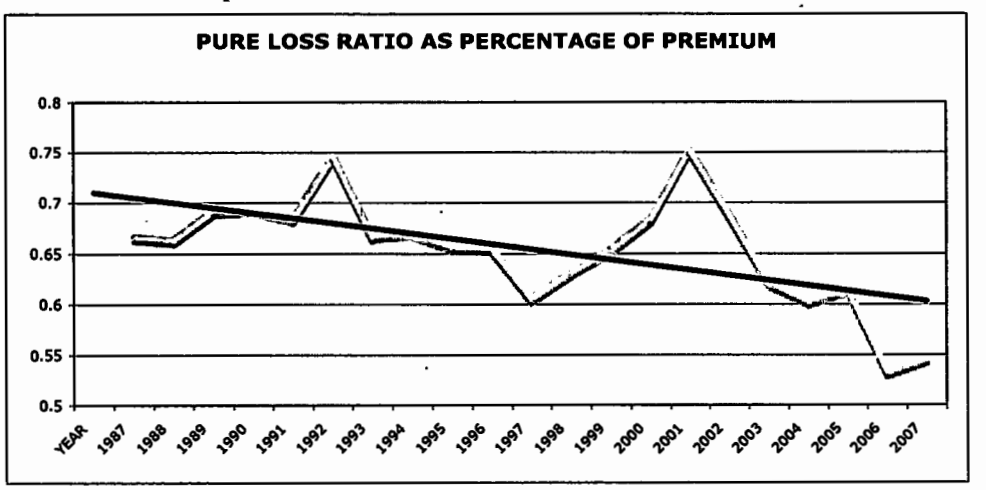
The study estimates that after-tax returns for 2007 are about $65 billion, just under the record level set in 2006. If insurers release even a small part of their swollen reserves as profits, final profits for 2007 will exceed those of 2006. Profits for the record years of 2004, 2005, 2006, and 2007 are estimated to be $253.1 billion. The loss and loss adjustment expense (LAE) ratio for 2007 is estimated to be 66.7 percent, the second lowest in the 28 years studied. Five of the seven lowest loss and LAE ratios in the last 28 years have occurred since 2003.

YEAR	INDUSTRY NET INCOME (Post-tax)	LOSS AND LOSS ADJ RATIO	POLICY-HOLDER SURPLUS
2003	$31.2	75.0%	$450.1
2004	$40.5	73.5%	$509.1
2005	$48.8	75.3%	$551.0
2006	$67.6	65.5%	$621.8
2007	$65.0	66.7%	$687.0

Source: A.M. Best Aggregates and Averages (2007 data estimated by CFA based on reported industry results for first nine months and Insurance Information Institute estimates)

Claim Payouts Continue to Drop

Consumers have experienced a startling drop in the amount of premium paid in benefits by the insurers, from 72 percent in the late 1980s to only 60 percent today when plotted on a straight-line trend over the period:



This drop in the efficiency of the insurance product for consumers is startling and calls for action by the regulators to control industry excesses.

Insurance is a Low-Risk Investment

Representatives of the insurance industry often claim that high premiums and profits are necessary to compensate for the excessive risks they must bear. In fact, insurance is a low-risk investment. Using standard measures of stock market performance that assess financial safety and

stock price stability, the property/casualty insurance industry represents a below-average risk compared to all stocks in the market, safer than investing in a diversified mutual fund.

In 2007, the study estimates that stock insurers will earn a return on equity (ROE) of more than 19 percent, well in excess of what is required by investors. The lower industry-wide ROE that insurers report underestimates the industry's actual ROE.

Surplus is Unprecedented: Insurers are Overcapitalized

The study estimates that retained earnings, or surplus, for the entire industry was $687 billion at the end of 2007. An adequate surplus guarantees a safe insurance industry, but this amount is excessive by any legitimate measure. To assess the financial solidity of an insurance company, regulators examine the ratio of net premium written to surplus, which, at the lowest level ever, 0.66 to 1 (66 cents of premium written for every dollar of surplus), is less than half of the extremely safe 1.5 to 1 ratio that is recommended by many observers and far less than the famous "Kenny" rule of 2 to 1 as an efficient surplus level. The largest loss ever suffered by the insurance industry, Hurricane Katrina, represented an after-tax loss of $26.7 billion, or 4 percent of current surplus when adjusted to 2007 dollars. The $12.2 billion in after-tax losses experienced by insurers after the September 11th terrorist attacks amounts to 2 percent of surplus. Many insurers are engaged in massive stock buy-back programs and the purchase of other corporations with this excess capital. Insurance chief executive officers now have the highest average cash compensation of any industry in America. Even the Insurance Information Institute (III) admits that the industry is overcapitalized: "...there is excess capital in the industry today – estimated by some analysts to be as much as $100 billion..." The excess capital approaches $175 to $200 billion if reserve redundancies (see below) are eliminated.

Loss and Loss Adjustment Expense Reserves are Padded with Hidden Profits

When industry profits are high, as they have been in record amounts since 2003, insurers tend to pad their reserves. This practice contributes to financial solidity. However, insurers also pad their reserves because it removes income from their profit statements, thus lowering their tax burden because reserves are not taxed and income is. This practice also allows insurers to point to inflated "losses," which rise due to reserve redundancies, as justification for not lowering rates.

The Insurance Services Office (ISO) estimates that loss and loss adjustment expense reserves at year-end 2006 were 9 percent redundant, a figure that represents over $50 billion in excessive reserves. Adjusting for the time value of money, ISO saw an additional $13 billion in padded reserves at year-end 2006. CFA estimates that the redundancy in reserves increased in 2007 and could be up to more than $80 billion by year-end 2007.

Insurers Have Lowered Risk and Maximized Profits through Legitimate and Illegitimate Means

In recent years, insurers have reduced their financial risk by making wise use of reinsurance and other risk-spreading techniques, such as securitization. However, the study cites several tactics that insurers have also used to shift costs and risk onto consumers and taxpayers. Some of the questionable methods that insurers have used to shift risk include:

- **Sharp limits on coverage and availability**. Insurers have imposed large hurricane deductibles, capped home replacement and rebuilding costs, added new exclusions such as

mold, and placed unjustifiable restrictions on claims. For example, "anti-concurrent-causation" clauses, now in wide use, attempt to strip all coverage for hurricane damage if a non-covered event like a flood occurs, even if the flood hits hours after a home is destroyed by wind. Some insurers have canceled policies, refused to renew policies, or refused to write new coverage in coastal areas and entire states from Texas to Maine.

- **Harsh homeowner's rate increases**. Insurers have imposed sharp rate increases on many homeowners throughout the nation. A major reason for these recent increases is that insurers are relying on short-term predictions of potential weather disasters, reneging on promises to use more scientific long-term computer predictions.
- **Programs designed to systematically underpay claims**. Many insurers are now using new computer-directed programs like "Colossus" and "Claims Outcome Advisor" that allow insurers to determine the amount of overall claims savings they want to achieve before claims are assessed for legitimacy.
- **Taxpayer subsidies**. Insurers and real estate interests were the major proponents of the Terrorism Risk Insurance Act, which Congress recently continued under industry pressure. The study estimates that insurance companies have received a subsidy of about $4 billion to date because insurance companies do not have to pay premiums for the reinsurance provided by the federal government. Some insurers have urged Congress to create a similar program to cover natural disasters. Insurers have also received significant taxpayer support at the state level, through the creation of state directed "insurers-of-last-resort." The existence of these companies allows insurers to "cherry pick," by insuring lower risk households themselves and sending higher risk households to the state company. Only Florida has taken steps to end this practice.

"Insurers have been so successful in shifting their risk onto consumers and taxpayers that they have produced record profits during a period of increased storm destruction," said Hunter. "This risk shift is reflected by the fact that insurers are paying less and less of the premium dollars they receive in benefits to consumers."

Recommendations for State Policymakers

1. Require insurers to offer an all-risk homeowners insurance policy. This would once again ensure that homes are protected from catastrophic events. It would also help consumers understand exactly what their policy covers, and encourage insurers to do more to prevent losses before they occur.

2. Better oversee the use of socio-economic factors used to set rates, like credit scoring. Insurers have been able to maintain excessive pricing through the use of such information as consumers' credit scores, prior insurance limits, occupation, and educational attainment. This information is opaque to consumers and has not been examined by most regulators to ensure that it results in the setting of fair rates. State regulators should require that pricing practices: promote risk reduction; are logically related to risk (so consumers know what steps to take to reduce rates); protect low income and minority consumers; and are open and transparent to the public.

3. Increase scrutiny of computer-based claims settlement procedures. The use of computer procedures has shielded insurers from scrutiny of questionable claims practices, while state insurance regulators have largely looked the other way. In 2008, regulators should pierce the mystery of how claims are settled and stop practices that deny the full payment of legitimate claims.

4. Make state-backed reinsurance available. States should join together to offer reinsurance to private insurers using the recent Florida legislation as a model. If all catastrophe-prone states joined together to underwrite reinsurance at actuarially sound rates (or even at a mark-up of 50 percent over actuarially sound rates), they would likely end or significantly diminish the periodic crises that follow big hurricanes or earthquakes.

5. Consider offering state-backed property and automobile insurance. Policymakers in coastal regions should consider whether the increasing rates, decreasing coverage, and turmoil created by large numbers of periodic non-renewals have reached the point where private insurers should not be offering certain coverage at all. In 2007, Florida allowed its primary insurer, Citizens Insurance Company, to offer comprehensive homeowners insurance policies at competitive rates. This forced private insurers to lower some rates and allowed Citizen's to spread risk more broadly. States should consider taking this approach further by offering automobile insurance, which would assure that, over time, the state would make a small profit or at least break even on its insurance offerings.

6. Better regulate the use of catastrophe modeling. States should follow Florida's example in blocking catastrophe-modeling firms from using short-term projections as the basis for establishing insurance rates and require them to return to the practice of using long-term projections. Coastal states should consider uniting to develop a coastal weather modeling system of their own to test the accuracy of private projections and to evaluate the fairness of insurer rate requests.

7. End unjustified geographic discrimination. If any insurer fails to market a line of insurance that it is selling in other parts of a state (or in other states), regulators should consider convening hearings to determine if the insurer's license should be revoked for geographic discrimination.

8. Review homeowners insurance policy forms for hidden provisions. Insurance regulators should carefully review the policy forms and exclusions they have allowed to become part of homeowner's policies, and require insurers to offer clear disclosure about exclusions and lower rates to reflect decreased risk that results from these exclusions.

Recommendations for Federal Policymakers

1. Repeal the McCarran-Ferguson Act's antitrust exemption for insurance. The excessive pricing and unjustified claims practices documented in this report are abetted by collusive and anticompetitive behavior allowed under this law. Congress should impose the same antitrust law relative to insurance with which virtually every other business in America must comply.

2. Authorize interstate cooperation on catastrophe insurance. Congress should authorize states to use interstate compacts to create multi-state risk "pools" to cover wind and other catastrophic losses. Such legislation should allow states to permit the accumulation of tax-free reserves if the funds collected are kept for the purpose of paying claims after wind disasters strike.

3. Repair the troubled National Flood Insurance Program (NFIP) before vesting it with any additional authority. Congress should not pass any legislation to subsidize wind insurance or to add wind coverage to the National Flood Insurance Program. The NFIP is in disarray. Out-of-date flood maps used by the NFIP have underestimated flood risk and resulted in unjustifiably low insurance rates. This has created hidden subsidies for unwise construction in the nation's flood-prone areas, helping to create a $20 billion shortfall in NFIP funding. The use of private insurers to run the program has resulted in between one-third and two-thirds of flood premiums flowing to

insurers, not to the payments of claims. There is also evidence that insurers have shifted the cost of wind claims they should have paid to taxpayers—who support the NFIP.

4. Eliminate any federal policies that might undermine the development of the securitization of insurance risk. The federal government should undertake a study of federal laws and rules to ensure that the responsible securitization of insurance risk is encouraged, not discouraged, by federal tax policy. Fostering increased securitization of catastrophe risk is a far more favorable option for consumers and taxpayers than insurer efforts to receive more taxpayer subsidies.

Advice for Consumers

1. If possible, do not do business with a company that has a history of anti-consumer behavior. When purchasing or renewing a homeowner's policy, consumers can contact their state insurance departments to get information on companies in their areas that have sharply raised rates and cut back in coverage in recent years.

2. Carefully review policies at purchase or renewal to determine whether high out-of-pocket costs will be imposed. Consumers should look for separate deductibles for wind damage, anti-concurrent-causation clauses, mold exclusions, limits on replacement costs, and other restrictions on coverage.

3. Consumers who live away from coastal areas should actively shop for better coverage and rates. Because insurance companies are overcapitalized, they are looking for new business in lower risk areas. Rate decreases and better coverage are possible.

4. Demand thorough oversight of insurer actions by state regulators. If consumers have a problem with rates or coverage, they should file an immediate complaint in writing with their state insurance agency and follow up for a response. Consumers should also contact insurance regulators to find out what they are doing to require that rates are fair and reasonable and that insurers are not unjustifiably withdrawing coverage.

The report was written by the Consumer Federation of America and released with national and state consumer organizations, including Americans for Insurance Reform, Center for Economic Justice, Center for Insurance Research, Center for Justice and Democracy, Consumers Union, Empire Justice, Florida Consumer Action Network, Foundation for Taxpayer and Consumer Rights, Neighborhood Economic Development Advocacy Project, New Jersey Citizen Action, Texas Watch, and United Policyholders. A copy of the report can be found at: www.consumerfed.org/pdfs/2008Insurance_White_Paper.pdf.

-30-

Consumer Federation of America (CFA) is a non-profit association of 300 consumer groups, with a combined membership of more than 50 million people. CFA was founded in 1968 to advance the consumer's interest through advocacy and education.

VISITOR REGISTRATION SHEET

House Committee on Insurance — 3-19-09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Stoller	State Farm
David Rice	Manning Fulton
David Boaz	MWC
Mallory Hatcher	MWC
Sue Taylor	NCRB
Rebecca Williams	NCRB
Rick Zechini	NC Assoc. of Realtors
Robert Pascal	Young Moore
Paul Stock	NCBA
Kenneth Willcox	/
John Miletti	Travelers Companies Inc.

VISITOR REGISTRATION SHEET

House Committee on Insurance — 3-19-09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	NMRS
Amy Powell	Nationwide
Roger Baddoff	NC Farm Bureau
Steve Carroll	NC Farm Bureau Ins Co.
Larry Wooten	NCFB Mutual
John Bowdish	
	Ogburn & Asso.

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Vicky Young	NCDOI
Ellen Sprenkel	NCDOT
Bob White	Alliance Mutual Ins Co, Greensboro
Liz Reynolds	National Assoc. of Mutual Ins. Cos.
Bill Tibbens	Farmers Ins. Group.
Dewey Meshaw	NCIUA/NCSUA
Lee E. Dunn	NCIUA/NCSUA
Alvin Ashworth	NCIUA/NCSUA
Mark Edwards	NCDOI

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cady Thomas	NC Assn of REALTORS
Charlotte Hicks	Independent Insurance Agents of NC
NEIL ANNAS	INDEPENDENT INSURANCE AGENTS OF NC
Duke Geraghty	Outer Banks Home Builders Association
Tim Lucas	NC Rate Bureau
Billy Trott	Young, Moore & Henderson
RAY EVANS	NC RATE BUREAU
Joe McClees	McClees Consulting
Bobby Outten	Dare County Attorney
Amy McCaskey	Smith Anderson
Barbara Canada	BSCGA

VISITOR REGISTRATION SHEET

House Committee on Insurance — 3-19-09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	State Farm
Bob Mack	NC DOI
Rose Williams	NCDCR
Kristin Milam	NCDOI
Kevin Conley	NCDOT
Judy Spear	
[illegible]	SA
Scott Palmer	Rep. Hollimon
Mike Mann	NCCC
Chris Hollis	Kelly Bates
Bill Scoggin	[illegible]

VISITOR REGISTRATION SHEET

House Committee on Insurance — 3-19-09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
TYLER NEWMAN	BASF
Cameron Moore	BASF
Jessi Hayes	NC HBA
Lisa Martin	NC HBA
John McMillan	MF+S
Michelle Frazier	MF+S
Jennifer Cohen	IFNC
Susan Valauri	Nationwide
FRANK FOLGER	NATIONWIDE
TOM THOMPSON	NC-20
Chris May	Cape Fear Region

House Pages

Name Of Committee: Insurance Date: 03-19-09

1. Name: Wilson Powell
   County: Buncombe
   Sponsor: Rep. Fisher
2. Name: DeShawn Henry-Adams
   County: Guilford
   Sponsor: Rep Wiley
3. Name: Kayla McCargo
   County: Dare
   Sponsor: Rep. Spear
4. Name: _____
   County: _____
   Sponsor: _____
5. Name: _____
   County: _____
   Sponsor: _____

Sgt-At-Arms

1. Name: Charles Williams
2. Name: Rod Fingers
3. Name: Martha Gadison
4. Name: Bob Rossi
5. Name: _____

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

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

DAY & DATE: **Thursday, March 19, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

HB 426 – STAY ON HOMEOWNERS INSURANCE ACTIONS – Rep. Tim Spear

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at **12:20 pm** on **March 17, 2009**.

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)

MINUTES

HOUSE COMMITTEE ON INSURANCE
March 24, 2009

The House Committee on Insurance met at 11:00 AM on Tuesday, March 24, 2009, in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael H. Wray; Vice Chairs: M. Dickson, J. Dockham and M. Setzer. Members attending were Reps. Blust, Braxton, Brubaker, Cole, Current, Faison, Gibson, Holliman, Howard, Pierce and Wainwright.

Chairman Wray called the meeting to order and welcomed visitors. He recognized Sgt-At-Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachment #1)

Chairman Wray stated speakers would be allowed to speak on HB 426-Stay on Homeowners Insurance Actions to be followed by questions, and he recognized Mr. Steve Carroll representing the NC Farm Bureau Mutual Insurance Company for remarks. (Attachment 2) Mr. Carroll thanked Insurance Commission Wayne Goodwin and members of the Legislature for recognizing that the Beach Plan issue impacts the insurance industry, the business community and economic development in our state. The North Carolina Farm Bureau Mutual supports Commissioner Goodwin's position that rate changes are necessary to maintain competition and guarantee availability of coverage in North Carolina. He does not believe the bill would be in the best interest of North Carolina.

Ms. Amy Powell, Nationwide, was called upon to speak. (Attachment 3) She is from eastern North Carolina and understands the impact of higher insurance rates on constituents. The amounts Nationwide were permitted to charge North Carolina policyholders last year did not cover the costs to serve their needs. The Beach Plan is not a money maker for the industry, and the proposed moratorium in HB 426 could result in higher insurances rates for all homeowner insurance customers.

Mr. Bob White, Alliance Mutual Insurance Company, spoke to the committee. (Attachment 4) He stated his company faces a disproportionate impact should the Beach Plan levy an assessment related to storm losses. The statewide homeowner rates scheduled to go into effect May 1st were actuarially determined by the Rate Bureau and reviewed and vetted by the Department of Insurance. The resulting rate change represents a compromise between what the Rate Bureau believes is needed to cover future loss costs and what the Department of insurance believes is fair and reasonable. He asked that the committee to accept the vetting process and allow the May 1st homeowner rates to become effective.

Mr. John McMillan, American Insurance Association, was recognized to speak. He stated Insurance Commissioner Goodwin has expressed his opposition to the bill and

has urged members of the General Assembly to reject bills proposing any stay of increased homeowners rates and Beach Plan taxes. He urged defeat of HB 426.

Mr. John Bode, Independent Insurance Agents of North Carolina, spoke next. He believes the problem is very serious. He thinks the Beach Plan needs to be restructured and offered to talk with members of the committee.

Mr. George Teague, Property Casualty Insurers Association of America, also spoke against passage of HB 426 which would have the General Assembly decide rate making judgments over that of the Insurance Commissioner and the statutorily created Rate Bureau that establishes homeowners' rates. This is a bad idea in that the General Assembly does not have expertise in establishing utility rates or the prices of other goods.

Chairman Wray asked for questions from the committee members and after committee discussion, he stated discussion of HB 426 would be continued at a later meeting. He thanked the industry for their presentations.

Chairman Wray adjourned the meeting at 11:50 AM.

Representative Michael H. Wray, Chair

Mary Capps, Committee Assistant

HOUSE INSURANCE COMMITTEE

March 24, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

(Continued Discussion)

HB 426 – Stay on Homeowner Insurance Actions
Representatives. Spear, Wainwright, Owens and McElraft

Adjourn

HOUSE BILL 426

Short Title:	Stay on Homeowners Insurance Actions.	(Public)
Sponsors:	Representatives Spear, Wainwright, Owens, McElraft (Primary Sponsors); Cleveland, Grady, Hughes, Justice, McComas, Mobley, Underhill, and Williams.	
Referred to:	Insurance, if favorable, Commerce, Small Business, and Entrepreneurship.	

March 5, 2009

A BILL TO BE ENTITLED

AN ACT TO IMPOSE A TEMPORARY STAY ON INCREASED SURCHARGES AND DEDUCTIBLES UNDER THE BEACH PLAN AND THE FAIR PLAN AND TO TEMPORARILY STAY PROPERTY INSURANCE RATE INCREASES FOR HOMEOWNERS POLICIES ACROSS THE STATE.

Whereas, the economy of the State is in historic decline, as evidenced by the projected $2.2 billion shortfall in revenue for the 2009-2010 fiscal year; and

Whereas, the unemployment rate for December 2008 by the Employment Security Commission was 8.7%, an increase of 85% over the rate in December 2007; and

Whereas, over 53,995 homes in North Carolina entered foreclosure in 2008, and an additional 2,221 homes entered foreclosure in January 2009; and

Whereas, the homeowners insurance rate increase approved by the Department of Insurance in December 2008 and scheduled to take effect in May 2009 increases rates by 22% in portions of Currituck, Hyde, Dare, and Pamlico Counties and increases rates by 29.8% in portions of Brunswick, New Hanover, Onslow, and Pender Counties; and

Whereas, over the last six years, the Department of Insurance estimates that homeowners insurance rates in the Beach Plan beach area have increased 90%, and rates in the Beach Plan coastal area have increased 65%; and

Whereas, seven of the counties included in the Beach Plan's beach and coastal areas are classified by the Department of Commerce as Tier One counties, meaning that they are among the 40 most economically distressed counties in the State and are eligible for the highest level of economic development incentives; and

Whereas, nine of the counties included in the Beach Plan's beach and coastal areas have poverty rates above the statewide average and median family income below the statewide average, according to U.S. Census Bureau 2007 estimates; and

Whereas, 57% of properties insured by the Beach Plan have an insured value for building and contents of $300,000 or less; and

Whereas, the citizens of North Carolina who are struggling to hold onto their homes and jobs should not be required to pay higher insurance rates during this economic crisis; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. The filing by the North Carolina Insurance Underwriting Association (NCIUA) approved by the Department of Insurance on November 21, 2008, and designated by the Department as PC121215 increasing from fifteen percent (15%) to twenty-five percent (25%) the factor or surcharge for homeowners coverage shall not take effect.

SECTION 2. The filing by the NCIUA approved by the Department on November 21, 2008, and designated by the Department as PC122445 increasing from five percent (5%) to fifteen percent (15%) the factor or surcharge for homeowners windstorm and hail only coverage shall not take effect.

SECTION 3. The residential deductible guideline submitted by the NCIUA, approved by the Department on November 21, 2008, and designated by the Department as PC122635 shall not take effect.

SECTION 4. The residential deductible guideline submitted by the North Carolina Joint Underwriting Association (NCJUA), approved by the Department on November 21, 2008, and designated by the Department as PC122682 shall not take effect.

SECTION 5. The commercial deductible guideline submitted by the NCIUA, approved by the Department on November 21, 2008, and designated by the Department as PC122637 shall not take effect.

SECTION 6. The commercial deductible guideline submitted by the NCJUA, approved by the Department on November 21, 2008, and designated by the Department as PC122683 shall not take effect.

SECTION 7. There shall be no surcharge or deductible increases or changes for coverages as specified in Sections 1 through 6 of this act on or after the effective date of this act.

SECTION 8. Rate increases resulting from the 2008 Rate Filing approved by the Commissioner of Insurance in the Consolidated Settlement Agreement and Consent Order dated December 18, 2008, shall not take effect, nor shall these rate increases be used by the NCIUA or the NCJUA when determining rates for coverage. In addition, there shall be no rate increases for coverage as specified in this section subsequent to the effective date of this act.

SECTION 9. Premiums or deductibles paid in violation of this act shall be refunded by insurers, the NCIUA, and the NCJUA, as applicable.

SECTION 10. Sections 1 through 9 of this act are effective when they become law and apply to policies issued or renewed on or after that date. The remainder of this act is effective when it becomes law. This act expires July 1, 2010.

HOUSE BILL 426:
Stay on Homeowners Insurance Actions

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Commerce, Small Business, and Entrepreneurship	**Date:**	March 18, 2009
Introduced by:	Reps. Spear, Wainwright, Owens, McElraft	**Prepared by:**	Tim Hovis Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***House Bill 426 would place a stay on surcharge increases for wind and hail portions of homeowners policies and separate homeowners' wind and hail policies issued by the North Carolina Insurance Underwriting Association (NCIUA), also known as the Beach Plan. The bill also stays all residential and commercial deductible increases for policies issued by the NCIUA and the North Carolina Joint Underwriting Association (NCJUA), also known as the FAIR Plan. Finally, the bill stays all statewide homeowners coverage rate increases approved by the Commissioner of Insurance and prohibits the use of these rate increases by the NCIUA and the NCJUA when determining base rates for homeowners coverage.***

House Bill 426 is effective when it becomes law and applies to policies issued or renewed on or after that date. The bill expires July 1, 2010.

BILL ANALYSIS: Below is a summary of current surcharges and deductibles under the Beach and FAIR Plans and increases to these surcharges and deductibles approved by the Commissioner of Insurance.

- **Section 1 of the bill**
  Surcharge on Homeowners Policies (wind portion)
  Increased from 15% to 25%
  Effective for policies issued or renewed on or after February 1, 2009

- **Section 2 of the bill**
  Surcharge on Wind Only Homeowners Policies
  Increased from 5% to 15%
  Effective for policies issued or renewed on or after February 1, 2009

- **Sections 3 and 4 of the bill**
  Residential Deductible Guidelines for Wind and Hail
  1. **Current residential deductible guidelines under the Beach Plan:**
     $500 flat deductible for less than $100,000 in coverage
     $1000 flat deductible for $149,999-$249,999
     $2,000 flat deductible for $250,000 and above
  2. **Current residential deductible guidelines under the FAIR Plan:**
     $500 flat deductible on all FAIR Plan residential properties
     (This deductible applies to all perils, not just wind and hail.)
  3. **Revised residential guidelines under both Beach and FAIR Plans:**
     $1,000 flat deductible for less than $50,000 in building coverage
     2% of building value for more than $50,000 in coverage
     (Bald Head Island—5%)
     (FAIR plan increases apply only to Territories 42 and 43.)

Revised deductibles are effective for policies issued on or after February 1, 2009 and for policies renewed on or after April 1, 2009.

All deductibles are per occurrence, not annual.

Deductible remains the same for all perils except wind and hail--$500 flat deductible for residential, $1,000 for commercial.

- **Sections 5 and 6 of the bill**
  Commercial Deductible Guidelines for Wind and Hail
  1. Current commercial deductible guidelines under Beach Plan
  $1000 flat deductible for less than $100,000 in coverage
  $2,500 flat deductible for less than $100,000-$249,999
  $5,000 flat deductible for $250,000 and above
  2. Current commercial deductible guidelines under FAIR Plan
  $500 flat deductible for less than $100,000 in coverage
  $1,000 flat deductible for $100,000-249,999
  $2,500 flat deductible for $250,000 and above
  3. Revised commercial deductible guidelines under both Beach and Fair Plans
  $1,000 flat deductible for less than $50,000 in building coverage
  2% of combined building value for more than $50,000 in coverage
  (FAIR Plan deductibles apply only to Group II, Seacoast Territories II and III.)

Revised deductibles are effective for policies issued on or after February 1, 2009 and for policies renewed on or after April 1, 2009.

Deductible remains the same for all perils except wind and hail: $1,000 flat deductible under Beach Plan and $500-$2500, depending on the amount of coverage, under the FAIR Plan.

- **Section 8**
  Statewide Rate Increases

The North Carolina Rate Bureau requested an average statewide homeowners rate increase of 19.5% in its filing to the Commissioner of Insurance. The Commissioner approved an average statewide rate increase of 4.05%. Attached to this summary is a chart showing percentage rate increases by territory as approved by the Commissioner.

BACKGROUND: The purpose of the Beach Plan is to serve as a market of last resort to make property insurance available to people who are unable to buy insurance through the standard or voluntary market. The Beach Plan functions as an insurance company by acting as an agent for insurers. All property and casualty insurers in the State are members of the Plan. By statute, the Plan covers two areas: (1) the barrier islands, referred to under the Plan as the beach area; and (2) 18 coastal counties, referred to as the coastal area. The Plan offers homeowners, dwelling, and wind only coverage in the beach area and homeowners and wind only coverage in the coastal area. Commercial coverage is also available under the Plan.

The Plan's members include all insurers authorized to write property insurance in North Carolina. All member companies share in the expenses, profits, and losses of the Plan. Each year that the Plan

generates revenues in excess of claims paid, the Plan may elect to return the excess funds to the member companies or hold those funds as "surplus." The surplus is used to cover Plan losses where claims filed are greater than the premium received. Should claims exceed the revenues from premiums, the amount of surplus, and any applicable reinsurance, member companies are assessed by the Plan to pay the claims. Assessments are calculated based on a member's market share and are reduced by credits given for writing coverage in the beach and coastal areas. Providing credits against assessments for coverage written in the beach and coastal area was intended to encourage insurers to write such policies and limit the growth of exposure to risk in the Beach Plan.

The NCIUA's Plan of Operation is adopted by its Board of Directors and submitted to the Commissioner of Insurance for approval. The Plan of Operation sets forth the administration of the Plan including the membership and manner of election of members to the Board of Directors.

The Plan also files with the Commissioner for his or her approval rates for separate policies of windstorm and hail, policy deductible plans to be paid by property owners, and the percentage differential or surcharge for coverage offered by the Plan. The surcharge is a percentage amount above the voluntary market rate approved by the Commissioner which all beach and coastal property owners must pay to purchase homeowners coverage through the Plan. The surcharge applies to homeowner's coverage and homeowner's wind and hail coverage only.

H426-SMRG-5(e1) v4

North Carolina Homeowners Rate Revision Breakdown by Territory
2009

Counties/Cities Located In This Territory	Territory	Current	Filed/NCRB	Filed %	Ordered	Ordered %
~~Carteret~~, Currituck, Dare & Hyde	5	$1,993	$2,636	32.1	$2,122	6.5
Brunswick, New Hanover, Onslow & Pender **(Carteret)**	6	$1,993	$3,010	50.9	$2,342	17.5
Durham & Raleigh	32	$631	$833	32.9	$663	5.0
Cumberland	34	$817	$939	15.6	$850	4.0
Winston-Salem & Greensboro	36	$545	$617	13	$562	3.0
Charlotte	38	$551	$576	3.9	$529	-4.0
Gaston, Mecklenburg & Union	39	$531	$540	1.2	$499	-6.0
Bladen, Columbus & Robeson	41	$945	$1,150	22.5	$1,059	12.0
Brunswick, New Hanover, Onslow & Pender **(Carteret)**	42	$1,245	$2,116	69.8	$1,616	29.8
~~Beaufort, Camden, Carteret, Chowan, Craven, Currituck, Dare, Hyde, Jones, Pamilco, Pasquotank, Perquimans, Tyrrell & Washington~~	43	$1,245	N/A	N/A	N/A	N/A
Currituck, Dare, Hyde, & Pamilco	**43 E**	$1,245	$2,564	106	$1,519	22.0
Beaufort, Camden, Chowan, Craven, Jones, Pasquotank, Perquimans, Tyrrell & Washington	**43 W**	$1,245	$1,596	28.2	$1,327	6.5
Anson, Montgomery & Richmond	44	$637	$774	22.2	$676	6.0

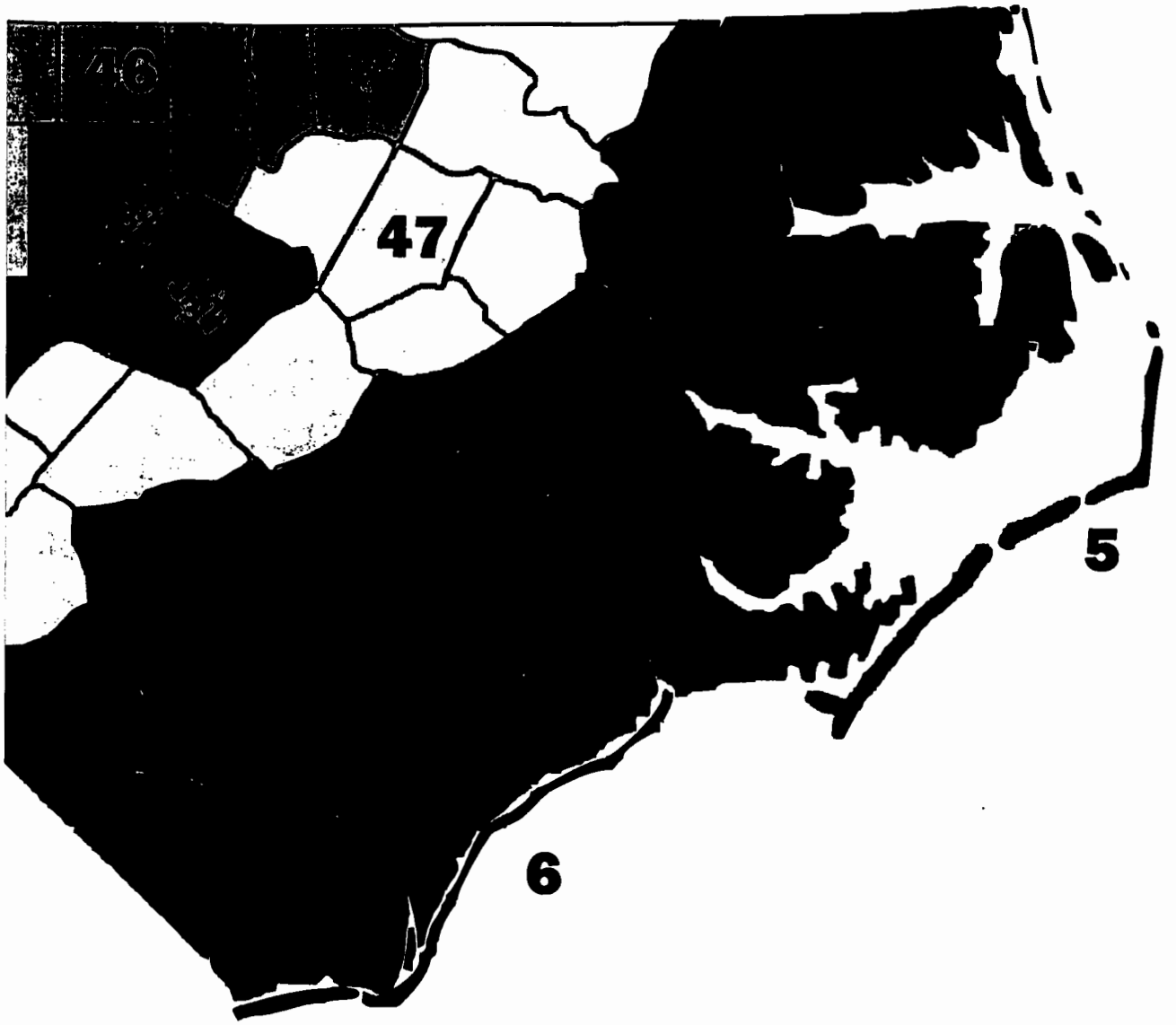
Examples are based on a frame home valued [illegible]50,000 and insured under the HO-3 policy, Protection [illegible]es 1 - 6.

North Carolina Homeowners Rate Revision Breakdown by Territory
2009

Counties/Cities Located In This Territory	Territory	Current	Filed/NCRB	Filed %	Ordered	Ordered %
Bertie, Duplin, Gates, Greene, Hertford, Lenoir, Martin, Pitt, Sampson & Wayne	45	$797	$914	15.4	$853	7.0
Caswell, Granville, Person, Vance & Warren	46	$605	$660	9.7	$587	-3.0
Edgecombe, Franklin, Halifax, Harnett, Hoke, Johnston, Lee, Moore, Nash, Northhampton, Scotland & Wilson	47	$686	$773	13.2	$700	2.0
Chatham, Durham, Orange & Wake	53	$613	$693	13.8	$625	2.0
Alamance, Davidson, Forsyth, Guilford, Randolph & Yadkin	57	$550	$613	11.2	$560	2.0
Alexander, Alleghany, Ashe, Avery, Buncombe, Burke, Cabarrus, Caldwell, Catawba, Cherokee, Clay, Cleveland, Davie, Graham, Haywood, Henderson, Iredell, Jackson, Lincoln, Macon, Madison, McDowell, Mitchell, Polk, Rockingham, Rowan, Rutherford, Stanly, Stoke, Surry, Swain, Transylvania, Watauga, Wilkes & Yancey	60	$486	$532	9.2	$480	-1.2
Overall Statewide Average				19.5		

Examples are based on a frame home valued .50,000 and insured under the HO-3 policy, Protection .es 1 - 6.

North Carolina Rate Bureau
Homeowners Territories
(Effective May 1, 2009)



ATTACHMENT #2

NC FARM BUREAU MUTUAL INSURANCE COMPANY
COASTAL INSURANCE COMMENTS

March 24, 2009

Thank you to the committee for hearing our perspectives.

I'd also like to thank Senator Rand and Representative Holliman, and all the members of the Joint Select Study Committee on the potential impact of major hurricanes for all the work done from September through January on this important problem.

Since 1953, Farm Bureau Mutual has been proud to serve Farm Bureau members across our great state with a complete line of auto, property, health and life insurance products. Farm Bureau Mutual is North Carolina's largest domestic property and casualty insurance company. We are the third largest writer of property insurance in our state.

Currently, North Carolina Farm Bureau Mutual Insurance Company serves over 500,000 members within every one of our 100 counties. We have over 542,000 property policies in force and insure over $125 billion in property value across the state. We service our members through 184 offices and 845 multi-line agents who are licensed to sell Farm Bureau products.

Additionally, we employ over 200 associate agents and almost 500 customer service representatives. Farm Bureau Mutual is proud to be a part of the business community in every county in North Carolina.

We are a single-state operation governed by a Board of Directors comprised of farmers who live and run businesses from the mountains to the coast. Our company is a mutual company, owned by our policyholders. We are a conservative company, striving to keep our costs manageable while providing the best quality coverage and customer service possible. While some people may argue that insurance companies can take profits from their operations in other states to pay for losses they experience in North Carolina, we operate solely within the state of North Carolina.

We are a North Carolina company. We will continue to sell in all of our state's 100 counties.

(Pause)

Our President and several board members are products of North Carolina's coastal area. They still live and farm there, and know well the impact that insurance rates have on others living in this region.

We thank Commissioner Goodwin and the members of our legislature for recognizing that the Beach Plan issue impacts the insurance industry, the business community, and economic development in our state. North Carolina Farm Bureau Mutual supports Commissioner Goodwin's position that rate changes are necessary to maintain competition and guarantee the availability of coverage in North Carolina.

It is a complicated subject that is worthy of our attention, discussion and debate.

We would like to stress that we do not take lightly the concerns that have been expressed by many in our coastal areas. We as a company have many of the same concerns as our coastal residents – increasing rates on our (reinsurance), high retentions (deductibles), and the possibility of multiple storms.

We acknowledge that this is not the best of time for rate increases, but we fear that "putting this off until another day" may, in the long run, make matters worse.

In fact, we believe we are where we are today because we have put off the problem for the past 15 years.

When availability began to be a problem in Coastal North Carolina in the mid-1990s, we did not address the real problem, which was rate inadequacy.

Instead, we forced expansion of the Beach Plan through legislation with the introduction of the wind-only product and the extension of the Beach Plan inland.

Again, in 2003, instead of dealing with rate inadequacy, we expanded the Beach Plan to offer a homeowners policy, something no other residual market we are aware of has done.

Continued expansion without addressing rate issues has led to the rapid growth of the Beach Plan in the past few years.

The request made by the Beach Plan Board of Directors and the North Carolina Rate Bureau and approved by the late Commissioner Long, and now supported by Commissioner Goodwin, has begun to address the problem.

While there has been much discussion that the rates approved were excessive, what we believe are actuarially sound and supportive data filed by the Beach Plan and North Carolina Rate Bureau indicates that the rate increases approved by Commissioner Long were actually on the very conservative side.

The rate request sought by the industry from the coast to the mountains was reduced substantially with the order approved by former Commissioner Long.

Our own company experience supports the need for these rate increases, particularly in the coastal areas. Net of reinsurance, we lost money statewide on homeowners insurance from 1999 – 2008 and our average hurricane loss per policy was 5.3 times greater in the 18 coastal counties when compared to the inland 82 counties.

Also, the question of the value and use of models in rate determination has been discussed at length. We as a company also know that the models are not guaranteed to be accurate. It is the work of people trying to predict what will happen in the future, which can never be entirely accurate. The concern our company has is, that in the past, when the models have been in error, they have generally erred on the low side.

One thing we know for certain is that from North Carolina to Texas, coastal areas are extremely vulnerable to hurricanes. We've seen the tremendous damage they can do, (Ms. Farm Bureau/$650 million) and know it is only a matter of time before North Carolina suffers another blow.

Of as much concern as a possibility of one large storm hitting is the possibility of multiple storms striking in one year. Multiple storms can cause more losses to our company than one large loss. We as a company have retentions (deductibles) for each storm that we must absorb on our own. Reinsurance must be re-purchased once it is used, as opposed to traditional primary insurance), and we must deal with capacity issues each time a catastrophe occurs in our state, or even anywhere in our country or world.

Without the changes that have been approved by the Department of Insurance, the following problems we now face as a company will continue to mount as the Beach Plan continues to be the market of choice rather than that of last resort, as was intended by our current statutes:

1. Companies may continue to leave the market, which puts more pressure on those that remain.

2. The Legislature's decision to override the existing structure of the rate approval process may cause companies to be even more leery of operating in North Carolina.

3. As possible assessments grow, it makes it more difficult to grow and serve all across North Carolina, as growth inland increases our required coastal participation.

4. As the plan grows and companies leave or reduce their writings, it makes it more and more difficult to "write ourselves out" of possible Beach Plan assessments with voluntary writings, which is our company goal and objective. With the changes that have been approved (that this bill would stay), North Carolina Farm Bureau Mutual Insurance Company as a company began the effort to insure wind on 4000 to 5000 policies that are currently insured through the Beach Plan.

5. As it becomes more difficult to write ourselves out, we have to not only manage our own exposure but the Beach Plan exposure. Inadequate surplus in the Beach Plan does not actually threaten the insolvency of the Beach Plan, but that of the companies that bear the cost of unlimited assessments. This burden could be particularly hard on smaller companies and one-state operations such as ours.

6. If the Beach Plan continues to grow, it will be forced to purchase more reinsurance, which in turn impacts reinsurance capacities available for primary companies like North Carolina Farm Bureau Mutual Insurance Company. These companies must purchase reinsurance for the financial stability required to serve its policyholders in the event of a

major storm. Additional pressure will be applied to our company where reinsurance already costs 25% of our entire property premiums.

7. As Beach Plan assessment exposure grows, it becomes more difficult for companies and particularly smaller ones to maintain an A.M. Best rating that is satisfactory to meet mortgagee requirements.

8. As property business in North Carolina becomes more and more difficult to write in a profitable manner, a stay on the Beach Plan changes and the rate increases which would lead to an increased exposure to Beach Plan assessments could affect our ability to successfully compete with larger national companies and the automobile-only insurance carriers in North Carolina.

In summary, we are a one-state company and will be here. We will do our best to operate as a financially strong and responsible company within whatever legal structure and parameters that the North Carolina General Assembly and the courts put in place. However, we do not believe that this bill would be in the best interest of North Carolina.

SC/pt/r16-SC/1-7

ATTACHMENT #3

Testimony to House Insurance Committee, Amy Powell, AVP Underwriting/Product

Good morning everyone. My name is Amy Powell and I work for Nationwide, the largest writer of auto and home insurance in North Carolina. Today, I would like to address the potential unintended consequences if HB 426 passes.

Being from eastern NC, I understand the impact of higher insurance rates on your constituents. I, too, hear the concerns across the Sunday dinner table.

We are all feeling the strains of the current economic climate. And we are all feeling the effects of increasingly harsher and more damaging weather. Both of these factors are dramatically impacting the North Carolina Property Insurance market.

In 2008, North Carolina was fortunate to not have any hurricanes hit our coastline. However, despite that good fortune, many homeowner insurance companies in North Carolina, like Nationwide, did not generate enough premium to cover the actual cost of property damage suffered in this state. Let me be clear, the amounts we were permitted to charge North Carolina policyholders last year did not cover the costs to serve their needs.

Our customers filed an increased number of claims for losses related to extreme non-hurricane weather throughout the state, and an increased number of claims not related to weather. And in 2009, we have already experienced extreme weather in the state again with the winter weather earlier this month.

To be able to serve our customers when they need us most, Nationwide and other homeowner insurance companies must have sufficient resources set aside to pay claims in North Carolina and all states. We must also set aside funds to meet obligations from state guaranty funds, and residual markets like the North Carolina Beach Plan. And we must demonstrate to state regulators and rating companies (e.g., Moody's, AM Best) that we are financially sound.

We have worked long and hard with the North Carolina Rate Bureau and the Department of Insurance to develop the rates in place today. Actuarial reports issued by the DOI confirm that these rate adjustments are necessary to offset the massive coastal hurricane risk exposure and other weather exposure throughout North Carolina.

Several factors are driving the need for additional resources to cover potential losses. First, despite the falling market prices of homes, the costs to repair and rebuild homes continue to increase. A recent report from Conning shows that building costs inflation remains as high at 9 to 11 percent, but is expected to flatten to about 2 percent in the Third Quarter of 2009. But then it is expected to rise again in 2010. So we face increased costs to fulfill our obligations to our customers.

Second, we have far more businesses and homes insured in the coastal counties than at any time before. Some of us remember Hurricane Hazel (and all of us remember the stories) from the 1950s. It packed a punch.

With the increase in costs and the number of properties in the area, if a Hazel-like hurricane were to take the same path today, it would cause about $6.5 billion in damages. In addition to our own policyholder losses, the insurance companies that support the Beach Plan would have to pay $1billion in assessments. If such a storm were to veer a little west of where Hazel went and then exit NC, the damages could total $30 billion. That would require the insurers to pay $8B in assessments to the Beach Plan.

So, let me talk about the Beach Plan for just a moment.

A speaker at last week's hearing mentioned that the Beach Plan made a "distribution" to companies. Let me put this in context. Since the inception of the

Beach Plan in 1969, the cost of assessments to companies has outweighed distributions by about $112-million dollars (469 million assessments/357-million distributions). That means companies have paid $112 million dollars without reimbursement.

The Beach Plan is not a money maker for the industry.

As challenging as it is to the communities that are impacted, the DOI rate decision strikes a balance that helps ensure available coastal property coverage without unfair increases on non-coastal residents.

This proposed moratorium in HB 426 could result in higher insurance rates for all homeowner insurance customers or, worse, availability issues. This proposal would create uncertainty for insurance carriers, potentially leading to further market disruption.

Nationwide remains committed to serving our policyholders in North Carolina. We've been here for more than 80 years and intend to be here for another 80. Passage of HB 426 would seriously challenge our ability to maintain long term viability and have the resources to pay the claims filed by our customers.

We appreciate the opportunity to be heard today.

ATTACHMENT #4

HOUSE INSURANCE COMMITTEE
DISCUSSION ON HB 426 – STAY ON HOMEOWNERS INSURANCE ACTIONS
MARCH 24, 2009

ROBERT A. (BOB) WHITE, CIC, ARM, AAI, ARe
ALLIANCE MUTUAL INSURANCE COMPANY

Mr. Chairman and members of the House Insurance Committee, thank you for the opportunity to discuss this proposed legislation. My name is Bob White, and I am President and CEO of Alliance Mutual Insurance Company.

Alliance Mutual is a small North Carolina domestic mutual insurance company based in Greensboro. Alliance Mutual was founded in 1976 and serves approximately 20,000 policyholders within North Carolina. As a mutual insurance company, Alliance Mutual is owned by its policyholders.

Like many small insurance companies doing business in North Carolina, Alliance Mutual faces a disproportionate impact should the Beach Plan levy an assessment related to storm losses. Using 2008 assessment and loss modeling data, Alliance Mutual would incur a $17 million assessment following a 100 year return period storm.

To put this assessment amount in perspective, a $17 million assessment represents an amount equal to:

- 231% of Alliance Mutual's total 2008 annual direct written premium;
- 432% of Alliance Mutual's estimated 2009 total annual property insurance direct written premium;
- 378% of Alliance Mutual's 2008 statutory surplus; and
- 196% of the estimated actual loss Alliance Mutual would incur from an 100 year return period storm to the property Alliance Mutual actually insures.

Without hesitation, I can tell you that a large assessment made by the Beach Plan is the single greatest threat to the solvency of Alliance Mutual, and it could lead to the total confiscation of the equity which belongs to our policyholder owners.

Since Alliance Mutual is a single state insurance company and not part of a large company or group of companies, Alliance Mutual must depend on either the equity that belongs to our policyholders or the ability to purchase reinsurance to cover the cost of any Beach Plan assessments. This dependence on reinsurance means our policyholder owners have already born a sizable cost related to a possible assessment.

For 2009, Alliance Mutual experienced a 167% increase in the costs to purchase property catastrophe reinsurance. 84% of this increase in reinsurance cost was related to reinsurance purchased solely to cover a potential Beach Plan assessment.

The reinsurance costs asscciated with the coverage purchased solely to cover the costs of a Beach Plan assessment represent 7.2¢ of every dollar of property insurance direct written premium from every policy Alliance Mutual writes throughout North Carolina. If looking strictly at the coastal counties where this Beach Plan assessment would be generated, the reinsurance costs associated with the coverage purchased solely to cover the costs of a Beach Plan

assessment represent 43¢ of every dollar Alliance Mutual collects for all Homeowner and Dwelling policies written within the 18 coastal counties. These large reinsurance costs are incurred by Alliance Mutual in addition to the reinsurance Alliance Mutual must purchase to provide protection for the properties Alliance Mutual actually insures and in addition to the claim costs and operating expenses associated with Alliance Mutual's normal operations.

The inability to offset increasing costs will lead to the shifting to all policyholders throughout the state the increased costs associated with a potential Beach Plan assessment either through:

- Higher pricing for those lines of business where Alliance Mutual does have discretionary pricing capability;
- Reduced availability of purchasing options for policyholders; or
- Simply through the erosion of the equity belonging to Alliance Mutual's North Carolina policyholder owners because Alliance Mutual has to absorb these increased costs.

While I can only speak on behalf of my company, the threat to the solvency of Alliance Mutual associated with a large Beach Plan assessment must be addressed. I realize there may be disagreement as to the likelihood of a catastrophic hurricane striking the North Carolina coastline, but the modeling tools available today are the best method of predicting future loss scenarios.

As with all companies doing business in North Carolina, Alliance Mutual's Board of Directors have a fiduciary duty to protect the solvency of the company. To ignore this responsibility or the factors that contribute to such a treat to the company's solvency would breach this fiduciary responsibility.

The statewide homeowner rates scheduled to go into effect May first were actuarially determined by the Rate Bureau and reviewed and vetted by the Department of Insurance. The resulting rate change represents a compromise between what the Rate Bureau believes was needed to cover future loss costs and what the Department of Insurance believed was fair and reasonable.

I would ask this Committee to accept this vetting process and allow the May first homeowner rates to become effective. We must begin the process of correcting the underfunding of the Beach Plan.

Mary Capps (Rep. Wray)

rom: Ann Jordan (Rep. Goforth)
ent: Thursday, March 19, 2009 12:10 PM
To: Rep. Tim Spear; Rep. William Wainwright; Rep. Bill Owens; Rep. Pat McElraft; @House/Insurance; @HouseCommitteeNotice; Ben Popkin (Research); Interested Parties; Tim Hovis (Research)
Subject: Meeting Notice for March 24.doc

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

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

DAY & DATE: **Tuesday, March 24, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

(Continued Discussion on HB 426)

HB 426 – STAY ON HOMEOWNERS INSURANCE ACTIONS – Reps. Spear, Wainwright, Owens & McElraft

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at **12:15 pm** on **March 18, 2009**.

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)

ATTACHMENT #1

VISITOR REGISTRATION SHEET

House Committee on Insurance — 3-24-09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Canales	BCCOA
Paul Stuart	NCBA
[illegible]	First Citizens Bank [illegible]
Patrick Biffi	NMRS
Michelle Frazier	MFS
John Mikth	Travelers
Allison Walter	Charlotte Chamber
Sandy Sands	WCSR
[illegible]	Poyner Spruill
Bill Scoggin	KLG

VISITOR REGISTRATION SHEET

House Committee on Insurance — 3-24-09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cady Thomas	NC Assn of REALTORS
TYLER NEWMAN	BASF
Rick Zechini	Nc Assn. of Realtors
Russ Dubitsky	State Farm
Bob MACK	NCDOT
FRANK FOLGER	NATIONWIDE
BOB WHITE	ALLIANCE MUTUAL
VICKY Young	NCDOT
ELLIE SPRENKEL	NCDOT
REBECCA WILLIAMS	NCRB
KAREN OTT	NCRB

VISITOR REGISTRATION SHEET

House Committee on Insurance — 3-24-09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
R. Paul Wiles	WCR
Alastair Macaulay	Cornerstone Solutions
Bill Tibbens	Farmers Ins.
Robert Rashad	Young Moore
Lee E Dunn	NCIUA/NCSUA
David Rice	Manning Fulton
Glenn Jernigan	BMAC Insurance
Tony Lange	DIMRS
Ray Farmer	AIA
Patrick Hanman	Liberty Mutual
Jenni for Cohen	IFNC

VISITOR REGISTRATION SHEET

House Committee on Insurance — 3-24-09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kevin Conley	NC DOI
Steve Carroll	Farm Bureau
Julian Philpott	NCFB
Willo Kelly	NC-20
Tom Thompson	NC-20
[illegible]	NC-20
Amy McConkey	Smith Anderson
Richard Thompson	Dominion

VISITOR REGISTRATION SHEET

House Committee on Insurance — 3-24-09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tim Lucas	NCRB
R. Baldorff	NCFB
Amy Powell	Nationwide
Sue Taylor	NC Rate Bureau
Cliff Ogburn	Town of Nags Head
WARREN JUDGE	DARE COUNTY
Bobby Outten	Dare County

House Pages

Name Of Committee: FINANCE Date: 3-24-09

1. Name: Kiara Hinton
   County: Guilford
   Sponsor: Earl Jones
2. Name: Christa Taylor
   County: Lumberton, NC
   Sponsor: Rev Pierce
3. Name: _____
   County: _____
   Sponsor: _____
4. Name: _____
   County: _____
   Sponsor: _____
5. Name: _____
   County: _____
   Sponsor: _____

Sgt-At-Arms

1. Name: CHARLES WILLIAMS
2. Name: ROD FINGER
3. Name: MARTHA GADISON
4. Name: BOB ROSS
5. Name: _____

MINUTES
HOUSE COMMITTEE ON INSURANCE
March 26, 2009

The House Committee on Insurance met at 11:00 AM on Thursday, March 26, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael Wray; Vice Chairs: M. Dickson, J. Dockham and M. Setzer. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Cole, Current, Faison, Gibson, Holliman, Howard, Hughes, Pierce, and Wainwright.

Chairman Goforth called the meeting to order and welcomed visitors. He recognized Sgt-At Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachments)

Chairman Goforth recognized Rep. Hugh Holliman to explain SB 287 – State Health Plan $/Good Health Initiatives. A copy of the bill, bill summary and actuarial note is attached to the minutes. Rep. Holliman asked for Gann Watson, Fiscal Research Division, to explain the plan. In summary the Plan needed to implement measures to contain costs in order to continue access for medically necessary health plan access. Changes were made through premium increases, benefit changes and health lifestyles programs that not only reduce costs but improve member health. The Plan estimated that coverage costs each year are $2,000 more per member for tobacco users and $2,334 for overweight members. There were also increases for co-payment of prescription drugs.

Rep. Howard wanted to offer an amendment which was ruled out of order because it did not have an actuarial note attached.

Rep. Blust questioned whether the bill was designed to be a short term fix. Rep. Holliman said that it was not intended to be the long range plan. Rep. Blust expressed concerns as to whether long range will be looked at.

After considerable discussion the meeting adjourned at 11:45 AM.

Representative Bruce Goforth, Chairman

Ann Jordan – Committee Assistant

HOUSE INSURANCE COMMITTEE

March 26 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

SB 287 – State Health Plan $/Good Health Initiatives
Senator Tony Rand

Adjourn

ATTACHMENT #1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 3

SENATE BILL 287
Select Committee on Employee Hospital and Medical Benefits Committee Substitute
Adopted 3/10/09
Third Edition Engrossed 3/24/09

Short Title: State Hlth Plan $/Good Health Initiatives. (Public)

Sponsors:

Referred to:

February 25, 2009

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES AND TO MAKE OTHER CHANGES RELATED TO THE STATE HEALTH PLAN.

Whereas, the General Assembly must act quickly and prudently to maintain a financially stable State Health Plan to ensure that all members of the Plan have affordable access to medically necessary health benefits and services within available resources; and

Whereas, in order to meet current fiscal obligations the General Assembly must appropriate $250,000,000 for the 2008-2009 fiscal year to cover the current year shortfall in funds; and

Whereas, estimates indicate that a substantially larger appropriation will be necessary to maintain the fiscal integrity of the Plan in the next and ensuing fiscal periods; and

Whereas, in order to ensure continued access to medically necessary health care to Plan members, the Plan must implement measures to contain costs through premium increases, benefit changes, and healthy lifestyle programs that not only reduce costs but improve member health; and

Whereas, the Plan estimates that over 70,000 Plan members use tobacco, resulting in a cost to the Plan of $2,000 per member per year more than the cost of providing coverage for nonusers of tobacco; and

Whereas, over 60% of North Carolina adults are obese or overweight; and

Whereas, obesity is linked to an over 37% increase in health care spending at a cost of $2,445 per member per year; and

Whereas, weight management and cessation of tobacco use have been demonstrated to result in improved member health and substantial savings in health care costs making it fiscally prudent to implement smoking cessation and weight management incentives and initiatives with mechanisms to verify member compliance with smoking cessation and weight management requirements; Now, therefore,

The General Assembly of North Carolina enacts:

PART ONE: APPROPRIATIONS, DEFINITIONS, AND SCOPE.

SECTION 1.(a) Appropriation for 2008-2009 fiscal year. – There is appropriated from the Savings Reserve Account established in G.S. 143C-4-2 to the Health Benefit Reserve Fund established in G.S. 135-44.5 the sum of two hundred fifty million dollars ($250,000,000) for the 2008-2009 fiscal year. These funds shall be used to address the shortfall in funds

available for the payment of health care and administrative costs under the State Health Plan for Teachers and State Employees ("Plan") for the 2008-2009 fiscal year.

SECTION 1.(b) General Fund appropriation for 2009-2011 fiscal biennium. – Notwithstanding G.S. 143C-5-2, there is appropriated from the General Fund to the Reserve for the State Health Plan in the Office of State Budget and Management the sum of one hundred twenty-eight million four hundred ten thousand two hundred eight dollars ($128,410,208) for the 2009-2010 fiscal year and the sum of two hundred sixty-seven million nine hundred four thousand one hundred fourteen dollars ($267,904,114) for the 2010-2011 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2009-2011 fiscal biennium.

SECTION 1.(c) Highway Fund appropriation for the 2009-2011 fiscal biennium. – Notwithstanding G.S. 143C-5-2, there is appropriated from the Highway Fund to the Reserve for the State Health Plan in the Office of State Budget and Management the sum of five million nine hundred ninety-two thousand four hundred seventy-six dollars ($5,992,476) for the 2009-2010 fiscal year and the sum of twelve million five hundred two thousand one hundred ninety-two dollars ($12,502,192) for the 2010-2011 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2009-2011 fiscal biennium.

SECTION 1.(d) All other agency funds required to fund the premium increase enacted in this act, other than funds appropriated in subsections (b) and (c) of this section, are appropriated for the 2009-2011 fiscal biennium.

SECTION 1.(e) Definitions. – As used in this act unless the context clearly requires otherwise:

(1) "Plan." – The State Health Plan for Teachers and State Employees.

(2) "Basic plan." – The Plan's PPO option providing for 70/30 in-network coverage after deductibles and co-payments.

(3) "Smoking" or "Smoking cessation." – Includes cessation of the use of all tobacco products.

(4) "Standard plan." – The Plan's PPO option providing for 80/20 in-network coverage after deductibles and co-payments.

SECTION 1.(f) Scope. – In the event of a conflict between the provisions of this act and Article 3A of Chapter 135 of the General Statutes, this act prevails.

PART TWO: HEALTH BENEFIT CHANGES.

SECTION 2.(a) Eliminate PPO Plus Option. – Effective July 1, 2009, the PPO Plus option (90/10 in-network coverage) under the State Health Plan for Teachers and State Employees ("Plan") is eliminated. The Executive Administrator shall provide notice to all members of the Plan that this option will no longer be available as of July 1, 2009. Employees enrolled in the Plan's Plus option shall have the choice of enrolling in the Basic or Standard plan options for the 2009-2010 benefit year.

SECTION 2.(b) Implement Comprehensive Wellness Initiative.

(1) Program development. – The Plan shall develop a Comprehensive Wellness Initiative that includes a focus on smoking cessation and weight management and that is designed to be implemented effective July 1, 2010, for smoking cessation and July 1, 2011, for weight management. Benefit levels shall be determined by the Plan based upon tobacco use or the inability of the member to meet national, evidence-based healthy weight clinical guidelines. For purposes of the Comprehensive Wellness Initiative, "member" includes all State Health Plan primary subscribers and their covered dependents. The Plan shall develop a process whereby a Plan member may appeal the Plan's basis for action it takes due to the member's failure or refusal to comply with the Plan's smoking cessation or weight management requirements.

(2) Smoking cessation. – Effective July 1, 2010, all members of the Plan who do not have Medicare as their primary coverage shall be enrolled in the Basic Plan under the Plan's PPO unless the subscriber can attest that the subscriber or any qualifying dependent does not smoke or otherwise use tobacco products. The Plan shall develop a mechanism for verifying that the member does not smoke or use other tobacco products. Tobacco use will be reassessed annually at the time of Plan enrollment. All subscribers who have attested that neither they nor their dependents use tobacco, or whose physician certifies in writing that the member is participating in a smoking cessation program, shall have the choice of remaining in the Basic plan option or enrolling in the Standard plan option. For purposes of the smoking cessation initiative, "member" includes all members covered under the Plan. As used in this section, "smoking cessation program" means active participation in a Plan-approved cessation program to include counseling or use of tobacco cessation medications.

(3) Weight management. – Effective July 1, 2011, all members of the Plan who do not have Medicare as their primary coverage shall be enrolled in the Basic Plan under the Plan's PPO Plan unless the subscriber attests that the weight and height ratio of the member is within a range determined by the Plan based on evidence-based healthy weight clinical guidelines, or unless the member's physician certifies in writing that the member has a medical condition that prevents the attainment of the specified weight range or that the member is actively participating in a Plan-approved weight management program. In either case, the member shall have the option to enroll in the Basic or Standard Plan.

Not later than October 1, 2009, the Executive Administrator shall inform Plan members of the healthy lifestyle initiatives, requirements for compliance, and consequences of noncompliance. The Executive Administrator shall provide to members education and training to assist members in complying with healthy lifestyle initiatives. The Executive Administrator may implement incentive initiatives to further encourage member achievement in smoking cessation, weight management, and other integrated health management programs.

The Executive Administrator shall report to the Committee on Employee Hospital and Medical Benefits recommendations the Plan may have for additional sanctions that may be imposed when the Executive Administrator finds that a member intentionally makes a false statement on a Plan document.

SECTION 2.(c) Prescription drug co-payments. – G.S. 135-45.6(b) reads as rewritten:

"(b) Prescription Drugs. – The Plan's allowable charges for prescription legend drugs to be used outside of a hospital or skilled nursing facility shall be as determined by the Plan's Executive Administrator and Board of Trustees, which determinations are not subject to appeal under Article 3 of Chapter 150B of the General Statutes. Co-payments and other allowable charges or coverage for prescription drugs shall be as follows:

(1) The Plan will pay allowable charges for each outpatient prescription drug less a copayment to be paid by each covered individual equal to the following amounts: pharmacy charges up to ten dollars ($10.00) for each generic prescription, ~~thirty dollars ($30.00)~~ thirty-five dollars ($35.00) for each preferred branded prescription without a generic equivalent, ~~and forty dollars ($40.00) for each preferred branded prescription with a generic equivalent drug,~~ and ~~fifty dollars ($50.00)~~ fifty-five dollars ($55.00) for each nonpreferred branded ~~or generic~~ prescription. For each branded prescription drug with a generic equivalent drug, the member shall pay the generic

co-payment plus the difference between the Plan's gross allowed cost for the generic prescription and the Plan's cost for the branded prescription drug.

(2) The Plan shall provide coverage of nonacute specialty medications under the Plan's pharmacy benefit through a specialty pharmacy vendor under contract with the Plan. The Plan may transfer coverage of specified specialty disease medications covered under the Plan's medical benefit to the contracted specialty pharmacy vendor. Specialty medications are covered biotech medications and other medications designated and classified by the Plan as specialty medications that are typically significantly more expensive than alternative drugs or therapies. Medications classified by the Plan as specialty medications generally have unique uses for the treatment of complex diseases, require special dosing or administration, require special handling, are typically prescribed by a specialist provider, and exceed four hundred dollars ($400.00) cost to the Plan per prescription. The Plan shall impose a co-payment in the amount of Plan per prescription. The Plan shall impose a co-payment in the amount of twenty-five percent (25%) of the Plan's gross allowed cost of the specialty drug not to exceed one hundred dollars ($100.00) per prescription per 30-day supply.

(3) The Plan may exclude coverage of drugs that have therapeutic equivalents that are available over the counter. Before excluding coverage under this subdivision, the Plan shall consult with the Plan's Pharmacy and Therapeutics Committee.

~~These co-paymentsapply to all optional alternative plans available under the Plan.~~

(4) Allowable charges shall not be greater than a pharmacy's usual and customary charge to the general public for a particular prescription. Prescriptions shall be for no more than a ~~34-day~~30-day supply for the purposes of the copayments paid by each covered individual. By accepting the copayments and any remaining allowable charges provided by this subsection, pharmacies shall not balance bill an individual covered by the Plan. A prescription legend drug is defined as an article the label of which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without Prescription." Such articles may not be sold to or purchased by the public without a prescription order. Benefits are provided for insulin even though a prescription is not required. ~~The Plan may use a pharmacy benefit manager to help manage the Plan's outpatient prescription drug coverage. In managing the Plan's outpatient prescription drug benefits, the Plan and its pharmacy benefit manager shall not provide coverage for sexual dysfunction, growth hormone, antiwrinkle, weight loss, and hair growth drugs unless such coverage is medically necessary to the health of the member. The Plan and its pharmacy benefit manager shall not provide coverage for growth hormone and weight loss drugs and antifungal drugs for the treatment of nail fungus and botulinium toxin without approval in advance by the pharmacy benefit manager.~~ The Plan may adopt utilization management procedures for certain drugs, but in no event shall the Plan provide coverage for sexual dysfunction or hair growth drugs or nonmedically necessary drugs used for cosmetic purposes. Any formulary used by the Plan's Executive Administrator and pharmacy benefit manager shall be an open formulary. Plan members shall not be assessed more than two thousand five hundred dollars ($2,500) per person per fiscal year in copayments required by this subsection. The Plan's Pharmacy Benefit

Manager, or any pharmacy or vendor participating in the Plan shall charge the Plan for any prescription legend drug dispensed under the Plan's pharmacy benefit based upon the original National Drug Code (NDC) as established by the manufacturer of the prescription legend drug and published by the United States Food and Drug Administration.

Copayments authorized under this subsection apply to all optional alternative plans available under the Plan."

SECTION 2.(d) Routine eye examinations not covered. – Effective January 1, 2010, G.S. 135-45.8(13) reads as rewritten:

"**§ 135-45.8. General limitations and exclusions.**

The following shall in no event be considered covered expenses nor will benefits described in G.S. 135-45.6 through G.S. 135-45.11 be payable for:

...

(13) Charges for routine eye examinations, eyeglasses or other corrective lenses (except for cataract lenses certified as medically necessary for aphakia persons) and hearing aids or examinations for the prescription or fitting thereof."

SECTION 2.(e) Deductible and co-payment changes. – Effective July 1, 2009, the Executive Administrator shall make the following changes to deductibles, coinsurance maximums, and co-payments under the Basic and Standard PPO Plans:

(1) Basic plan (70/30):

a. Increase the in-network annual deductible to eight hundred dollars ($800.00) for member-only coverage and to one thousand six hundred dollars ($1,600) for the out-of-network annual deductible for member-only coverage.

The aggregate maximum annual deductible for employee-child and employee-family coverage shall be three times the member-only annual deductibles.

b. Increase the in-network coinsurance maximum to three thousand two hundred fifty dollars ($3,250) for member-only coverage and to six thousand five hundred dollars ($6,500) for member-only out-of-network maximum coinsurance. The aggregate maximum coinsurance for employee-child and employee-family coverage shall be three times the member-only coinsurance maximums.

c. Increase the in-network primary care co-payment to thirty dollars ($30.00) per covered individual.

d. Increase the in-network specialist co-payment to seventy dollars ($70.00) per covered individual.

e. Increase the in-network and out-of-network inpatient co-payment to two hundred fifty dollars ($250.00) per covered individual.

f. Increase prescription drug co-pays as required under G.S. 135-45.6(b) as enacted by this act.

g. Except as otherwise provided in this act, co-payments and coinsurance for coverage not otherwise listed in this subdivision shall remain as applicable in the 2008-2009 benefit year.

(2) Standard plan (80/20):

a. Increase the in-network annual deductible to six hundred dollars ($600.00) for member-only coverage and to one thousand two hundred dollars ($1,200) for the member-only out-of-network annual deductible.

The aggregate maximum annual deductible for employee-child and employee-family coverage shall be three times the member-only annual deductibles.

b. Increase the in-network coinsurance maximum to two thousand seven hundred fifty dollars ($2,750) for member-only coverage and to five thousand five hundred dollars ($5,500) for member-only out-of-network maximum coinsurance. The aggregate maximum coinsurance for employee-child and employee-family coverage shall be three times the member-only coinsurance maximums.

c. Increase the in-network urgent care co-payment to seventy-five dollars ($75.00) per covered individual.

d. Increase the in-network primary care co-payment to twenty-five dollars ($25.00) per covered individual.

e. Increase the in-network specialist co-payment to sixty dollars ($60.00) per covered individual.

f. Increase the in-network and out-of-network inpatient co-payment to two hundred dollars ($200.00) per covered individual.

g. Increase prescription drug co-pays as required under G.S. 135-45.6(b) as enacted by this act.

h. Except as otherwise provided in this act, co-payments and coinsurance for coverage not otherwise listed in this subdivision shall remain as applicable in the 2008-2009 benefit year.

SECTION 2.(f) Limitation on authority to change benefits. – G.S. 135-45(g) reads as rewritten:

"(g) The Executive Administrator and Board of Trustees shall not change the Plan's comprehensive health benefit coverage, co-payments, deductibles, out-of-pocket expenditures, and lifetime maximums in effect on ~~July 1, 2008,~~ July 1, 2009, or a later act of the General Assembly, that would result in a net increased cost to the Plan or in a reduction in benefits to Plan members as a whole unless and until the proposed changes are directed to be made in an act of the General Assembly."

SECTION 2.(g) Premium increases. – Premium rates for contributory coverage established in accordance with G.S. 135-44.6 shall be increased to eight and six-tenths percent (8.6%) for contributory coverage for the 2009-2010 fiscal year and shall be increased by an additional eight and six-tenths percent (8.6%) over the premium rate for contributory coverage for the 2010-2011 fiscal year.

SECTION 2.(h) Pharmacy benefit savings. – The Plan shall direct its pharmacy benefit manager (PBM), within the terms of the Plan's PBM contract, to achieve the sum of eighteen million dollars ($18,000,000) in savings in pharmacy benefit costs in the 2009-2010 fiscal year, and the sum of twenty million dollars ($20,000,000) in savings in pharmacy benefit costs in the 2010-2011 fiscal year through reduced reimbursements paid to pharmacies for prescription drugs. If the savings achieved in each six-month period of the fiscal year do not exceed one hundred-five percent (105%) of the savings amount specified in this section for that fiscal year, there shall be no further adjustment to reimbursements paid to pharmacies for that six-month period. If the total savings achieved, by fiscal year, exceeds one hundred five percent (105%) of the specified savings amount in each six month period of the fiscal year, the Plan shall adjust pharmacy reimbursement reductions accordingly. The Plan shall review savings achieved twice annually to ensure compliance with this section. The Plan shall calculate the savings to be achieved based on Plan enrollment and estimated cost and utilization trends incorporated in the Plan's Financial Projections as of March 20, 2009. The total savings by fiscal year achieved in this section may be increased or decreased without adjustment based on a change in total enrollment provided that the rate of savings achieved on a per member per

month basis remains constant. Not later than 60 days immediately following each six-month period, the Plan shall report the amount of savings achieved and any adjustments made for that period to the Committee on Employee Hospital and Medical Benefits."

PART THREE: ELIGIBILITY CLARIFICATION.

SECTION 3.(a) Dependent child clarifications. – G.S. 135-45.1(10) reads as rewritten:

"(10) Dependent child. – A natural, legally adopted, or foster child or children of the employee and or spouse, unmarried, up to the first of the month following his or her 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for such child's maintenance and support. Dependent child also includes a stepchild of the member who is married to the stepchild's natural parent. To be eligible, the stepchild must have his or her primary residence with the member. Dependent child shall also include any child under age 19 who has reached his or her 18th birthday, provided the employee was legally responsible for such child's maintenance and support on his or her 18th birthday. Dependent children of firefighters, rescue squad workers, and members of the national guard are subject to the same terms and conditions as are other dependent children covered by this subdivision. Eligibility of dependent children is subject to the requirements of G.S. 135-45.2(d). The Plan may require documentation from the member confirming a child's eligibility to be covered as the member's dependent."

SECTION 3.(b) Eligibility of full-time students. – G.S. 135-45.2(d) reads as rewritten:

"(d) A foster child is covered as a dependent child (i) if living in a regular parent-child relationship with the expectation that the employee will continue to rear the child into adulthood, (ii) if at the time of enrollment, or at the time a foster child relationship is established, whichever occurs first, the employee applies for coverage for such child and submits evidence of a bona fide foster child relationship, identifying the foster child by name and setting forth all relevant aspects of the relationship, (iii) if the claims processor accepts the foster child as a participant through a separate written document identifying the foster child by name and specifically recognizing the foster child relationship, and (iv) if at the time a claim is incurred, the foster child relationship, as identified by the employee, continues to exist. Children placed in a home by a welfare agency which obtains control of, and provides for maintenance of the child, are not eligible participants.

Coverage of a dependent child may be extended beyond the 19th birthday under the following conditions:

(1) If the dependent is a full-time student, ~~aged 19 years and one month~~ through the end of the month following the student's 26th ~~birthday,~~birthday. As used in this section, a full-time student is a student who is pursuing a course of study that represents at least the normal workload of a full-time student at a school or college accredited by the state of jurisdiction. In accordance with applicable federal law, coverage of a full-time student that loses full-time status due to illness may be extended for one year from the effective date of the loss of full-time status provided that the student was enrolled at the time of the onset of the illness.

(2) The dependent is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and (i) such handicap developed or began to develop before the dependent's 19th birthday, or (ii) such handicap developed or began to develop before the dependent's 26th birthday if the dependent was covered by the Plan in accordance with G.S. 135-45.2(5)a."

SECTION 3.(c) Waiting periods subject to federal law. – G.S. 135-45.3(b) reads as rewritten:

"(b) ~~"Newly~~ Except as otherwise required by applicable federal law, newly acquired dependents (spouse/child) enrolled within 30 days of becoming an eligible dependent will not be subject to the 12-month waiting period for preexisting conditions. A dependent can become qualified due to marriage, adoption, entering a foster child relationship, due to the divorce of a dependent child or the death of the spouse of a dependent child, and at the beginning of each legislative session (applies only to enrolled legislators). Effective date for newly acquired dependents if application was made within the 30 days can be the first day of the following month. Effective date for an adopted child can be date of adoption, or date of placement in the adoptive parents' home, or the first of the month following the date of adoption or placement. Firefighters, rescue squad workers, and members of the national guard, and their eligible dependents, are subject to the same terms and conditions as are new employees and their dependents covered by this subdivision. Enrollments in these circumstances must occur within 30 days of eligibility to enroll."

SECTION 3.(d) G.S. 135-45.4(b)(5) reads as rewritten:

"(5) To administer the 12-month waiting period for preexisting conditions under this that Article, the Plan must give credit against the 12-month period for the time a person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 63 days before the effective date of coverage. As used in this subdivision, a "previous plan" means any policy, certificate, contract, or any other arrangement provided by any accident and health insurer, any hospital or medical service corporation, any health maintenance organization, any preferred provider organization, any multiple employer welfare arrangement, any self-insured health benefit arrangement, any governmental health benefit or health care plan or program, or any other health benefit arrangement. Waiting periods for preexisting conditions administered under this Article are subject to applicable federal law."

SECTION 3.(e) Eligibility audit. – The Executive Administrator shall provide for an audit of dependent eligibility under the Plan. The audit shall be designed to determine whether all dependents currently covered under the Plan are eligible for coverage under current law. Upon identification of an individual who is enrolled as a dependent but not eligible, the Plan shall disenroll the ineligible dependent effective within 10 days of sending written termination notice to the employee. The notice shall state the date upon which disenrollment will become effective and the basis on which the determination of dependent ineligibility is made. Notwithstanding any other provision of law, the Executive Administrator may waive requirements to collect from the member reimbursement for claims paid for the ineligible covered individual.

SECTION 3.(f) Cessation of coverage of ineligible individuals. – G.S. 135-45.12 is amended by adding the following new subdivision to read:

"(8) The last day of the month in which a covered individual is found to be ineligible for coverage."

SECTION 3.(g) Documentation of dependent eligibility. – G.S. 135-45.3 is amended by adding the following new subsection to read:

"(c) When an eligible or enrolled member applies to enroll the member's eligible dependent child or spouse, the member shall provide the documentation required by the Plan to verify the dependent's eligibility for coverage."

PART FOUR: NC HEALTH CHOICE CHANGES.

SECTION 4.(a) Over-the-counter medications. – Coverage of over-the-counter medication authorized under G.S. 108A-70.21(d) for the NC Health Choice Program shall

become effective on the later of July 1, 2010, or the date upon which the Department of Health and Human Services assumes full responsibility for administration and processing of claims under the NC Health Choice Program.

SECTION 4.(b) Subrogation. – For the period authorized under subsection (a) of this section, the right of subrogation under G.S. 108A-57 applies to the State Health Plan for payments made by the Plan under the NC Health Choice Program. This subsection expires on the later of July 1, 2010, or the date upon which the Department of Health and Human Services assumes full responsibility for administration, processing, and payment of claims under the NC Health Choice Program.

SECTION 4.(c) DHHS Subrogation under NC Health Choice. – G.S. 108A-57 is amended by adding the following new subsection to read:

"(c) This section applies to the administration of and claims payments made by the Department of Health and Human Services under the NC Health Choice Program established under Part 8 of this Article."

SECTION 4.(d) G.S. 108A-70.21(g) reads as rewritten:

"(g) Purchase of Extended Coverage. – An enrollee in the Program who loses eligibility due to an increase in family income above two hundred ~~fifty percent (250%)~~percent (200%) of the federal poverty level and up to and including two hundred ~~seventy-five percent (275%)~~ twenty-five percent (225%) of the federal poverty level may purchase at full premium cost continued coverage under the Program for a period not to exceed one year beginning on the date the enrollee becomes ineligible under the income requirements for the Program. The benefits, copayments, and other conditions of enrollment under the Program applicable to extended coverage purchased under this subsection shall be the same as those applicable to an NC Kids' Care enrollee whose family income equals two hundred ~~fifty percent (250%)~~ percent (200%) of the federal poverty level."

PART FIVE: OTHER CHANGES.

SECTION 5.(a) G.S. 135-45.4(b)(2) reads as rewritten:

"(2) Employees not enrolling or not adding dependents when first eligible may enroll later on the first of any following month, but will be subject to a twelve-month waiting period for preexisting conditions except as provided in subdivision (a)(3) of this section. The waiting period under this subdivision is subject to applicable federal law."

SECTION 5.(b) Utilization management functions. – G.S. 135-44.4 is amended by adding the following new subdivisions to read:

"(13a) The Plan and its pharmacy benefit manager may implement and administer pharmacy and medical utilization management programs and programs to detect and address utilization abuse of benefits.

...

(29) For transplant and bariatric medical procedures, the Plan may restrict coverage to certain in-network providers that are designated by the Plan's claims processing contractor."

SECTION 5.(c) G.S. 135-44.1(b) reads as rewritten:

"(b) ~~Six~~ A majority of the members of the Board of Trustees in office shall constitute a quorum. Decisions of the Board of Trustees shall be made by a majority vote of the Trustees present, except as otherwise provided in this Part."

SECTION 5.(d) G.S. 135-45.9(b) reads as rewritten:

"(b) Notwithstanding any other provision of this Part, the following necessary services for the care and treatment of chemical dependency and mental illness shall be covered as provided in this section: allowable institutional and professional charges for inpatient care, outpatient care, intensive outpatient program services, partial hospitalization treatment, and residential care and treatment:

(1) For mental illness treatment:
a. Licensed psychiatric ~~hospitals;~~ hospitals or State psychiatric hospitals accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
b. Licensed psychiatric beds in licensed general hospitals;
c. Licensed residential treatment facilities that have 24-hour on-site care provided by a registered nurse who is physically located at the facility at all times and that hold current accreditation by a national accrediting body approved by the Plan's mental health case manager;
d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities or County Programs in accordance with G.S. 122C-141;
e. Licensed intensive outpatient treatment programs; and
f. Licensed partial hospitalization programs.

(2) For chemical dependency treatment:
a. Licensed chemical dependency units in licensed psychiatric ~~hospitals;~~ hospitals or in State psychiatric hospitals accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
b. Licensed chemical dependency hospitals;
c. Licensed chemical dependency treatment facilities;
d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities or County Programs in accordance with G.S. 122C-141;
e. Licensed intensive outpatient treatment programs;
f. Licensed partial hospitalization programs; and
g. Medical detoxification facilities or units."

SECTION 5.(e) Section 28.22A(k) of S.L. 2007-323 reads as rewritten:

"**SECTION 28.22A.(k)** Subsection (j) of this section expires ~~June 30, 2009.~~ June 30, 2011."

SECTION 5.(f) G.S. 135-43(b) reads as rewritten:

"(b) Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees may contract with providers of institutional and professional medical care and services to establish preferred provider networks.

~~The terms pertaining to reimbursement rates or other terms of consideration of any contract between hospitals, hospital authorities, doctors, or other medical providers, or a pharmacy benefit manager and the Plan, or contracts pertaining to the provision of any medical benefit offered under the Plan, including its optional alternative comprehensive benefit plans, and programs available under the optional alternative plans, shall not be a public record under Chapter 132 of the General Statutes for a period of 30 months after the date of the expiration of the contract.~~ The terms of a contract between the Plan and its third party administrator or between the Plan and its pharmacy benefit manager are a public record except that the terms in those contracts that contain trade secrets or proprietary or competitive information are not a public record under Chapter 132 of the General Statutes and any such proprietary or competitive information and trade secrets contained in the contract shall be redacted by the Plan prior to making it available to the public. ~~Provided, however, nothing in this subsection shall be deemed to~~This subsection shall not be construed to prevent or restrict the release of any information made not a public record under this subsection to the State Auditor, the Attorney General, the Director of the State Budget, the Plan's Executive Administrator, ~~the Department of Health and Human Services solely for the purpose of implementing the transition of NC Health Choice from the Plan to the Department of Health and Human Services,~~ and the

Committee on Employee Hospital and Medical Benefits solely and exclusively for their use in the furtherance of their duties and ~~responsibilities.~~responsibilities, and to the Department of Health and Human Services solely for the purpose of implementing the transition of NC Health Choice from the Plan to the Department of Health and Human Services. The design, adoption, and implementation of the preferred provider contracts, networks, and optional alternative comprehensive health benefit plans, and programs available under the optional alternative plans, as authorized under G.S. 135-45 are not subject to the requirements of Chapter 143 of the General Statutes. The Executive Administrator and Board of Trustees shall make reports as requested to the President of the Senate, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Committee on Employee Hospital and Medical Benefits."

PART SIX: SALARY-RELATED CONTRIBUTIONS.

SECTION 6.(a) Effective for the 2009-2011 fiscal biennium, required employer salary-related contributions for employees whose salaries are paid from department, office, institution, or agency receipts shall be paid from the same source as the source of the employees' salary. If an employee's salary is paid in part from the General Fund or Highway Fund and in part from department, office, institution, or agency receipts, required employer salary-related contributions may be paid from the General Fund or Highway Fund only to the extent of the proportionate part paid from the General Fund or Highway Fund in support of the salary of the employee, and the remainder of the employer's requirements shall be paid from the source that supplies the remainder of the employee's salary. The requirements of this section as to source of payment are also applicable to payments on behalf of the employee for hospital-medical benefits, longevity pay, unemployment compensation, accumulated leave, workers' compensation, severance pay, separation allowances, and applicable disability income benefits.

Notwithstanding any other provision of law, an employing unit that is subject to Part 3A of Article 3A of Chapter 135 of the General Statutes and that hires or has hired as an employee a retiree that is in receipt of monthly retirement benefits from any retirement system supported in whole or in part by contributions of the State shall enroll the retiree in the active group and pay the cost for the hospital-medical benefits if that retiree is employed in a position that would require the employer to pay hospital-medical benefits if the individual had not been retired.

SECTION 6.(b) Effective July 1, 2009, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2009-2010 fiscal year are: (i) eight and forty-four hundredths percent (8.44%) – Teachers and State Employees; (ii) thirteen and forty-four hundredths percent (13.44%) – State Law Enforcement Officers; (iii) eleven and seventy-six hundredths percent (11.76%) – University Employees' Optional Retirement System; (iv) eleven and seventy-six hundredths percent (11.76%) – Community College Optional Retirement Program; (v) seventeen and sixty-one hundredths percent (17.61%) – Consolidated Judicial Retirement System; and (vi) four and forty hundredths percent (4.40%) – Legislative Retirement System. Each of the foregoing contribution rates includes four and forty hundredths percent (4.40%) for hospital and medical benefits. The rate for Teachers and State Employees, State Law Enforcement Officers, Community College Optional Retirement Program, and for the University Employees' Optional Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

SECTION 6.(c) Effective July 1, 2010, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2010-2011 fiscal year are: (i) eight and eighty-four hundredths percent (8.84%) – Teachers and State

Employees; (ii) thirteen and eighty-four hundredths percent (13.84%) – State Law Enforcement Officers; (iii) twelve and sixteen hundredths percent (12.16%) – University Employees' Optional Retirement System; (iv) twelve and sixteen hundredths percent (12.16%) – Community College Optional Retirement Program; (v) eighteen and one hundredths percent (18.01%) – Consolidated Judicial Retirement System; and (vi) four and eighty hundredths percent (4.80%) – Legislative Retirement System. Each of the foregoing contribution rates includes four and eighty hundredths percent (4.80%) for hospital and medical benefits. The rate for Teachers and State Employees, State Law Enforcement Officers, Community College Optional Retirement Program, and for the University Employees' Optional Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

SECTION 6.(d) Effective July 1, 2009, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2009-2010 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand four hundred thirty-eight dollars ($3,438) and (ii) non-Medicare-eligible employees and retirees – four thousand five hundred fifteen dollars ($4,515).

SECTION 6.(e) Effective July 1, 2010, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2010-2011 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand seven hundred thirty-five dollars ($3,735) and (ii) non-Medicare-eligible employees and retirees – four thousand nine hundred five dollars ($4,905).

PART SEVEN: EFFECTIVE DATE.

SECTION 7. Sections 1(b), 1(c), 1(d), 2(c) through (e), 2(g), and 2(h) of this act become effective July 1, 2009. Section 4(d) of this act applies to applications for the purchase of extended coverage made on and after July 1, 2008. The remainder of this act is effective when it becomes law.

ATTACHMENT #2

SUMMARY
S287 – 3d Edition
STATE HEALTH PLAN

FUNDS (Part One, pages 1-2)

Appropriate $250,000,000 for 2008-2009 [from Savings Reserve]

Appropriate $128.4 million 2009-2010; $267.9 million 2010-2011

BENEFIT changes:

Eliminate PPO Plus effective July 1, 2009 (Section 2(a), p. 2)

Healthy Lifestyles Initiative: (Section 2(b), pp. 2-3)

Smoking cessation:

July 1, **2010,** all members are enrolled in 70/30 plan. If at the time of enrollment the member attests that the member and the member's adult covered dependents are nonsmokers then, upon attestation, the member may enroll in the 80/20 plan.

Weight management:

July 1, **2011,** all members are enrolled in the 70/30 plan. If at the time of enrollment the member is a nonsmoker and meets the weight management requirements the member may choose to enroll in the 80/20 plan. If the member is a nonsmoker but does not meet the weight requirements the member may enroll in the 80/20 plan **if** the member is enrolled in a Plan-approved weight management program, or, **if** the member's physician certifies in writing that the member has a condition that prevents the member from attaining the weight requirement.

The Plan must provide education and training to assist members in complying with smoking cessation and weight management requirements.

Prescription drug co-payments (Section 2(c) pp. 3-4)

No increase for generics ($10)

$35 for preferred brand **w/o generic** ($5 increase)

$55 for non-preferred branded ($5 increase)

Branded w/generic – members pays generic co-pay ($10) **plus** the difference between the Plan's cost for the generic and the Plan's cost for the branded drug.

No coverage for drugs for sexual dysfunction, hair growth, and non-medically necessary drugs used for cosmetic purposes. (Section 2(c), p. 4, lines 36-39)

Prohibits re-packaging by the vendor. (Section 2(c), pp. 4, lines 43-48)

Specialty drugs (Section 2(c) p4.) Specialty medications are covered biotech medications and other medications designated by the Plan that generally have unique uses for the treatment of complex diseases, require special dosing or administration, require special handling, are typically prescribed by a specialist provider, and exceed $400 cost to the Plan. Examples of these medications are those prescribed for such conditions as Hemophilia, or are Growth Hormone drugs or certain drugs prescribed for rheumatoid arthritis.

The member will be required to:

a. Purchase the drug from a "specialty pharmacy vendor" under contract with the Plan, and

b. Pay a co-payment in the amount of 25% of the Plan's cost of the drug but not more than $100. For example, if the Plan's cost of the drug is $1,000, 25% of $1,000 is $250 but the member would only be required to pay $100.

Deductibles/co-pays/coinsurance changes (Section 2(e), pages 5-6)
These amounts go into effect July 1, 2009. They differ in the Basic and Standard plans. Deductibles and coinsurance listed are for member-only coverage. Dependent coverage is 3x the member-only amounts.

Basic Plan (70/30)		**Standard Plan (80/20)**
$800	in-network annual deductible	$600
$1,600	out-of-network annual deductible	$1,200
$3,250	in-network coinsurance	$2,750
$6,500	out-of-network coinsurance	$5,500
$30	in-network primary care	$25
$70	for in-network specialist care	$60
$250	for inpatient co-pay (in-network and out-of-network)	$200
$75 (no change)	urgent care	$75 (increased from $50)

Premium increase for **contributory** (dependent) coverage – 8.6%. (Sec. 2(g), p.6)
The Plan does not charge a premium for member-only coverage.
Eliminate coverage for routine eye exams – Effective 1/1/2010 (Sec.2(d), p. 5.)
Extend sunset on no-limitation on occupational, physical, and speech therapies. (Sec. 5(e), p.10)

Pharmacy benefit savings. (Sec. 2(h), pp. 6-7)
The language in this section replaces that in the 2nd edition pertaining to retail pharmacy networks and mail-order. Under this section there would be reductions in pharmacy reimbursements expected to yield $18,000,000 in savings to the Plan in the first year (2009-2010) and $20,000,000 in savings in the second year (2010-2011). If the savings are greater than these amounts the Plan will adjust the reimbursements accordingly. If the savings do not reach 105% of the savings specified, the pharmacy reimbursement reduction will remain. The Plan will review the savings achieved every six months. Within 60 days of determining the savings achieved, the Plan will report the results to the Committee on Employee Hospital and Medical Benefits. Members will not be required to choose between a network pharmacy and mail-order.

TECHNICAL and conforming changes:(pp. 7-12)
Clarifies dependent coverage (p. 7-8)
Requires eligibility audit to ensure all covered dependents are eligible for coverage (p. 8)
Authorizes programs to address utilization abuse (p. 9)
Changes to employer contribution rates (pp. 11-12)
NC Health Choice (pp 8-9):
Delays effective date of coverage for over-the-counter meds

Authorizes subrogation
Technical correction re purchase of extended coverage
Makes the contracts between the Plan and BC/BS and its pharmacy benefit manager a public record except that information that is competitive, proprietary, or trade secret shall be redacted from the contract before releasing it. (pp. 10-11).

EFFECTIVE DATE.

3/14/gw

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: Senate Bill 287 (Third Edition)

SHORT TITLE: State Hlth Plan $/Good Health Initiatives.

SPONSOR(S): Senator Rand

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY: The third edition of Senate Bill 287, as passed by the Senate, appropriates funds from various sources, authorizes annual premium rate increases, makes various benefit and provider related changes to achieve financial savings, and directs other various changes to the Plan.

EFFECTIVE DATE: Sections 1(b), 1(c), 1(d), 2(c) through (e), 2(g), and 2(h) of this act become effective July 1, 2009. The benefit changes in Section 2(b)(2) become effective July 1, 2010, in Section 2(b)(3) on July 1, 2011, and in Section 2(d) on January 1, 2010. The remainder of this act is effective when it becomes law.

ESTIMATED IMPACT ON STATE:

Current FY 2008-2009

Appropriated Funds

Section 1(a) appropriates the sum of $250 million from the Savings Reserve Account ("Rainy Day Fund") of the General Fund for the 2008-09 fiscal year. These funds are to be used to finance a shortfall in funds available to pay health care benefits, administrative costs, and adequately fund the Plan's beginning cash balance on July 1, 2009.

2009-2011 Biennium

Increased Premium Contributions

Appropriated Funds

Sections 1(b), (c), and (d) appropriate the estimated required funds to support increased employer contributions to continue non-contributory benefit coverage for eligible employees and retired employees enrolled in the Plan for the 2009-2011 Biennium. These appropriations correspond to an annual 8.6% premium increase in non-contributory premium rates for the fiscal year beginning July 1, 2009, and an

additional annual premium increase of 8.6% for the fiscal year beginning July 1, 2010. Historically, the Plan has applied a premium increase in October of the first fiscal year of a biennium; however, the premium increases in the bill propose to change that methodology to an annual increase at the beginning of each fiscal year of a biennium. The table below reflects the allocation of appropriated funds by fund source:

Additional Employer Contributions
Appropriated Funds

Fund Source	FY 2009-10	FY 2010-11	Biennium
General Fund	$128,410,208	$267,904,114	$396,314,322
Highway Fund	$5,992,476	$12,502,192	$18,494,668
Other Funds	$26,491,180	$55,268,941	$81,760,121
Total	$160,893,864	$335,675,247	$496,569,111

Employee Funds

Section 2(g) of the proposed bill authorizes an annual 8.6% premium increase in contributory premium rates for the fiscal year beginning July 1, 2009, and an additional annual premium increase of 8.6% for the fiscal year beginning July 1, 2010. The estimated additional premium contributions from this proposed change is listed below:

Additional Employee Contributions
For Contributory Dependent Coverage

Fund Source	FY 2009-10	FY 2010-11	Biennium
Employee Contributions	$32,939,207	$68,721,555	$101,660,762

Total Increased Premium Contributions From Appropriated and Employee Funds

The table below reflects the total additional premium contributions projected to be received by the Plan over the 2009-2011 Biennium as a result of the proposed rate increase of premium increase:

Total Additonal Premium Contributions
From Appropriated and Employee Funds

Fund Source	FY 2009-10	FY 2010-11	Biennium
Appropriated			
General Fund	$128,410,208	$267,904,114	$396,314,322
Highway Fund	$5,992,476	$12,502,192	$18,494,668
Other Funds	$26,491,180	$55,268,941	$81,760,121
Sub-total	$160,893,864	$335,675,247	$496,569,111
Employee Contributions	$32,939,207	$68,721,555	$101,660,762
Total	$193,833,071	$404,396,802	$598,229,873

Financial Savings for the 2009 Biennium

Per the requirements of Senate Rule 42.2, House Rule 36.2, and G.S. 120-114 actuarial analyses have been prepared with respect to the bill's proposed benefit and other changes that are estimated to affect the financial condition of the Plan. A summary of the proposed changes are described below including the estimated actuarial impact of these changes.

Sections 2(c), (d), and (e) of the bill propose various benefit changes to include increased annual deductibles, annual co-insurance maximums, increased office visit co-pays, increased outpatient prescription drug co-pays, a new specialty drug co-pay and utilization of a specialty drug vendor. Effective January 1, 2010, the proposed bill also eliminates the current in-network routine eye examination benefit offered under the Plan.

A summary of the out-of-pocket changes for medical benefit related services are summarized in the table below:

Medical Benefits	PPO Basic		PPO Standard	
Plan Member Co-pays (per visit)	**Current**	**New Co-pay**	**Current**	**New Co-pay**
Primary Care	$25	$30	$20	$25
Specialty Care	$50	$70	$40	$60
Urgent Care	$75	$75	$50	$75
Inpatient Hospital	$200	$250	$150	$200
Annual Deductible				
In-network	$600	$800	$300	$600
Out-of-network	$1,200	$1,600	$600	$1,200
Coinsurance Maximum				
In-network	$2,500	$3,250	$1,750	$2,750
Out-of-network	$5,000	$6,500	$3,500	$5,500

For acute and maintenance prescription drugs, the co-pay for brand drugs increases from $30 per script to $35 per script, brand drugs with a generic equivalent from $40 per script to $10 plus the difference in the Plan's gross allowed cost of the brand drug and the Plan's cost of the generic equivalent drug, and from $50 per script to $55 per script for non-preferred brand drugs.

The proposed bill authorizes a new co-pay tier for specialty prescription drugs determined to be "biotech" medications or other select costly medications that cost the Plan in excess of $400 per prescription. The new per script co-pay will be equal to 25% of the Plan's cost for the drug or a maximum of $100. The current co-pays for specialty drugs range from $30 to $50 per script. The bill also authorizes the Plan to contract with a specialty drug vendor through which to channel plan member purchases of specialty drugs on an outpatient basis or in a professional office or institution setting.

Aon Consulting, the consulting actuary for the State Health Plan for Teachers and State Employees, estimates that the implementation of the bill's proposed benefit changes will yield the following projected savings:

Aon Consulting
Projected Financial Savings
Benefit and Provider Related Changes

Category	FY 2009-10	FY 2010-11	Biennium
Medical Benefits	$118,866,918	$139,542,217	$258,409,135
Outpatient Prescription Drugs (acute drugs)	$22,162,147	$24,092,234	$46,254,381
Specialty Drugs	$3,086,315	$3,396,887	$6,483,202
Total	$144,115,380	$167,031,338	$311,146,718

Hartman & Associates, the consulting actuary for the General Assembly's Fiscal Research Division, estimates that estimates that the implementation of the bill's proposed benefit changes will yield the following projected savings:

Hartman & Associates
Projected Financial Savings
Benefit and Provider Related Changes

Category	FY 2009-10	FY 2010-11	Biennium
Medical Benefits	$118,684,000	$143,713,000	$262,397,000
Outpatient Prescription Drugs (acute drugs)	$24,015,000	$24,225,000	$48,240,000
Specialty Drugs	$3,136,000	$3,417,000	$6,553,000
Total	$145,835,000	$171,355,000	$317,190,000

Provided below is a comparison table reflecting the specific results of each consulting actuary by the type of benefit and provider change proposed in the bill:

Projected Financial Savings by Type

Category	Aon Consulting (Plan) FY 2009-10	FY 2010-11	Biennium	Hartman & Assoc. (General Assembly) FY 2009-10	FY 2010-11	Biennium
Medical Benefits						
Primary Care Co-pay (Increase)	$8,518,038	$9,571,177	$18,089,215	$8,116,000	$9,257,000	$17,373,000
Specialist Co-pay (Increase)	$29,077,025	$32,672,003	$61,749,028	$27,125,000	$31,713,000	$58,838,000
Urgent Care Co-pay (Increase)	$739,560	$830,997	$1,570,557	$854,000	$994,000	$1,848,000
Inpatient Co-pay (Increase)	$2,158,037	$2,424,849	$4,582,886	$1,970,000	$2,247,000	$4,217,000
Routine Eye Exam (Eliminate Benefit) (Eff. 1/2010)	$2,158,693	$7,193,591	$9,352,284	$2,540,000	$7,039,000	$9,579,000
Deductible and Coinsurance Max (Increase)	$76,215,565	$86,849,600	$163,065,165	$78,079,000	$92,463,000	$170,542,000
Sub-total	$118,866,918	$139,542,217	$258,409,135	$118,684,000	$143,713,000	$262,397,000
Outpatient Prescription Drugs (acute drugs)						
Brand Drug Co-pay (Increase)	$11,734,884	$12,173,684	$23,908,568	$12,010,000	$11,741,000	$23,751,000
Brand Drug with Generic Equivalent (Increase)	$4,632,720	$5,644,491	$10,277,211	$6,285,000	$6,536,000	$12,821,000
Non-Preferred Brand Drug Co-pay (Increase	$3,089,092	$3,204,602	$6,293,694	$3,530,000	$3,671,000	$7,201,000
Reduce from 34-Day supply to 30-Day Supply	$2,705,451	$3,069,457	$5,774,908	$2,190,000	$2,277,000	$4,467,000
Sub-total	$22,162,147	$24,092,234	$46,254,381	$24,015,000	$24,225,000	$48,240,000
Specialty Drugs						
Establish a Specialty Drug vendor	$1,682,177	$1,835,102	$3,517,279	$1,665,000	$1,887,000	$3,552,000
Specialty Drug Copay (Establish)	$1,404,138	$1,561,785	$2,965,923	$1,471,000	$1,530,000	$3,001,000
Sub-total	$3,086,315	$3,396,887	$6,483,202	$3,136,000	$3,417,000	$6,553,000
Grand Total	$144,115,380	$167,031,338	$311,146,718	$145,835,000	$171,355,000	$317,190,000

Other Proposed Changes Affecting the Plan

Section 2(a) of the proposed bill eliminates the PPO Plus benefit alternative for plan members effective July 1, 2009. Employees currently in this plan will be provided the option to enroll in the remaining PPO Basic or PPO Standard plans. The PPO Plus alternative currently offers 90/10 coverage for an additional premium charge paid by the plan member.

Section 2(b) of the proposed bill implements a "Comprehensive Wellness Initiative" to focus on smoking cessation and weight management efforts.

The smoking cessation program will commence July 1, 2010 and will require all non-Medicare plan members to be enrolled in the PPO Basic plan unless the subscribing employee or retired employee can attest that they or any enrolled dependent do not smoke or otherwise use tobacco products. For eligible employees or retired employees who have attested that neither they nor their enrolled dependents use tobacco products, or if their medical provider certifies that a plan member is in a smoking cessation program, they will have the option to enroll in the PPO Standard plan.

Aon Consulting, consulting actuary for the Plan, estimates the smoking cessation program will save approximately $3.4 million in claims cost for the FY 2010-11. However, the administrative costs to begin implementation are estimated by Aon to offset any first year savings. Aon consulting noted that until further administrative costs and program implementation issues are determined, estimating future savings to the Plan is not possible at this time. Hartman and Associates, consulting actuary for the General Assembly's Fiscal Research Division, does not project any financial impact to the Plan from the proposed smoking cessation program. According to Hartman and Associates, the lack of program parameters and specific administrative costs prevents any reasonable analysis to be conducted.

The weight management program authorized in the proposed bill will begin effective July 1, 2011. Under this program all non-Medicare plan members will be enrolled in the PPO Basic plan unless the subscribing employee or retired employee attests that the ratio of weight and height of the employee or retired employee, or for any of their enrolled dependents, meets certain evidence-based healthy weight clinical guidelines. A plan member who cannot meet the Plan's weight and height ratio guidelines will remain in

the PPO Basic plan unless a medical provider certifies the plan member has a medical condition that prevents them from attaining a specified ration of weight and height, or if the member is actively participating in a Plan-approved weight management program.

Neither the Plan's consulting actuary, Aon Consulting, nor the General Assembly's consulting actuary, Hartman and Associates, have estimated any financial impact due to the weight management program. The July 1, 2011 implementation date and yet to be developed administrative costs and program implementation requirements do not allow for any reliable financial projection at this time.

Section 2(h) of the bill directs the Plan to achieve a reduction of $18 million in FY 2009-10 and $20 million in FY 2010-11 in pharmacy provider costs through its existing contract authority with the Plan's Pharmacy Benefit Manager. These savings are based on the Plan's actuarial projection dated March 20, 2009 which makes specific assumptions about enrollment, estimated costs and utilization trends. Total savings under this authority may increase or decrease without adjustment based on a change in total enrollment provided that the rate of savings achieved on a per member per month basis remains constant. Adjustments to total savings may be made within 60-days after each six-month period of a fiscal year if savings exceed 105% of the specified savings.

Reconciliation of Plan's Financial Requirements

According to available information from the Executive Administrator of the Plan, the Plan needs an immediate appropriation of $250 million for the current 2008-2009 fiscal year to operate through June 30, 2009, and to provide for an adequate beginning cash balance to begin operations for the new fiscal year commencing July 1, 2009. In addition, for the new biennium beginning July 1, 2009 the Plan is estimated to require over $1.2 billion in additional financial support to remain solvent and maintain minimum claim stabilization reserves for the 2009-2011 biennium. If the Plan were to maintain current benefit levels and assuming a 9% per capita claims trend, the Plan would require an estimated 30.8% premium increase for the biennium (effective October 1, 2009).

The proposed bill addresses this projected shortfall by authorizing the following changes:

1. Proposing a 8.6% annual premium increase on July 1 of each fiscal year of the biennium for non-contributory and contributory premium rates; this change moves the historical date to increase premium rates from October 1 in the first year of a biennium, and moves to an annual premium increase;

2. Eliminating the current PPO Plus option benefit alternative;

3. Increase plan member out-of-pocket requirements for certain medical and prescription drug benefits; and

4. Directing the Plan to achieve a reduction of $18 million in FY 2009-10 and $20 million in FY 2010-11 in pharmacy provider costs through its existing contract authority with the Plan's Pharmacy Benefit Manager.

A financial summary table provided below provides a projected reconciliation of the financial related changes authorized under the bill assuming the Plan's consulting actuary's estimate of projected financial need for the 2009-2011 biennium, their projected financial savings due to benefit and other provider related changes, and their estimate of additional premium contributions:

State Health Plan
Summary of Financial Changes
Amendment to Senate Bill 287 (3rd Edition)
($ Million)

	FY 2009-10	FY 2010-11	Biennium
1) Projected Financial Support Required Before Any Adjustments	$528.1	$704.2	$1,232.3
2) Adjust for Proposed FY 2008-09 Special Appropriation of $250M	($107.1)	($142.9)	($250.0)
3) Adjust for Elimination of PPO Plus (Net Adjustment)	($14.4)	($24.4)	($38.8)
4) Adjusted Financial Support Required for the 2009-11 Biennium	$406.6	$536.9	$943.5
5) Benefit Reductions Effective July 1, 2009			
Medical			
Primary Care Co-pay (Increase)	($8.5)	($9.6)	($18.1)
Specialist Co-pay (Increase)	($29.1)	($32.7)	($61.8)
Urgent Care Co-pay (Increase)	($0.7)	($0.8)	($1.5)
Inpatient Co-pay (Increase)	($2.2)	($2.4)	($4.6)
Deductible and Coinsurance Maximum (Increase)	($76.2)	($86.9)	($163.1)
Routine Eye Exam (Eliminate Benefit) {Effective January 1, 2010}	($2.2)	($7.2)	($9.4)
Sub-total	($118.9)	($139.6)	($258.5)
Outpatient Acute and Specialty Prescription Drugs			
Brand Drug Co-pay (Increase)	($11.8)	($12.2)	($24.0)
Brand Drug with Generic Equivalent (Increase)	($4.6)	($5.6)	($10.2)
Non-Preferred Brand Drug Co-pay (Increase	($3.1)	($3.2)	($6.3)
Reduce from 34-Day supply to 30-Day Supply per script	($2.7)	($3.1)	($5.8)
Specialty Drug Copay (Establish)	($1.4)	($1.6)	($3.0)
Establish a Specialty Drug vendor	($1.7)	($1.8)	($3.5)
Sub-total	($25.3)	($27.5)	($52.8)
Total -- Benefit Reductions	($144.2)	($167.1)	($311.3)
6) Additional Pharmacy Discounts to be Implemented by the Plan	($18.0)	($20.0)	($38.0)
7) Appropriations by the General Assembly			
Premium increase for Employing Agencies (July 1, 2009 = 8.6%, July 1, 2010 = 8.6%)			
General Fund	($128.4)	($267.9)	($396.3)
Highway Fund	($6.0)	($12.5)	($18.5)
Other Employer Funds	($26.5)	($55.3)	($81.8)
Total Employer Funds	($160.9)	($335.7)	($496.6)
8) Premium increases for Dependent Coverage (July 1, 2009 = 8.6%, July 1, 2010 = 8.6%) Paid by Employees and Retirees for Enrolled Spouses and Dependent Children			
Total Employee Funds	($32.9)	($68.7)	($101.6)
9) Plan's Other Operating Adjustments	($0.2)	$6.6	$6.4
10) Balance	$50.4	($48.0)	$2.4

Note: The $2.4 balance remaining at the end of the biennium is a product of rounding error and a $2.1 million difference in projected ending cash balances between financial projections estimating total financial requirements and final requirements after the proposed premium increases, benefit changes, and other program changes. This difference is not expected to have an adverse effect on the Plan's finances.

ASSUMPTIONS AND METHODOLOGY:

The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2008, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.6 billion for FY 2008-09. The Plan's PPO benefit design includes three alternative benefit levels offered to plan members. The three alternative benefit levels include the following:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums;

2) The "Standard" 80/20 plan; and

3) The "Plus" 90/10 plan with enhanced benefits via lower out-of pocket requirements as compared to the other PPO plan alternatives offered.

Employees and retired employees electing coverage under the Plus alternative must make a partially contributory premium contribution for their own coverage. The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under all plans is offered on a fully contributory basis.

Financial Condition

Financial Projection (Revised) for FY 2008-09 – For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year are projected to be $2.3 billion from premium collections, $53.9 million from Medicare Part D subsidies, and $2.7 million from investment earnings, for a total of slightly over $2.3 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.4 billion in claim-payment expenses and $168.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating loss is projected to be approximately $264.4 million for the fiscal year, assuming a 9% annual claims growth trend.

Projected operating losses are expected to deplete the Plan's cash balance of $139.8 million and leave it without sufficient operating resources to continue operations for the fiscal year. It is currently estimated by the Plan's Executive Administrator that the Plan will not be able to pay claims on a timely basis by March 31, 2009.

Consequently, the reforecast of Plan finances now indicates that the Plan will require up to $300 million in additional resources to operate for the balance of the 2008-09 fiscal year. This amount represents the estimated funds necessary to pay claims and administrative expenses through June 30, 2009, plus funding a minimum stabilization reserve equal to 7.5% of projected claims, and assuming a future premium rate increase effective October 1, 2009.

Other Information

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment Data as of December 31, 2008

I. No. of Participants	Basic	Standard	Plus	Total	Percent of Total
Actives					
Employees	11,623	271,243	47,687	330,553	49.6%
Dependents	20,454	115,875	28,156	164,485	24.7%
Sub-total	32,077	387,118	75,843	495,038	74.2%
Retired					
Employees	1,726	127,081	17,967	146,774	22.0%
Dependents	1,117	14,935	3,476	19,528	2.9%
Sub-total	2,843	142,016	21,443	166,302	24.9%
Former Employees with Continuation Coverage					
Employees	60	1,349	344	1,753	0.3%
Dependents	61	501	182	744	0.1%
Sub-total	121	1,850	526	2,497	0.4%
Firefighters, Rescue Squad & National Guard					
Employees	-	3	2	5	0.0%
Dependents	-	3	-	3	0.0%
Sub-total	-	6	2	8	0.0%
Local Governments					
Employees	72	1,577	319	1,968	0.3%
Dependents	141	637	218	996	0.1%
Sub-total	213	2,214	537	2,964	0.4%
Total					
Employees	13,481	401,253	66,319	481,053	72.1%
Dependents	21,773	131,951	32,032	185,756	27.9%
Grand Total	**35,254**	**533,204**	**98,351**	**666,809**	**100%**
Percent of Total	**5.3%**	**80.0%**	**14.7%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	2,684	328,635	49,246	380,565
Employee Child(ren)	4,958	36,903	8,589	50,450
Employee Spouse	2,274	18,145	4,469	24,888
Employee Family	3,565	17,570	4,015	25,150
Total	**13,481**	**401,253**	**66,319**	**481,053**

Percent Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	19.9%	81.9%	74.3%	79.1%
Employee Child(ren)	36.8%	9.2%	13.0%	10.5%
Employee Spouse	16.9%	4.5%	6.7%	5.2%
Employee Family	26.4%	4.4%	6.1%	5.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Enrollment Data Continued

III. Enrollment by Sex	Basic	Standard	Plus	Total
Female	18,837	334,917	61,752	415,506
Male	16,417	198,287	36,599	251,303
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Sex	Basic	Standard	Plus	Total
Female	53.4%	62.8%	62.8%	62.3%
Male	46.6%	37.2%	37.2%	37.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	17,390	136,277	27,211	180,878
30 to 44	8,125	107,375	17,315	132,815
45 to 54	5,164	94,548	18,277	117,989
55 to 64	3,195	102,901	23,452	129,548
65 & Over	1,380	92,103	12,096	105,579
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	49.3%	25.6%	27.7%	27.1%
30 to 44	23.0%	20.1%	17.6%	19.9%
45 to 54	14.6%	17.7%	18.6%	17.7%
55 to 64	9.1%	19.3%	23.8%	19.4%
65 & Over	3.9%	17.3%	12.3%	15.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	49,534	12,080	61,614
Medicare Eligible	97,240	7,448	104,688
Total	**146,774**	**19,528**	**166,302**

Percent by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.7%	61.9%	37.0%
Medicare Eligible	66.3%	38.1%	63.0%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

Aon Consulting, North Carolina State Health Plan, Financial Projections – October 2008, Total For All Plans – 9% Trend, October 10, 2008.

Aon Consulting, North Carolina State Health Plan, Financial Projections – October 2008, Total For All Plans – 9% Trend, July 2009 & 2010 Rate Increases, $250 Million Grant, No Plus Option – July 2009, Benefit Option, Pharmacy Initiatives, March 20, 2009.

Medco Health Solutions, various outpatient acute, specialty, and maintenance drug data and discount assumptions, March 2009.

State Health Plan, various summarized claims reports for medical claims by category and purpose and time period, December 2008, January 2009.

-Actuarial Note, Hartman & Associates, " Senate Bill 287 (Third Edition): An Act to Appropriate Funds for the State Health Plan and to Make Other Changes to the State Health Plan", March 25, 2009, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "Senate Bill 287 Proposed Committee Substitute S287 [v.3], State Health Plan $/Good Health Initiatives", March, 25 2009, original of which is on file with the Comprehensive Major Medical Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Marilyn Chism, Director
Fiscal Research Division

DATE: March 26, 2009

Signed Copy Located in the NCGA Principal Clerk's Offices

NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

SENATE BILL 287
PROPOSED COMMITTEE SUBSTITUTE
S287 [V.3]

State Health Plan $/Good Health Initiatives

Prepared by:

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March 2009

ACTUARIAL STATEMENT

The North Carolina State Health Plan for Teachers and State Employees has requested that Aon Consulting prepare an Actuarial Note in response to Senate Bill 287 proposed committee substitute S287 [v.3] entitled "An Act To Appropriate Funds For The State Health Plan For Teachers And State Employees And To Make Other Changes Related To The State Health Plan."

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

March 25, 2009

Kenneth C. Vieira, F.S.A., M.A.A.A.
Senior Vice President

Date

March 25, 2009

Kirsten R. Schatten, A.S.A., M.A.A.A.
Assistant Vice President

Date

STATE HEALTH PLAN $/GOOD HEALTH INITIATIVES

PLAN CHANGES

The proposed legislation is divided into seven sections. The full text of the bill is attached to this actuarial note. Below is brief summary of the key components of each section.

PART ONE: APPROPRIATIONS, DEFINITIONS, AND SCOPE

This section primarily deals with the appropriations required to fund the program for the next biennium. Section (a) details the appropriation of $250 million from the Savings Reserve Account. Sections (b) & (c) are appropriations needed by the general and highway funds.

The amounts set forth in this section were determined based on a financial projection provided by Aon Consulting.

PART TWO: HEALTH BENEFIT CHANGES

This section encompasses the bulk of the financial impact on to State Health Plan related to benefit changes effective July 1, 2009. Each component is summarized below with details of our key assumptions in the "Pricing Approach and Comments" section of this actuarial note.

SECTION 2.(a) Eliminate PPO Plus Option

Effective July 1, 2009, the PPO Plus option (90/10 in-network coverage) under the State Health Plan for Teachers and State Employees ("Plan") is eliminated. The Executive Administrator shall provide notice to all members of the Plan that this option will no longer be available as of July 1, 2009. Employees enrolled in the Plan's Plus option shall have the choice of enrolling in the Basic or Standard plan options for the 2009-2010 benefit year.

SECTION 2.(b) Implement Comprehensive Wellness Initiative

The first section allows the Plan to develop a Comprehensive Wellness Initiative that starts with a focus on smoking cessation and weight management. It is designed to be implemented effective July 1, 2010, for smoking cessation and July 1, 2011, for weight management.

The second and third sections detail how certain members who do not meet the program requirements will be enrolled into the Basic plan. Further details of the program are being developed. The program is assumed to be cost neutral.

SECTION 2.(c) Prescription drug co-payments

The legislation will alter the co-payments for the prescription drug program depending on the category of drug. Below are the major components:

The first section changes the current copays:

1. Formulary brand drugs will increase from $30 to $35
2. Non-Formulary brand drugs will increase from $50 to $55
3. For each branded prescription drug with a generic equivalent drug, the member shall pay the generic co-payment plus the difference between the Plan's gross allowed cost for the generic prescription and the Plan's cost for the branded prescription drug.

The second section allows the plan to provide coverage of nonacute specialty medications under the Plan's pharmacy benefit through a specialty pharmacy vendor under contract with the Plan. The Plan may transfer coverage of specified specialty disease medications covered under the Plan's medical benefit to the contracted specialty pharmacy vendor. The Plan shall impose a co-payment in the amount of twenty-five percent (25%) of the Plan's gross allowed cost of the specialty drug not to exceed one hundred dollars ($100.00) per prescription per 30-day supply.

The third section allows the plan to exclude coverage of certain over the counter medications.

The fourth section reduces the day supply to 30 days from 34 days. It also addresses utilization management procedures and options for the plan.

2.(d) Routine eye examinations not covered

Routine eye exams will no longer be a covered benefit as of January 1, 2010.

2.(e) Deductible and co-payment changes

There were a number of changes made to the Basic (70/30) and Standard (80/20) plans. These involved increased deductibles, coinsurance maximums, primary and specialty physician office visit co-payments, urgent care co-payments and inpatient co-payments. Details of each change can be found in the attached bill.

2.(f) Limitation on authority to change benefits

This section limits the authority of The Executive Administrator and Board of Trustees to make changes, requiring them to be made by the General Assembly.

2.(g) Premium increases

This section sets the premium increase to 8.6% for each July in the next biennium. This is consistent with the financial projections.

2.(h) Pharmacy Benefit Savings

This section directs the Plan to reduce pharmaceutical costs by $18 million in FY2010 and $20 million in FY 2011 through reduced reimbursements paid to pharmacies within the terms of the Plan's PBM contract. Achieved savings will be reviewed twice annually to adjust the PBM contract terms so actual savings will be within 105% of the savings amounts specified above.

PART THREE: ELIGIBILITY CLARIFICATION.

This section contains clarifications on various dependent categories. It also contains a section that allows the Plan to perform a dependent eligibility audit. The savings resulting from the audit should exceed the cost of performing the audit.

PART FOUR: NC HEALTH CHOICE CHANGES.

This section is related to NC Health Choice and has no financial impact on the State Health Plan.

PART FIVE: OTHER CHANGES

This section contains miscellaneous changes and clarification that have no financial impact on the State Health Plan.

PART SIX: SALARY-RELATED CONTRIBUTIONS

This section sets the funding percentages of the various groups and has no additional cost to the State Health Plan. The percentages are designed to be consistent with the financial projections.

PART SEVEN: EFFECTIVE DATE

Sections 1(b), 1(c), 1(d), 2(c), 2(e), 2(g), and 2(h) of this act become effective July 1, 2009. Section 2(d) becomes effective January 1, 2010. The remainder of this act is effective when it becomes law.

PROJECTED SAVINGS

Section	Plan Design Change			Based on "Midpoint" Increase		
				2009-2010 Fiscal Year Cost	2010-2011 Fiscal Year Cost	Total Biennium Cost
Part 1 – Appropriations, Definitions & Scope						
1(a)	$250 million appropriation from savings reserve account			Included in baseline projection		
1(b) - 1(c)	General Fund and Highway Appropriations			Included in baseline projection		
1(d) - 1(f)	Other funds, definition & scope			Included in baseline projection		
Part 2 - Health Benefit Changes						
2(a)	Eliminate PPO Plus Option			Included in baseline projection. Details of savings summarized in pricing		
2(b)	Implement Comprehensive Wellness			Administrative cost assumed to be offset by future savings. No net impact to the plan in the biennium		
2(c)	Prescription Drug Co-payment					
(1)	Preferred Brand	$30 to $35		($11.8)	($12.2)	($24.0)
	Brand with Generic Available	Pay as generic		($4.6)	($5.6)	($10.2)
	Non-Preferred Brand	$50 to $55		($3.1)	($3.2)	($6.3)
(2)	Specialty Drugs	25% coinsurance, $100 max		($1.4)	($1.6)	($3.0)
		Specialty Vendor		($1.7)	($1.8)	($3.5)
(3)	OTC drugs may be excluded			No Cost Impact		
(4)	Day Supply	Reduce from 34 to 30		($2.7)	($3.1)	($5.8)
2(d)	Routine eye exams not covered			($2.1)	($7.2)	($9.3)
2(e)	Deductible and co-payment changes					
		Basic	Standard			
	Deductible to	$800/1600	$600/$1200	($51.8)	($57.6)	($109.4)
	Coinsurance to	$3250/$6500	$2750/$5500	($24.4)	($29.2)	($53.6)
	Primary care copay to	$30	$25	($8.5)	($9.6)	($18.1)
	Specialty care copay to	$70	$60	($29.1)	($32.7)	($61.8)
	Urgent care copay to	$75	$75	($0.7)	($0.8)	($1.5)
	Inpatient copay to	$250	$200	($2.2)	($2.4)	($4.6)
2(f)	Limitation on authority to change benefits			No Cost Impact		
2(g)	Premium Increase of 8.6% for FY10 & FY11			Included in baseline projection		
2(h)	Pharmacy benefit savings			Included in baseline projection		
Part 3 - Eligibility Clarification						
3(a)	Dependent child clarifications			No Cost Impact		
3(b)	Eligibility of full-time students			No Cost Impact		
3(c) - 3(d)	Waiting periods subject to federal law			No Cost Impact		
3(e)	Executive administrator shall provide for an audit of the dependent eligibility under the plan			Savings from the audit should be greater than the cost to provide it		
3(f)	Cessation of coverage of ineligible individuals			No Cost Impact		
3(g)	Documentation of dependent eligibility			No Cost Impact		

		Based on "Midpoint" Increase		
Section	Plan Design Change	2009-2010 Fiscal Year Cost	2010-2011 Fiscal Year Cost	Total Biennium Cost
Part 4 - NC Health Choice Changes				
4(a) - 4(c)	Changes to NC Health Choice have no cost impact on the Plan			
Part 5 - Other Changes				
5(a) - 5(e)	Minor clarifications or changes that have no cost impact			
Part 6 - Salary Related Contributions				
6(a) - 6(f)	Required contribution rates for various entities. These amounts are developed from the baseline projections.			
Total cost of health benefit changes		($144.1)	($167.0)	($311.1)

The baseline projections produced total projected expenses of $2,687,502,073 and $2,919,5 07,795 for the 2010 and 2011 fiscal years respectively.

PRICING APPROACH AND COMMENTS

The following information was compiled and utilized in determining the projected costs or savings of each benefit component addressed in this actuarial note. Due to the inclusion of multiple benefit changes incorporated with imperfect data, all projected savings incorporate a 10% risk factor:

Eliminate PPO Plus Option

- Information was collected from the Plan's data warehouse, EinfoNow. It included detailed eligibility and claims data by plan for Fiscal Year 2008. From this information we were able to develop experience rates specifically for the PPO plus option.

- The claims were then trended at 9% per year and adjusted for the most recent membership levels. We also reviewed the elections effective 7/1/2008 and adjusted our projected expenditures by plan for FY 2010 and 2011 to reflect the experience of the members who moved. These would include prior CMMP members who moved to the Plus option, adjusting their experience accordingly.

- It was then assumed that a benefit reduction of 11.5% would be applied to the medical claims only. Assuming a one month lag produced FY 2010 savings of $56 million and FY 2011 savings of $66 million.

- The savings from lower claims is offset by reduced dependent contributions. Based on the current contribution levels, $41.6 million would not be received as revenue by the Plan. In order to accurately measure the net impact of this benefit you would need to adjust the premium levels appropriately and maintain a consistent reference point.

Implement Comprehensive Wellness Initiative

- Information was provided by the Plan that detailed the administrative costs for implementing the smoking cessation and weight management programs. The costs were projected to be $3,384,308 in FY 2010 and $7,253,282 in FY2011.

- Through conversation with the Plan and the IHM vendors it was assumed that the future savings from these programs would more than offset current expenditures.

- There is currently no net impact to the Plan at this point until further administrative costs and program implementations are determine in the future.

Brand Prescription Drug Copay Changes (Increase Preferred and Non-Preferred Brand $5; Change Brand with Generic Equivalent to Generic Copay and Member pay Cost Difference between Brand and Generic)

- Claims data was received from the Plan's Pharmacy Benefit Manager (PBM) for the period April 5, 2008 through June 27,2008.

- For this period annualized, active employees, non-Medicare retirees and Medicare retirees generated $143,999,486 of paid Brand copayments with 4,069,848 scripts.

- The annualized Brand claims data was projected forward with -4% utilization trend per year and 10% cost trend 1st year/11% cost trend per year thereafter.

- Brand prescription drugs with generic equivalents were assumed to have the same AWP for Brand or Generic with a Generic discount applied.

- The projected claims data was used to quantify the impact of the copay changes.

- Based on an effective date of July 1, 2009, the FY 2010 projected savings for Brand Prescription Drug copays is $19,456,696. The FY 2011 projected savings for Brand Prescription Drug copays is $21,022,777.

Specialty Drug Copay and Exclusive Vendor Changes (Increase Copay to 25% with $100 Max/script and Create Specialty Vendor for all Specialty Drugs)

- Claims data was received from the Plan's Pharmacy Benefit Manager (PBM) for the period July 1, 2007 through June 30,2008.

- For this period, active employees, non-Medicare retirees and Medicare retirees generated $2,232,086 of paid Brand copayments with 46,389 scripts.

- The specialty claims data was used to quantify the impact of the benefit design changes with $2,500 out-of-pocket max applied to total projected prescription drug spend. Trend levels starting at 8.3% were reduced in savings projections to recognize anti-leveraging associated with the benefit design maximums.

- The specialty Vendor network savings projections are provided by Medco and are based on enhanced discounts for a list of specialty drugs that will only be covered in the specialty network by implementing a retail lockout. The list of drugs with retail lockout does not include specialty drugs that may be required on an acute basis. Medco's analysis is based only on ingredient cost with discounts and estimates 4,755 impacted members based on 2008 data.

- Based on an effective date of July 1, 2009, the FY 2010 projected savings for Specialty Prescription Drug changes is $3,086,315. The FY 2011 projected savings for Specialty Prescription Drug changes is $3,396,887.

Prescription Drug Day Supply (Reduce to 30)

- Claims data was received from the Plan's Pharmacy Benefit Manager (PBM) for the period July 1, 2007 through June 30, 2008.

- For this period, active employees, non-Medicare retirees and Medicare retirees generated $25,474,207 of paid co-payments with 1,210,194 scripts for scripts with 1 month fills of 31 to 34 days, 2 month fills of 61 to 68 days and 3 month fills of 91 to 102 days.

- The detailed claims data (FY 2008) was projected forward with 4% utilization trend per year.

- The claims data for these scripts was used to quantify the copay impact of limiting a 1 month fill to 30 days, a 2 month fill to 60 days and a 3 month fill to 90 days.

- Based on an effective date of July 1, 2009, the FY 2010 projected savings for Day Supply changes is $2,705,451. The FY 2011 projected savings for Day Supply changes is $3,069,457.

Routine Eye Coverage Eliminated

- Claims data was received from the Plan's Claims Processing Contractor (CPC) showing Routine Eye office visit claims experience for the period January 1, 2008 through March 31,2008 for all PPO plans separately. The claims experience was also separated for active employees, non-Medicare retirees and Medicare retirees.

- For this period annualized, active employees, non-Medicare retirees and Medicare retirees generated $6,557,857 of Plan paid claims with 109,573 visits.

- The annualized claims data was projected forward with 3% utilization trend per year and 6% cost trend per year.

- Based on an effective date of January 1, 2010, the FY 2010 projected savings for eliminating Routine Eye coverage is $2,158,693. The FY 2011 projected savings for eliminating Routine Eye coverage is $7,193,591.

Deductible and Coinsurance Maximum Changes (Increase Basic Deductible $200/$400 and Coinsurance Maximum $750/$1,500; Increase Standard Deductible $300/$600 and Coinsurance Maximum $1,000/$2,000)

- Claims data was received from the Plan's Claims Processing Contractor (CPC) showing claims experience for all claims subject to deductible and coinsurance for the period July 1, 2007 through June 30,2008 (FY 2008) for the CMM and all PPO plans separately. The claims experience was also separated for active employees, non-Medicare retirees and Medicare retirees.

- For this 12 month period, active employees, non-Medicare retirees and Medicare retirees generated $91,954,962 of paid deductible and $116,899,421 of paid coinsurance.

- The detailed claims data (FY 2008) was projected forward with 3% utilization trend per year and 6% cost trend per year.

- The projected claims data was used to quantify the impact of the deductible and coinsurance maximum changes.

- Based on an effective date of July 1, 2009, the FY 2010 projected savings for deductible and coinsurance maximum changes is $76,215,565. The FY 2011 projected savings for deductible and coinsurance maximum changes is $86,849,600.

Office Visit Copay Change (Increase PCP $5 and Specialty $20)

- Claims data was received from the Plan's Claims Processing Contractor (CPC) showing PCP and Specialty claims experience for the period July 1, 2007 through June 30,2008 (FY 2008) for the CMM and all PPO plans separately. The claims experience was also separated for active employees, non-Medicare retirees and Medicare retirees.

- For this 12 month period, active employees, non-Medicare retirees and Medicare retirees generated $40,327,380 of paid PCP copayments with 2,082,505 visits.

- For this 12 month period, active employees, non-Medicare retirees and Medicare retirees generated $61,139,448 of paid Specialty copayments with 2,109,138 visits.

- The detailed claims data (FY 2008) was projected forward with 3% utilization trend per year and 6% cost trend per year. An additional 10% utilization trend was included for the CMM plan in FY 2009 assuming a first year spike in utilization for all members moving to PPO.

- The projected claims data was used to quantify the impact of the copay changes.

- An adjustment for Specialty copays was applied for Medicare retirees assuming the plan would recover 25% of the savings based on Coordination of Benefits with Medicare.

- Based on an effective date of July 1, 2009, the FY 2010 projected savings for PCP copays is $8,518,038. The FY 2011 projected savings for PCP copays is $9,571,177.

- Based on an effective date of July 1, 2009, the FY 2010 projected savings for Specialty copays is $29,077,025. The FY 2011 projected savings for Specialty copays is $32,672,003

Urgent Care Copay Change (Increase Standard $25)

- Claims data was received from the Plan's Claims Processing Contractor (CPC) showing Urgent Care claims experience for the period July 1, 2007 through June 30,2008 (FY 2008) for the CMM and all PPO plans separately. The claims experience was also separated for active employees, non-Medicare retirees and Medicare retirees.

- For this 12 month period, active employees, non-Medicare retirees and Medicare retirees generated $1,671,386 of paid Urgent Care copayments with 35,753 visits.

- The detailed claims data (FY 2008) was projected forward with 3% utilization trend per year and 6% cost trend per year. An additional 10% utilization trend was included for the CMM plan in FY 2009 assuming a first year spike in utilization for all members moving to PPO.

- The projected claims data was used to quantify the impact of the copay changes.

- An adjustment for Urgent Care copays was applied for Medicare retirees assuming the plan would recover 40% of the savings based on Coordination of Benefits with Medicare.

- Based on an effective date of July 1, 2009, the FY 2010 projected savings for Urgent Care copays is $739,560. The FY 2011 projected savings for PCP copays is $830,997.

Inpatient Copay Change (Increase $50)

- Claims data was received from EinfoNow showing Inpatient claims experience for the period July 1, 2007 through June 30,2008 (FY 2008) for the CMM and all PPO plans separately. The claims experience was also separated for active employees, non-Medicare retirees and Medicare retirees.

- For this 12 month period, active employees, non-Medicare retirees and Medicare retirees generated $6,699,263 of paid Inpatient copayments with 51,076 admissions.

- The detailed claims data (FY 2008) was projected forward with 3% utilization trend per year and 6% cost trend per year.

- The projected claims data was used to quantify the impact of the copay changes.

- An adjustment for Inpatient copays was applied for Medicare retirees assuming the plan would recover 91% of the savings based on Coordination of Benefits with Medicare.

- Based on an effective date of July 1, 2009, the FY 2010 projected savings for Inpatient copays is $2,158,037. The FY 2011 projected savings for Inpatient copays is $2,424,849.

Pharmacy Benefit Savings

- March 20, 2009 financial projections include $38 million of savings over the biennium to reflect the improved contract terms guaranteed by the Plan's PBM.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 3

SENATE BILL 287

Select Committee on Employee Hospital and Medical Benefits Committee Substitute Adopted 3/10/09
Third Edition Engrossed 3/24/09

Short Title: State Hlth Plan $/Good Health Initiatives. (Public)

Sponsors:

Referred to:

February 25, 2009

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES AND TO MAKE OTHER CHANGES RELATED TO THE STATE HEALTH PLAN.

Whereas, the General Assembly must act quickly and prudently to maintain a financially stable State Health Plan to ensure that all members of the Plan have affordable access to medically necessary health benefits and services within available resources; and

Whereas, in order to meet current fiscal obligations the General Assembly must appropriate $250,000,000 for the 2008-2009 fiscal year to cover the current year shortfall in funds; and

Whereas, estimates indicate that a substantially larger appropriation will be necessary to maintain the fiscal integrity of the Plan in the next and ensuing fiscal periods; and

Whereas, in order to ensure continued access to medically necessary health care to Plan members, the Plan must implement measures to contain costs through premium increases, benefit changes, and healthy lifestyle programs that not only reduce costs but improve member health; and

Whereas, the Plan estimates that over 70,000 Plan members use tobacco, resulting in a cost to the Plan of $2,000 per member per year more than the cost of providing coverage for nonusers of tobacco; and

Whereas, over 60% of North Carolina adults are obese or overweight; and

Whereas, obesity is linked to an over 37% increase in health care spending at a cost of $2,445 per member per year; and

Whereas, weight management and cessation of tobacco use have been demonstrated to result in improved member health and substantial savings in health care costs making it fiscally prudent to implement smoking cessation and weight management incentives and initiatives with mechanisms to verify member compliance with smoking cessation and weight management requirements; Now, therefore,

The General Assembly of North Carolina enacts:

PART ONE: APPROPRIATIONS, DEFINITIONS, AND SCOPE.

SECTION 1.(a) Appropriation for 2008-2009 fiscal year. – There is appropriated from the Savings Reserve Account established in G.S. 143C-4-2 to the Health Benefit Reserve Fund established in G.S. 135-44.5 the sum of two hundred fifty million dollars ($250,000,000) for the 2008-2009 fiscal year. These funds shall be used to address the shortfall in funds

available for the payment of health care and administrative costs under the State Health Plan for Teachers and State Employees ("Plan") for the 2008-2009 fiscal year.

SECTION 1.(b) General Fund appropriation for 2009-2011 fiscal biennium. – Notwithstanding G.S. 143C-5-2, there is appropriated from the General Fund to the Reserve for the State Health Plan in the Office of State Budget and Management the sum of one hundred twenty-eight million four hundred ten thousand two hundred eight dollars ($128,410,208) for the 2009-2010 fiscal year and the sum of two hundred sixty-seven million nine hundred four thousand one hundred fourteen dollars ($267,904,114) for the 2010-2011 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2009-2011 fiscal biennium.

SECTION 1.(c) Highway Fund appropriation for the 2009-2011 fiscal biennium. – Notwithstanding G.S. 143C-5-2, there is appropriated from the Highway Fund to the Reserve for the State Health Plan in the Office of State Budget and Management the sum of five million nine hundred ninety-two thousand four hundred seventy-six dollars ($5,992,476) for the 2009-2010 fiscal year and the sum of twelve million five hundred two thousand one hundred ninety-two dollars ($12,502,192) for the 2010-2011 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2009-2011 fiscal biennium.

SECTION 1.(d) All other agency funds required to fund the premium increase enacted in this act, other than funds appropriated in subsections (b) and (c) of this section, are appropriated for the 2009-2011 fiscal biennium.

SECTION 1.(e) Definitions. – As used in this act unless the context clearly requires otherwise:

(1) "Plan." – The State Health Plan for Teachers and State Employees.

(2) "Basic plan." – The Plan's PPO option providing for 70/30 in-network coverage after deductibles and co-payments.

(3) "Smoking" or "Smoking cessation." – Includes cessation of the use of all tobacco products.

(4) "Standard plan." – The Plan's PPO option providing for 80/20 in-network coverage after deductibles and co-payments.

SECTION 1.(f) Scope. – In the event of a conflict between the provisions of this act and Article 3A of Chapter 135 of the General Statutes, this act prevails.

PART TWO: HEALTH BENEFIT CHANGES.

SECTION 2.(a) Eliminate PPO Plus Option. – Effective July 1, 2009, the PPO Plus option (90/10 in-network coverage) under the State Health Plan for Teachers and State Employees ("Plan") is eliminated. The Executive Administrator shall provide notice to all members of the Plan that this option will no longer be available as of July 1, 2009. Employees enrolled in the Plan's Plus option shall have the choice of enrolling in the Basic or Standard plan options for the 2009-2010 benefit year.

SECTION 2.(b) Implement Comprehensive Wellness Initiative.

(1) Program development. – The Plan shall develop a Comprehensive Wellness Initiative that includes a focus on smoking cessation and weight management and that is designed to be implemented effective July 1, 2010, for smoking cessation and July 1, 2011, for weight management. Benefit levels shall be determined by the Plan based upon tobacco use or the inability of the member to meet national, evidence-based healthy weight clinical guidelines. For purposes of the Comprehensive Wellness Initiative, "member" includes all State Health Plan primary subscribers and their covered dependents. The Plan shall develop a process whereby a Plan member may appeal the Plan's basis for action it takes due to the member's failure or refusal to comply with the Plan's smoking cessation or weight management requirements.

(2) Smoking cessation. – Effective July 1, 2010, all members of the Plan who do not have Medicare as their primary coverage shall be enrolled in the Basic Plan under the Plan's PPO unless the subscriber can attest that the subscriber or any qualifying dependent does not smoke or otherwise use tobacco products. The Plan shall develop a mechanism for verifying that the member does not smoke or use other tobacco products. Tobacco use will be reassessed annually at the time of Plan enrollment. All subscribers who have attested that neither they nor their dependents use tobacco, or whose physician certifies in writing that the member is participating in a smoking cessation program, shall have the choice of remaining in the Basic plan option or enrolling in the Standard plan option. For purposes of the smoking cessation initiative, "member" includes all members covered under the Plan. As used in this section, "smoking cessation program" means active participation in a Plan-approved cessation program to include counseling or use of tobacco cessation medications.

(3) Weight management. – Effective July 1, 2011, all members of the Plan who do not have Medicare as their primary coverage shall be enrolled in the Basic Plan under the Plan's PPO Plan unless the subscriber attests that the weight and height ratio of the member is within a range determined by the Plan based on evidence-based healthy weight clinical guidelines, or unless the member's physician certifies in writing that the member has a medical condition that prevents the attainment of the specified weight range or that the member is actively participating in a Plan-approved weight management program. In either case, the member shall have the option to enroll in the Basic or Standard Plan.

Not later than October 1, 2009, the Executive Administrator shall inform Plan members of the healthy lifestyle initiatives, requirements for compliance, and consequences of noncompliance. The Executive Administrator shall provide to members education and training to assist members in complying with healthy lifestyle initiatives. The Executive Administrator may implement incentive initiatives to further encourage member achievement in smoking cessation, weight management, and other integrated health management programs.

The Executive Administrator shall report to the Committee on Employee Hospital and Medical Benefits recommendations the Plan may have for additional sanctions that may be imposed when the Executive Administrator finds that a member intentionally makes a false statement on a Plan document.

SECTION 2.(c) Prescription drug co-payments. – G.S. 135-45.6(b) reads as rewritten:

"(b) Prescription Drugs. – The Plan's allowable charges for prescription legend drugs to be used outside of a hospital or skilled nursing facility shall be as determined by the Plan's Executive Administrator and Board of Trustees, which determinations are not subject to appeal under Article 3 of Chapter 150B of the General Statutes. Co-payments and other allowable charges or coverage for prescription drugs shall be as follows:

(1) The Plan will pay allowable charges for each outpatient prescription drug less a copayment to be paid by each covered individual equal to the following amounts: pharmacy charges up to ten dollars ($10.00) for each generic prescription, ~~thirty dollars ($30.00)~~ thirty-five dollars ($35.00) for each preferred branded prescription without a generic equivalent, ~~and forty dollars ($40.00) for each preferred branded prescription with a generic equivalent drug,~~ and ~~fifty dollars ($50.00)~~ fifty-five dollars ($55.00) for each nonpreferred branded ~~or generic~~ prescription. For each branded prescription drug with a generic equivalent drug, the member shall pay the generic

co-payment plus the difference between the Plan's gross allowed cost for the generic prescription and the Plan's cost for the branded prescription drug.

(2) The Plan shall provide coverage of nonacute specialty medications under the Plan's pharmacy benefit through a specialty pharmacy vendor under contract with the Plan. The Plan may transfer coverage of specified specialty disease medications covered under the Plan's medical benefit to the contracted specialty pharmacy vendor. Specialty medications are covered biotech medications and other medications designated and classified by the Plan as specialty medications that are typically significantly more expensive than alternative drugs or therapies. Medications classified by the Plan as specialty medications generally have unique uses for the treatment of complex diseases, require special dosing or administration, require special handling, are typically prescribed by a specialist provider, and exceed four hundred dollars ($400.00) cost to the Plan per prescription. The Plan shall impose a co-payment in the amount of Plan per prescription. The Plan shall impose a co-payment in the amount of twenty-five percent (25%) of the Plan's gross allowed cost of the specialty drug not to exceed one hundred dollars ($100.00) per prescription per 30-day supply.

(3) The Plan may exclude coverage of drugs that have therapeutic equivalents that are available over the counter. Before excluding coverage under this subdivision, the Plan shall consult with the Plan's Pharmacy and Therapeutics Committee.

~~These co-paymentsapply to all optional alternative plans available under the Plan.~~

(4) Allowable charges shall not be greater than a pharmacy's usual and customary charge to the general public for a particular prescription. Prescriptions shall be for no more than a ~~34-day~~30-day supply for the purposes of the copayments paid by each covered individual. By accepting the copayments and any remaining allowable charges provided by this subsection, pharmacies shall not balance bill an individual covered by the Plan. A prescription legend drug is defined as an article the label of which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without Prescription." Such articles may not be sold to or purchased by the public without a prescription order. Benefits are provided for insulin even though a prescription is not required. ~~The Plan may use a pharmacy benefit manager to help manage the Plan's outpatient prescription drug coverage. In managing the Plan's outpatient prescription drug benefits, the Plan and its pharmacy benefit manager shall not provide coverage for sexual dysfunction, growth hormone, antiwrinkle, weight loss, and hair growth drugs unless such coverage is medically necessary to the health of the member. The Plan and its pharmacy benefit manager shall not provide coverage for growth hormone and weight loss drugs and antifungal drugs for the treatment of nail fungus and botulinium toxin without approval in advance by the pharmacy benefit manager.~~ The Plan may adopt utilization management procedures for certain drugs, but in no event shall the Plan provide coverage for sexual dysfunction or hair growth drugs or nonmedically necessary drugs used for cosmetic purposes. Any formulary used by the Plan's Executive Administrator and pharmacy benefit manager shall be an open formulary. Plan members shall not be assessed more than two thousand five hundred dollars ($2,500) per person per fiscal year in copayments required by this subsection. The Plan's Pharmacy Benefit

Manager, or any pharmacy or vendor participating in the Plan shall charge the Plan for any prescription legend drug dispensed under the Plan's pharmacy benefit based upon the original National Drug Code (NDC) as established by the manufacturer of the prescription legend drug and published by the United States Food and Drug Administration.

Copayments authorized under this subsection apply to all optional alternative plans available under the Plan."

SECTION 2.(d) Routine eye examinations not covered. – Effective January 1, 2010, G.S. 135-45.8(13) reads as rewritten:

"**§ 135-45.8. General limitations and exclusions.**

The following shall in no event be considered covered expenses nor will benefits described in G.S. 135-45.6 through G.S. 135-45.11 be payable for:

...

(13) Charges for routine eye examinations, eyeglasses or other corrective lenses (except for cataract lenses certified as medically necessary for aphakia persons) and hearing aids or examinations for the prescription or fitting thereof."

SECTION 2.(e) Deductible and co-payment changes. – Effective July 1, 2009, the Executive Administrator shall make the following changes to deductibles, coinsurance maximums, and co-payments under the Basic and Standard PPO Plans:

(1) Basic plan (70/30):

a. Increase the in-network annual deductible to eight hundred dollars ($800.00) for member-only coverage and to one thousand six hundred dollars ($1,600) for the out-of-network annual deductible for member-only coverage.

The aggregate maximum annual deductible for employee-child and employee-family coverage shall be three times the member-only annual deductibles.

b. Increase the in-network coinsurance maximum to three thousand two hundred fifty dollars ($3,250) for member-only coverage and to six thousand five hundred dollars ($6,500) for member-only out-of-network maximum coinsurance. The aggregate maximum coinsurance for employee-child and employee-family coverage shall be three times the member-only coinsurance maximums.

c. Increase the in-network primary care co-payment to thirty dollars ($30.00) per covered individual.

d. Increase the in-network specialist co-payment to seventy dollars ($70.00) per covered individual.

e. Increase the in-network and out-of-network inpatient co-payment to two hundred fifty dollars ($250.00) per covered individual.

f. Increase prescription drug co-pays as required under G.S. 135-45.6(b) as enacted by this act.

g. Except as otherwise provided in this act, co-payments and coinsurance for coverage not otherwise listed in this subdivision shall remain as applicable in the 2008-2009 benefit year.

(2) Standard plan (80/20):

a. Increase the in-network annual deductible to six hundred dollars ($600.00) for member-only coverage and to one thousand two hundred dollars ($1,200) for the member-only out-of-network annual deductible.

The aggregate maximum annual deductible for employee-child and employee-family coverage shall be three times the member-only annual deductibles.

b. Increase the in-network coinsurance maximum to two thousand seven hundred fifty dollars ($2,750) for member-only coverage and to five thousand five hundred dollars ($5,500) for member-only out-of-network maximum coinsurance. The aggregate maximum coinsurance for employee-child and employee-family coverage shall be three times the member-only coinsurance maximums.

c. Increase the in-network urgent care co-payment to seventy-five dollars ($75.00) per covered individual.

d. Increase the in-network primary care co-payment to twenty-five dollars ($25.00) per covered individual.

e. Increase the in-network specialist co-payment to sixty dollars ($60.00) per covered individual.

f. Increase the in-network and out-of-network inpatient co-payment to two hundred dollars ($200.00) per covered individual.

g. Increase prescription drug co-pays as required under G.S. 135-45.6(b) as enacted by this act.

h. Except as otherwise provided in this act, co-payments and coinsurance for coverage not otherwise listed in this subdivision shall remain as applicable in the 2008-2009 benefit year.

SECTION 2.(f) Limitation on authority to change benefits. – G.S. 135-45(g) reads as rewritten:

"(g) The Executive Administrator and Board of Trustees shall not change the Plan's comprehensive health benefit coverage, co-payments, deductibles, out-of-pocket expenditures, and lifetime maximums in effect on ~~July 1, 2008,~~ July 1, 2009, or a later act of the General Assembly, that would result in a net increased cost to the Plan or in a reduction in benefits to Plan members as a whole unless and until the proposed changes are directed to be made in an act of the General Assembly."

SECTION 2.(g) Premium increases. – Premium rates for contributory coverage established in accordance with G.S. 135-44.6 shall be increased to eight and six-tenths percent (8.6%) for contributory coverage for the 2009-2010 fiscal year and shall be increased by an additional eight and six-tenths percent (8.6%) over the premium rate for contributory coverage for the 2010-2011 fiscal year.

SECTION 2.(h) Pharmacy benefit savings. – The Plan shall direct its pharmacy benefit manager (PBM), within the terms of the Plan's PBM contract, to achieve the sum of eighteen million dollars ($18,000,000) in savings in pharmacy benefit costs in the 2009-2010 fiscal year, and the sum of twenty million dollars ($20,000,000) in savings in pharmacy benefit costs in the 2010-2011 fiscal year through reduced reimbursements paid to pharmacies for prescription drugs. If the savings achieved in each six-month period of the fiscal year do not exceed one hundred-five percent (105%) of the savings amount specified in this section for that fiscal year, there shall be no further adjustment to reimbursements paid to pharmacies for that six-month period. If the total savings achieved, by fiscal year, exceeds one hundred five percent (105%) of the specified savings amount in each six month period of the fiscal year, the Plan shall adjust pharmacy reimbursement reductions accordingly. The Plan shall review savings achieved twice annually to ensure compliance with this section. The Plan shall calculate the savings to be achieved based on Plan enrollment and estimated cost and utilization trends incorporated in the Plan's Financial Projections as of March 20, 2009. The total savings by fiscal year achieved in this section may be increased or decreased without adjustment based on a change in total enrollment provided that the rate of savings achieved on a per member per

month basis remains constant. Not later than 60 days immediately following each six-month period, the Plan shall report the amount of savings achieved and any adjustments made for that period to the Committee on Employee Hospital and Medical Benefits."

PART THREE: ELIGIBILITY CLARIFICATION.

SECTION 3.(a) Dependent child clarifications. – G.S. 135-45.1(10) reads as rewritten:

"(10) Dependent child. – A natural, legally adopted, or foster child or children of the employee and or spouse, unmarried, up to the first of the month following his or her 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for such child's maintenance and support. Dependent child also includes a stepchild of the member who is married to the stepchild's natural parent. To be eligible, the stepchild must have his or her primary residence with the member. Dependent child shall also include any child under age 19 who has reached his or her 18th birthday, provided the employee was legally responsible for such child's maintenance and support on his or her 18th birthday. Dependent children of firefighters, rescue squad workers, and members of the national guard are subject to the same terms and conditions as are other dependent children covered by this subdivision. Eligibility of dependent children is subject to the requirements of G.S. 135-45.2(d). The Plan may require documentation from the member confirming a child's eligibility to be covered as the member's dependent."

SECTION 3.(b) Eligibility of full-time students. – G.S. 135-45.2(d) reads as rewritten:

"(d) A foster child is covered as a dependent child (i) if living in a regular parent-child relationship with the expectation that the employee will continue to rear the child into adulthood, (ii) if at the time of enrollment, or at the time a foster child relationship is established, whichever occurs first, the employee applies for coverage for such child and submits evidence of a bona fide foster child relationship, identifying the foster child by name and setting forth all relevant aspects of the relationship, (iii) if the claims processor accepts the foster child as a participant through a separate written document identifying the foster child by name and specifically recognizing the foster child relationship, and (iv) if at the time a claim is incurred, the foster child relationship, as identified by the employee, continues to exist. Children placed in a home by a welfare agency which obtains control of, and provides for maintenance of the child, are not eligible participants.

Coverage of a dependent child may be extended beyond the 19th birthday under the following conditions:

(1) If the dependent is a full-time student, ~~aged 19 years and one month~~ through the end of the month following the student's 26th ~~birthday,~~birthday. As used in this section, a full-time student is a student who is pursuing a course of study that represents at least the normal workload of a full-time student at a school or college accredited by the state of jurisdiction. In accordance with applicable federal law, coverage of a full-time student that loses full-time status due to illness may be extended for one year from the effective date of the loss of full-time status provided that the student was enrolled at the time of the onset of the illness.

(2) The dependent is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and (i) such handicap developed or began to develop before the dependent's 19th birthday, or (ii) such handicap developed or began to develop before the dependent's 26th birthday if the dependent was covered by the Plan in accordance with G.S. 135-45.2(5)a."

SECTION 3.(c) Waiting periods subject to federal law. – G.S. 135-45.3(b) reads as rewritten:

"(b) ~~"Newly~~ Except as otherwise required by applicable federal law, newly acquired dependents (spouse/child) enrolled within 30 days of becoming an eligible dependent will not be subject to the 12-month waiting period for preexisting conditions. A dependent can become qualified due to marriage, adoption, entering a foster child relationship, due to the divorce of a dependent child or the death of the spouse of a dependent child, and at the beginning of each legislative session (applies only to enrolled legislators). Effective date for newly acquired dependents if application was made within the 30 days can be the first day of the following month. Effective date for an adopted child can be date of adoption, or date of placement in the adoptive parents' home, or the first of the month following the date of adoption or placement. Firefighters, rescue squad workers, and members of the national guard, and their eligible dependents, are subject to the same terms and conditions as are new employees and their dependents covered by this subdivision. Enrollments in these circumstances must occur within 30 days of eligibility to enroll."

SECTION 3.(d) G.S. 135-45.4(b)(5) reads as rewritten:

"(5) To administer the 12-month waiting period for preexisting conditions under this that Article, the Plan must give credit against the 12-month period for the time a person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 63 days before the effective date of coverage. As used in this subdivision, a "previous plan" means any policy, certificate, contract, or any other arrangement provided by any accident and health insurer, any hospital or medical service corporation, any health maintenance organization, any preferred provider organization, any multiple employer welfare arrangement, any self-insured health benefit arrangement, any governmental health benefit or health care plan or program, or any other health benefit arrangement. Waiting periods for preexisting conditions administered under this Article are subject to applicable federal law."

SECTION 3.(e) Eligibility audit. – The Executive Administrator shall provide for an audit of dependent eligibility under the Plan. The audit shall be designed to determine whether all dependents currently covered under the Plan are eligible for coverage under current law. Upon identification of an individual who is enrolled as a dependent but not eligible, the Plan shall disenroll the ineligible dependent effective within 10 days of sending written termination notice to the employee. The notice shall state the date upon which disenrollment will become effective and the basis on which the determination of dependent ineligibility is made. Notwithstanding any other provision of law, the Executive Administrator may waive requirements to collect from the member reimbursement for claims paid for the ineligible covered individual.

SECTION 3.(f) Cessation of coverage of ineligible individuals. – G.S. 135-45.12 is amended by adding the following new subdivision to read:

"(8) The last day of the month in which a covered individual is found to be ineligible for coverage."

SECTION 3.(g) Documentation of dependent eligibility. – G.S. 135-45.3 is amended by adding the following new subsection to read:

"(c) When an eligible or enrolled member applies to enroll the member's eligible dependent child or spouse, the member shall provide the documentation required by the Plan to verify the dependent's eligibility for coverage."

PART FOUR: NC HEALTH CHOICE CHANGES.

SECTION 4.(a) Over-the-counter medications. – Coverage of over-the-counter medication authorized under G.S. 108A-70.21(d) for the NC Health Choice Program shall

become effective on the later of July 1, 2010, or the date upon which the Department of Health and Human Services assumes full responsibility for administration and processing of claims under the NC Health Choice Program.

SECTION 4.(b) Subrogation. – For the period authorized under subsection (a) of this section, the right of subrogation under G.S. 108A-57 applies to the State Health Plan for payments made by the Plan under the NC Health Choice Program. This subsection expires on the later of July 1, 2010, or the date upon which the Department of Health and Human Services assumes full responsibility for administration, processing, and payment of claims under the NC Health Choice Program.

SECTION 4.(c) DHHS Subrogation under NC Health Choice. – G.S. 108A-57 is amended by adding the following new subsection to read:

"(c) This section applies to the administration of and claims payments made by the Department of Health and Human Services under the NC Health Choice Program established under Part 8 of this Article."

SECTION 4.(d) G.S. 108A-70.21(g) reads as rewritten:

"(g) Purchase of Extended Coverage. – An enrollee in the Program who loses eligibility due to an increase in family income above two hundred ~~fifty percent (250%)~~percent (200%) of the federal poverty level and up to and including two hundred ~~seventy-five percent (275%)~~ twenty-five percent (225%) of the federal poverty level may purchase at full premium cost continued coverage under the Program for a period not to exceed one year beginning on the date the enrollee becomes ineligible under the income requirements for the Program. The benefits, copayments, and other conditions of enrollment under the Program applicable to extended coverage purchased under this subsection shall be the same as those applicable to an NC Kids' Care enrollee whose family income equals two hundred ~~fifty percent (250%)~~ percent (200%) of the federal poverty level."

PART FIVE: OTHER CHANGES.

SECTION 5.(a) G.S. 135-45.4(b)(2) reads as rewritten:

"(2) Employees not enrolling or not adding dependents when first eligible may enroll later on the first of any following month, but will be subject to a twelve-month waiting period for preexisting conditions except as provided in subdivision (a)(3) of this section. The waiting period under this subdivision is subject to applicable federal law."

SECTION 5.(b) Utilization management functions. – G.S. 135-44.4 is amended by adding the following new subdivisions to read:

"(13a) The Plan and its pharmacy benefit manager may implement and administer pharmacy and medical utilization management programs and programs to detect and address utilization abuse of benefits.

...

(29) For transplant and bariatric medical procedures, the Plan may restrict coverage to certain in-network providers that are designated by the Plan's claims processing contractor."

SECTION 5.(c) G.S. 135-44.1(b) reads as rewritten:

"(b) ~~Six~~ A majority of the members of the Board of Trustees in office shall constitute a quorum. Decisions of the Board of Trustees shall be made by a majority vote of the Trustees present, except as otherwise provided in this Part."

SECTION 5.(d) G.S. 135-45.9(b) reads as rewritten:

"(b) Notwithstanding any other provision of this Part, the following necessary services for the care and treatment of chemical dependency and mental illness shall be covered as provided in this section: allowable institutional and professional charges for inpatient care, outpatient care, intensive outpatient program services, partial hospitalization treatment, and residential care and treatment:

(1) For mental illness treatment:
a. Licensed psychiatric ~~hospitals;~~ hospitals or State psychiatric hospitals accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
b. Licensed psychiatric beds in licensed general hospitals;
c. Licensed residential treatment facilities that have 24-hour on-site care provided by a registered nurse who is physically located at the facility at all times and that hold current accreditation by a national accrediting body approved by the Plan's mental health case manager;
d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities or County Programs in accordance with G.S. 122C-141;
e. Licensed intensive outpatient treatment programs; and
f. Licensed partial hospitalization programs.

(2) For chemical dependency treatment:
a. Licensed chemical dependency units in licensed psychiatric ~~hospitals;~~ hospitals or in State psychiatric hospitals accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
b. Licensed chemical dependency hospitals;
c. Licensed chemical dependency treatment facilities;
d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities or County Programs in accordance with G.S. 122C-141;
e. Licensed intensive outpatient treatment programs;
f. Licensed partial hospitalization programs; and
g. Medical detoxification facilities or units."

SECTION 5.(e) Section 28.22A(k) of S.L. 2007-323 reads as rewritten:

"**SECTION 28.22A.(k)** Subsection (j) of this section expires ~~June 30, 2009.~~ June 30, 2011."

SECTION 5.(f) G.S. 135-43(b) reads as rewritten:

"(b) Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees may contract with providers of institutional and professional medical care and services to establish preferred provider networks.

~~The terms pertaining to reimbursement rates or other terms of consideration of any contract between hospitals, hospital authorities, doctors, or other medical providers, or a pharmacy benefit manager and the Plan, or contracts pertaining to the provision of any medical benefit offered under the Plan, including its optional alternative comprehensive benefit plans, and programs available under the optional alternative plans, shall not be a public record under Chapter 132 of the General Statutes for a period of 30 months after the date of the expiration of the contract.~~ The terms of a contract between the Plan and its third party administrator or between the Plan and its pharmacy benefit manager are a public record except that the terms in those contracts that contain trade secrets or proprietary or competitive information are not a public record under Chapter 132 of the General Statutes and any such proprietary or competitive information and trade secrets contained in the contract shall be redacted by the Plan prior to making it available to the public. ~~Provided, however, nothing in this subsection shall be deemed to~~This subsection shall not be construed to prevent or restrict the release of any information made not a public record under this subsection to the State Auditor, the Attorney General, the Director of the State Budget, the Plan's Executive Administrator, ~~the Department of Health and Human Services solely for the purpose of implementing the transition of NC Health Choice from the Plan to the Department of Health and Human Services,~~ and the

Committee on Employee Hospital and Medical Benefits solely and exclusively for their use in the furtherance of their duties and ~~responsibilities.~~responsibilities, and to the Department of Health and Human Services solely for the purpose of implementing the transition of NC Health Choice from the Plan to the Department of Health and Human Services. The design, adoption, and implementation of the preferred provider contracts, networks, and optional alternative comprehensive health benefit plans, and programs available under the optional alternative plans, as authorized under G.S. 135-45 are not subject to the requirements of Chapter 143 of the General Statutes. The Executive Administrator and Board of Trustees shall make reports as requested to the President of the Senate, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Committee on Employee Hospital and Medical Benefits."

PART SIX: SALARY-RELATED CONTRIBUTIONS.

SECTION 6.(a) Effective for the 2009-2011 fiscal biennium, required employer salary-related contributions for employees whose salaries are paid from department, office, institution, or agency receipts shall be paid from the same source as the source of the employees' salary. If an employee's salary is paid in part from the General Fund or Highway Fund and in part from department, office, institution, or agency receipts, required employer salary-related contributions may be paid from the General Fund or Highway Fund only to the extent of the proportionate part paid from the General Fund or Highway Fund in support of the salary of the employee, and the remainder of the employer's requirements shall be paid from the source that supplies the remainder of the employee's salary. The requirements of this section as to source of payment are also applicable to payments on behalf of the employee for hospital-medical benefits, longevity pay, unemployment compensation, accumulated leave, workers' compensation, severance pay, separation allowances, and applicable disability income benefits.

Notwithstanding any other provision of law, an employing unit that is subject to Part 3A of Article 3A of Chapter 135 of the General Statutes and that hires or has hired as an employee a retiree that is in receipt of monthly retirement benefits from any retirement system supported in whole or in part by contributions of the State shall enroll the retiree in the active group and pay the cost for the hospital-medical benefits if that retiree is employed in a position that would require the employer to pay hospital-medical benefits if the individual had not been retired.

SECTION 6.(b) Effective July 1, 2009, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2009-2010 fiscal year are: (i) eight and forty-four hundredths percent (8.44%) – Teachers and State Employees; (ii) thirteen and forty-four hundredths percent (13.44%) – State Law Enforcement Officers; (iii) eleven and seventy-six hundredths percent (11.76%) – University Employees' Optional Retirement System; (iv) eleven and seventy-six hundredths percent (11.76%) – Community College Optional Retirement Program; (v) seventeen and sixty-one hundredths percent (17.61%) – Consolidated Judicial Retirement System; and (vi) four and forty hundredths percent (4.40%) – Legislative Retirement System. Each of the foregoing contribution rates includes four and forty hundredths percent (4.40%) for hospital and medical benefits. The rate for Teachers and State Employees, State Law Enforcement Officers, Community College Optional Retirement Program, and for the University Employees' Optional Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

SECTION 6.(c) Effective July 1, 2010, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2010-2011 fiscal year are: (i) eight and eighty-four hundredths percent (8.84%) – Teachers and State

Employees; (ii) thirteen and eighty-four hundredths percent (13.84%) – State Law Enforcement Officers; (iii) twelve and sixteen hundredths percent (12.16%) – University Employees' Optional Retirement System; (iv) twelve and sixteen hundredths percent (12.16%) – Community College Optional Retirement Program; (v) eighteen and one hundredths percent (18.01%) – Consolidated Judicial Retirement System; and (vi) four and eighty hundredths percent (4.80%) – Legislative Retirement System. Each of the foregoing contribution rates includes four and eighty hundredths percent (4.80%) for hospital and medical benefits. The rate for Teachers and State Employees, State Law Enforcement Officers, Community College Optional Retirement Program, and for the University Employees' Optional Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

SECTION 6.(d) Effective July 1, 2009, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2009-2010 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand four hundred thirty-eight dollars ($3,438) and (ii) non-Medicare-eligible employees and retirees – four thousand five hundred fifteen dollars ($4,515).

SECTION 6.(e) Effective July 1, 2010, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2010-2011 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand seven hundred thirty-five dollars ($3,735) and (ii) non-Medicare-eligible employees and retirees – four thousand nine hundred five dollars ($4,905).

PART SEVEN: EFFECTIVE DATE.

SECTION 7. Sections 1(b), 1(c), 1(d), 2(c) through (e), 2(g), and 2(h) of this act become effective July 1, 2009. Section 4(d) of this act applies to applications for the purchase of extended coverage made on and after July 1, 2008. The remainder of this act is effective when it becomes law.

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668 Link Road
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March 25, 2009

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Senate Bill 287 (Third Edition): An Act to Appropriate Funds for the State Health Plan and to Make Other Changes to the State Health Plan

Dear Mr. Trogdon:

The third edition of this bill, engrossed March 24, 2009, appropriates funds and makes various changes to the North Carolina State Health Plan for Teachers and State Employees (the "Plan"). Unless otherwise noted, these changes are effective July 1, 2009.

The proposed changes to the Plan are as follows:

1. Increase the member copayments for outpatient prescription drugs

	Rx Copays	
	Current	Revised
Preferred Brand	$30	$35
Brand with Generic Equivalent	$40	Generic copayment plus the difference in the allowed cost of the brand and the allowed cost of the generic
Non-preferred Brand	$50	$55
Specialty Drugs	$30-$50	25% of allowed cost, not to exceed $100

The bill, as amended, defines specialty drugs as covered biotech medications or other medications classified as specialty by the Plan that are significantly more expensive than other therapies. These are to be drugs that have unique uses to treat complex diseases and require special dosing or handling and exceed $400 cost to the Plan per prescription. Specialty drugs under the pharmacy benefit are to be provided through a specialty pharmacy vendor under contract with the Plan.

2. Reduce the maximum prescription drug supply for purposes of member copayments from 34 days to 30 days

3. Increase the member copayments for hospitalization and office visits

	Member Copayments			
	PPO Standard		PPO Basic	
	Current	Revised	Current	Revised
Primary Care	$20	$25	$25	$30
Specialist	$40	$60	$50	$70
Urgent Care	$50	$75	$75	$75
Inpatient	$150	$200	$200	$250

4. Remove coverage for routine eye exams, effective January 1, 2010

5. Increase the member deductible and coinsurance maximums

	Member Deductible and Coinsurance			
	PPO Standard		PPO Basic	
	Current	Revised	Current	Revised
Deductible In/Out Network	$300/$600	$600/$1200	$600/$1200	$800/$1600
Coinsurance Maximum	$1,750/ $3,500	$2,750/ $5,500	$2,500/ $5,000	$3,250/ $6,500

The maximum annual deductible and coinsurance for members with dependent coverage remains at three times the member-only limits.

6. Pharmacy benefit savings
   The Plan is to direct its pharmacy benefit manager to achieve savings of $18,000,000 in the 2009-2010 fiscal year and $20,000,000 in the 2010-2011 fiscal year through reduced reimbursements paid to pharmacies for prescription drugs. Reimbursement rates are to be reviewed twice annually and adjusted if the actual savings exceed 105% of the above targets. Savings are measured from the Plan's Financial Projects as of March 20, 2009.

7. Eliminate the current PPO Plus option

8. Implement two wellness initiatives
   A smoking cessation program, effective July 1, 2010, would require all members who use tobacco and do not have Medicare as their primary coverage to enroll in the PPO Basic option. A weight management program, effective July 1, 2011, would require all members who do not meet healthy weight guidelines and do not have Medicare as their primary coverage to enroll in the PPO Basic option.

9. Make clarifying and technical corrections related to member eligibility, Plan coverage, and approved providers

I have valued the financial impact on the Plan of each benefit change described in items 1 through 5 above, and the estimated savings are itemized in the table below. The level of appropriations to the Plan and the premium increases included in this bill are not part of my analysis, nor is the Plan's ability to achieve the pharmacy benefit savings. Elimination of the

PPO Plus Option has been included by the Plan in determining the baseline funding needs, so I have not included itemization of the impact of that change. No impact is included for the wellness initiatives, since program parameters and administrative costs have not yet been determined. Also, no financial impact is estimated for the clarifying and technical corrections.

The estimated savings to the Plan for each benefit change is shown in the following chart for the next two fiscal years:

	Estimated Savings for Fiscal Year Beginning	
Component	July 1, 2009	July 1, 2010
Primary Care Copay	$ 8,116,000	$ 9,257,000
Specialist Copay	27,125,000	31,713,000
Urgent Care Copay	854,000	994,000
Inpatient Copay	1,970,000	2,247,000
Routine Eye Exam Coverage	2,540,000	7,039,000
Deductible & Coinsurance	78,079,000	92,463,000
Preferred Brand Copay	12,010,000	11,741,000
Brand w/ Generic Equiv. Copay	6,285,000	6,536,000
Non-Preferred Brand Copay	3,530,000	3,671,000
Specialty Drug Copay	1,471,000	1,530,000
Decrease 34-day Supply to 30-days	2,190,000	2,277,000
Specialty Drug Contract Change	1,665,000	1,887,000
Total Savings	$145,835,000	$171,355,000

As noted above, the impact of eliminating the PPO Plus option effective July 1, 2009 was included in the Plan's baseline funding projection. Thus, it is not included in the above table. I have estimated the net impact of removing this option will be cost neutral. This results from a loss of member premiums of approximately $42.1 million per year, and a reduction in net plan benefits of the same amount.

The savings estimates shown above are based on analysis of medical and prescription drug claims information for the Plan. Data was primarily used from fiscal years 2008 and 2009 to date. These projections assume that the members currently covered under the PPO Plus option will elect the PPO Standard option. The data and assumptions used in this analysis are outlined in Attachment #1.

Projected savings include a two-week claim payment lag for prescription drugs and 45-day lag for medical services. The projections also assume the plan membership remains constant at the December 2008 level of 666,809. All projected savings have been discounted with a risk factor, generally 5-10%, as shown in Attachment #1.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, FCA, EA
Consulting Actuary

Actuarial Assumptions and Data

Data Sources:

State Health Plan for Teachers and State Employees
- Charge Summary
- Coinsurance and Deductible Levels – Full Population
- Coinsurance and Deductible Levels – Closed Population
- Copay Report
- Financial Reconciliation Report

The above reports were available for Fiscal Year 2008 and Fiscal Year 2009 through January. Reports are on both a paid and an incurred basis.

SHP Distribution of Participants by Age and Gender

State of NC Rx Drug Pull – 1st half FY2009
State of NC Rx Drugs – FY 2007/FY2008

Data Summary:

Distribution of Claims Active Members			
Allowed Charges </=	Percent of Members		
	Standard	Basic	Plus
$0	62.55%	64.71%	40.24%
$100	2.30%	2.71%	2.55%
$200	2.34%	4.07%	2.80%
$300	2.07%	1.58%	2.57%
$400	1.78%	0.90%	2.23%
$500	1.45%	1.36%	1.67%
$600	1.09%	0.90%	1.52%
$700	0.96%	1.36%	1.54%
$800	1.02%	0.90%	1.45%
$900	0.92%	1.58%	1.30%
$1,000	0.85%	0.23%	1.25%
$1,500	3.83%	3.62%	5.16%
$2,000	2.56%	1.58%	4.23%
$2,500	1.73%	2.49%	2.97%
$3,000	1.42%	0.90%	2.49%
$5,000	3.54%	2.94%	6.33%
$10,000	4.91%	4.75%	9.15%
$20,000	3.05%	2.04%	6.18%
$9,999,999	1.64%	1.36%	4.38%
Total	100.00%	100.00%	100.00%

Includes only claims subject to deductible and coinsurance
Separate distributions used for Medicare and non-Medicare retirees

Office Visit Rates PPO Standard FY2008				
Status	Type	Visit Rate Per Member	Copay Increases	Effective Rate
Active Employee	Primary Care	2.87	5	100.0%
	Specialist	2.17	20	98.7%
	Urgent Care	0.08	25	98.4%
	Inpatient	0.05	50	97.7%
	Routine Eye	0.19	n/a	n/a
Medicare Eligible Retiree	Primary Care	3.78	5	70.0%
	Specialist	5.87	20	25.0%
	Urgent Care	0.06	25	15.0%
	Inpatient	0.23	50	65.0%
	Routine Eye	0.04	n/a	n/a
Non-Medicare Retirees	Primary Care	3.24	5	100.0%
	Specialist	3.89	20	98.3%
	Urgent Care	0.06	25	96.7%
	Inpatient	0.06	50	95.7%
	Routine Eye	0.25	n/a	n/a

Separate rates used for PPO Basic and Plus.

Prescription Drug Data Summary July – December 2008			
Category	Rx Count	Gross Cost	Member Copay
Single Source Preferred Brand	1,517,485	$240,708,957	$49,186,024
Single Source Non-Preferred Brand	419,651	69,475,149	20,891,702
Multi Source Brand	167,344	12,811,482	5,690,735
Generic	3,897,258	106,199,847	40,728,123
TOTAL	6,001,738	$429,195,435	$116,496,583

Specialty Drug Data Summary July 2007– June 2008			
Category	Rx Count	Gross Cost	Member Copay
Outpatient Specialty Drugs	43,615	$88,891,916	$2,250,965

Membership:

Distribution by Option and Status				
Status	Standard	Basic	Plus	Total
Active Employee	380,833	31,204	75,109	487,146
Medicare Eligible Retiree	90,918	1,350	11,604	103,872
Non-Medicare Retirees	50.910	1,472	9,667	62,049
Total	522,661	34,026	96,380	653,067

This represents the average membership within each category for the second quarter of Fiscal Year 2009.

Actuarial Assumptions and Methods:

Medical Claim Trends

Office Visit & Inpatient Annual Utilization Trends	
Category	Percent
Primary Care	0.0%
Specialist	2.5%
Urgent Care	1.0%
Inpatient	0.0%

Annual Price Increase: 5.0%

Prescription Drugs

Prescription Drugs Annual Trend Assumptions		
Component	Generic	Brand
Utilization	3.0%	-3.0%
Price	6.0%	9.0%

Maintenance Drugs Percent of Non-Specialty Scripts	
Tier	Percent
Generic	70.4%
Single Source Preferred	92.1%
Other Brand	85.1%
Total	77.3%

Percent of Rx currently at 3-month Supply: 5.0%
Members Meeting $2,500 OOP Max: 5,000
Brand Copay Increase Realization Rate: 92.0%

Specialty Drugs

Savings for the Specialty Drug Contract Change are based on proposed additional discounts the Plan may obtain under an exclusive contract with a specialty pharmacy vendor. While these savings reflect proposed larger discounts, I note that over 60% of the savings is due to six specialty drugs. Thus, this amount could change dramatically with any price or utilization changes in these drugs, and a higher risk factor was applied to this category.

The savings due to the increased member copay on specialty drugs was estimated by analyzing the specialty drug claims from fiscal year 2008. Approximately 85% of these prescriptions are in the non-preferred brand tier. To avoid double counting the effect of the $5 copay increase for that tier and to

account for the $2,500 out of pocket maximum for prescriptions, a 67% realization factor was applied to the increased copayments in this category.

Risk Factors

Estimated savings were reduced by the risk factors shown below. This provides a margin for adverse deviation and reflects data limitations. In particular, both the projection period and the periods of available data contain significant movement of members between plan options, increasing the likelihood that future experience will not follow past patterns. The risk factors also reflect any conservatism inherent in other assumptions.

Risk Factors	
Category	Percent
Medical Copays	5.0%
Deductible/Coinsurance	5.0%
SS Brand Copays	5.0%
Multi Source Rx Copay	10.0%
Specialty Rx Copay	5.0%
Specialty Rx Contract	20.0%
30 Day Supply Limit	10.0%

CORRECTED NOTICE

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION
(Remove HB 426 and add SB 287

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

DAY & DATE: **Thursday, March 26, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

(Continued Discussion on HB 426)

SB 287 – STATE HEALTH PLAN $/GOOD HEALTH INITIATIVES – Senator Tony Rand

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at **1:00 pm** on **March 24, 2009.**

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

VISITOR REGISTRATION SHEET

House Committee on Insurance — 3/26/09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amy McConkey	Smith Anderson
Michelle Frazier	MFS
Cam Cover	BPMHL
Bill Johnston	ACB
Bill Rustin	ACP
Elizabeth Dalton	NCRMA
Andy Ellen	NCRMA
Rick Kaylor	Kaylor Cone Frazier
Dana Sipes	Smith Anderson
Joanne Stevens	Stevens
David Barnes	Pryor Sparrill

VISITOR REGISTRATION SHEET

House Committee on Insurance — March 26, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jim Crouch	NCBA
Jon Peter	NCEOA
Paige Johnson	Planned Parenthood
E Vaga	UNC TV
Christine Cray	WakeMed

VISITOR REGISTRATION SHEET

House Committee on Insurance — **Name of Committee**

March 26, 2009 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Gary Robertson	AP
Becki Gray	John Locke Foundation
Lori Ann Harris	LA HA
Hubert Wilson	NCHA
Gary Salamido	GSK
Patty Meyer	
Chip Baggett	NCMS
Chris Hollis	Kirk Gates
Kristi Huff	NCHCFA
Steve Shaw	NC Pediatric Society
Jonathan Liles	Rep. Crawford

VISITOR REGISTRATION SHEET

House Committee on Insurance — March 26, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	ACSR
Harrison Gilbert	Governor's Office
Ellen Sprenkel	NC DOT
Evelyn Hawthorne	DHHR
Carol Vandenbergh	PENC
Katherine Joyce	NCASA
Emily Doyle	NCPAPA
Mary Alice Bell	SEANC
[signature]	WCPSS
C. Brockett	NCSBA
Ed Regan	NCRGEA

VISITOR REGISTRATION SHEET

House Committee on Insurance — March 26, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lorraine Munk	State Health Plan
Linda McCrudden	State Health Plan
Tracy Stephenson	State Health Plan
Anne Rogers	State Health Plan
Lacey Barnes	State Hlth. Plan
Jack W. Walker	State Hlth Plan
Mona Moon	SHP
Chris Fitzsimon	NC Policy Watch
David Boaz	NWC
Patrick Buffkin	NMRS
Dan Lunn	NW

VISITOR REGISTRATION SHEET

House Committee on Insurance

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Marvin Musselwhite	Pepsi Spirit
Chuck Stone	SEANC
Mitch Leonard	SEANC
Dick Barnes	OSA
Ken Mc	CFSA-NC
MR MANN	CNC
Marc Hall	SEANC
Mark Dearman	SEANC
Elizabeth Thompson	DNC

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Maria Wilding	Novant Health
Zeb Spector	UNC Pediatrics
Stephanie Nantz	YAIO
Kathryn Millican	
Erica Stevenson	
Henry Taylor	
George Lassiter	
Akdis Watkins	SEANC
Faye Childers	SEANC
Suzanne Beasley Malysz	SEANC
Jim Stegall	UCPS.

House Pages

Name Of Committee: Insurance Date: 4/26/09

1. Name: Demetrius Tyson
   County: Moore County
   Sponsor: Will Newman
2. Name: Christa Taylor
   County: Robeson
   Sponsor: Mr. Pierce
3. Name: Destiny Bullock
   County: Pitt
   Sponsor: Warren E.
4. Name: _____
   County: _____
   Sponsor: _____
5. Name: _____
   County: _____
   Sponsor: _____

Sgt-At-Arms

1. Name: Martha Gadison
2. Name: Trey Raley
3. Name: Rod Zeiger
4. Name: Charles Williams

2009-2010

HOUSE INSURANCE

MINUTES

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 2, 2009

The House Committee on Insurance met at 11:00 AM on Thursday, April 2, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael H. Wray; Vice Chairs: M. Dickson, J. Dockham and M. Setzer. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Cole, Current, Faison, Gibson, Holliman, Howard, Hughes, Pierce and Wainwright.

Chairman Wray called the meeting to order and welcomed visitors. He recognized Sgt-At-Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachment #1)

Chairman Wray stated that the committee had requested that Mr. Bob Greczyn, chief executive officer of Blue Cross and Blue Shield, come before the committee to discuss the State Health Plan. After questions the committee will move forward on amendments, and actuarial notes are required for the amendments. We will recess at 11:50 and immediately after session we will continue to debate the bill.

Mr. Bob Greczyn stated on behalf of the state of North Carolina Blue Cross and Blue Shield administers the State Health Plan, which covers teaches, state employee, retirees and their dependents and have been doing so for more than 20 years. Of every dollar paid out by the State Health Plan, 94 cents pays for hospitals, doctors and other health are providers. We do not set the plan's budget, make financial projections or perform actuarial services for the State Health Plan. We administer the plan based on the state's direction. We have partnered with you not just on the State Health Plan but also on the patients' bill of rights, the high-risk pool and mental health parity. We look forward to our continued work with you. (Attachment #2)

Chairman Wray stated the committee will take up SB 287-State Hlth Plan $/Good Health Initiatives and asked members to send forth amendments. He recognized Rep. Howard to explain her amendment (Attachment #3) which amends the third edition of SB 287 by excluding cancer drugs from the provision in Section 2(c) of the bill requiring specialty drugs to be provided through an exclusive specialty pharmacy vendor. Rep. Holliman moved to support the amendment and Rep. Howard moved the amendment be accepted, it was seconded and it carried.

Rep. Faison was recognized to explain his amendment (Attachment #4). His amendment would address the problem of younger people not joining the State Health Plan and lowering the cost for everyone in part because we are running the plan on a fiscal year instead of a calendar year. The amendment requires an actuarial note and he requested the note two weeks ago. He moved that we suspend the rules which require us to have an actuarial note in hand so that we may consider this amendment with the understanding that the amendment would be available in a week to go with the bill as it goes to Appropriations for further consideration. Rep. Holliman said we decided today where we can do the calendar year and we decided on January 2011. He agrees that we need to suspend the rules, vote on the amendment, and take care of it in Appropriations. He seconded the motion for the amendment. Rep. Blust called for the ayes and noes on the motion. The vote was unanimous. Under the suspended rules, Rep. Faison moved

for adoption of his amendment which would begin January 1, 2011 changing the plan from a fiscal year to an annual year for its premium base.

Mr. Jack Walker, Executive Administrator, State Health Plan, stated he is in favor of going to a calendar year. A vote was taken, and the amendment passed.

Rep. Cole was recognized to explain his amendment (Attachment #5) amends the third edition of SB 287 by allowing any retail pharmacy to dispense any specialty drug at the same price as determined by a specialty drug vendor authorized under Section 2 (c) of the bill. He knows of no fiscal impact, and Rep. Holliman supports the amendment. A vote was taken, and the amendment passed.

Rep. Cole explained another amendment (Attachment #6) which allows a specialty pharmacy vendor. Specialty medications are covered biotech medications and other medications designated and classified by the Plan as specialty medications that are significantly more expensive than alternative drugs or therapies. It has no impact from an actuarial sense, and he moved for adoption of the amendment. Rep. Holliman supports the amendment. A vote was taken, and the amendment passed.

Rep. Cole continued with an amendment (Attachment #7) that speaks to required disclosure. It is important we be able to get from the pharmacy benefit managers the actual cost of the drug versus what they charge us. There is no actuarial note. Rep. Holliman thinks the amendment is good but he wants to be sure it does apply to the current contract. He asked Dr. Jack Walker to speak to the amendment. Dr. Walker stated he had no objection as long as it does not apply to the current contract. A vote was taken, and the amendment passed.

The committee recessed at 11:50 AM and will continue after Session today.

Representative Michael H. Wray, Chairman

Mary Capps

Mary Capps – Committee Assistant

HOUSE INSURANCE COMMITTEE

April 2, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

SB 287 – State Health Plan $/Good Health Initiatives
Senator Tony Rand

(Continued Discussion)

Adjourn

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 3

SENATE BILL 287

Select Committee on Employee Hospital and Medical Benefits Committee Substitute Adopted 3/10/09
Third Edition Engrossed 3/24/09

Short Title: State Hlth Plan $/Good Health Initiatives. (Public)

Sponsors:

Referred to:

February 25, 2009

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES AND TO MAKE OTHER CHANGES RELATED TO THE STATE HEALTH PLAN.

Whereas, the General Assembly must act quickly and prudently to maintain a financially stable State Health Plan to ensure that all members of the Plan have affordable access to medically necessary health benefits and services within available resources; and

Whereas, in order to meet current fiscal obligations the General Assembly must appropriate $250,000,000 for the 2008-2009 fiscal year to cover the current year shortfall in funds; and

Whereas, estimates indicate that a substantially larger appropriation will be necessary to maintain the fiscal integrity of the Plan in the next and ensuing fiscal periods; and

Whereas, in order to ensure continued access to medically necessary health care to Plan members, the Plan must implement measures to contain costs through premium increases, benefit changes, and healthy lifestyle programs that not only reduce costs but improve member health; and

Whereas, the Plan estimates that over 70,000 Plan members use tobacco, resulting in a cost to the Plan of $2,000 per member per year more than the cost of providing coverage for nonusers of tobacco; and

Whereas, over 60% of North Carolina adults are obese or overweight; and

Whereas, obesity is linked to an over 37% increase in health care spending at a cost of $2,445 per member per year; and

Whereas, weight management and cessation of tobacco use have been demonstrated to result in improved member health and substantial savings in health care costs making it fiscally prudent to implement smoking cessation and weight management incentives and initiatives with mechanisms to verify member compliance with smoking cessation and weight management requirements; Now, therefore,

The General Assembly of North Carolina enacts:

PART ONE: APPROPRIATIONS, DEFINITIONS, AND SCOPE.

SECTION 1.(a) Appropriation for 2008-2009 fiscal year. – There is appropriated from the Savings Reserve Account established in G.S. 143C-4-2 to the Health Benefit Reserve Fund established in G.S. 135-44.5 the sum of two hundred fifty million dollars ($250,000,000) for the 2008-2009 fiscal year. These funds shall be used to address the shortfall in funds

available for the payment of health care and administrative costs under the State Health Plan for Teachers and State Employees ("Plan") for the 2008-2009 fiscal year.

SECTION 1.(b) General Fund appropriation for 2009-2011 fiscal biennium. – Notwithstanding G.S. 143C-5-2, there is appropriated from the General Fund to the Reserve for the State Health Plan in the Office of State Budget and Management the sum of one hundred twenty-eight million four hundred ten thousand two hundred eight dollars ($128,410,208) for the 2009-2010 fiscal year and the sum of two hundred sixty-seven million nine hundred four thousand one hundred fourteen dollars ($267,904,114) for the 2010-2011 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2009-2011 fiscal biennium.

SECTION 1.(c) Highway Fund appropriation for the 2009-2011 fiscal biennium. – Notwithstanding G.S. 143C-5-2, there is appropriated from the Highway Fund to the Reserve for the State Health Plan in the Office of State Budget and Management the sum of five million nine hundred ninety-two thousand four hundred seventy-six dollars ($5,992,476) for the 2009-2010 fiscal year and the sum of twelve million five hundred two thousand one hundred ninety-two dollars ($12,502,192) for the 2010-2011 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2009-2011 fiscal biennium.

SECTION 1.(d) All other agency funds required to fund the premium increase enacted in this act, other than funds appropriated in subsections (b) and (c) of this section, are appropriated for the 2009-2011 fiscal biennium.

SECTION 1.(e) Definitions. – As used in this act unless the context clearly requires otherwise:

(1) "Plan." – The State Health Plan for Teachers and State Employees.

(2) "Basic plan." – The Plan's PPO option providing for 70/30 in-network coverage after deductibles and co-payments.

(3) "Smoking" or "Smoking cessation." – Includes cessation of the use of all tobacco products.

(4) "Standard plan." – The Plan's PPO option providing for 80/20 in-network coverage after deductibles and co-payments.

SECTION 1.(f) Scope. – In the event of a conflict between the provisions of this act and Article 3A of Chapter 135 of the General Statutes, this act prevails.

PART TWO: HEALTH BENEFIT CHANGES.

SECTION 2.(a) Eliminate PPO Plus Option. – Effective July 1, 2009, the PPO Plus option (90/10 in-network coverage) under the State Health Plan for Teachers and State Employees ("Plan") is eliminated. The Executive Administrator shall provide notice to all members of the Plan that this option will no longer be available as of July 1, 2009. Employees enrolled in the Plan's Plus option shall have the choice of enrolling in the Basic or Standard plan options for the 2009-2010 benefit year.

SECTION 2.(b) Implement Comprehensive Wellness Initiative.

(1) Program development. – The Plan shall develop a Comprehensive Wellness Initiative that includes a focus on smoking cessation and weight management and that is designed to be implemented effective July 1, 2010, for smoking cessation and July 1, 2011, for weight management. Benefit levels shall be determined by the Plan based upon tobacco use or the inability of the member to meet national, evidence-based healthy weight clinical guidelines. For purposes of the Comprehensive Wellness Initiative, "member" includes all State Health Plan primary subscribers and their covered dependents. The Plan shall develop a process whereby a Plan member may appeal the Plan's basis for action it takes due to the member's failure or refusal to comply with the Plan's smoking cessation or weight management requirements.

(2) Smoking cessation. – Effective July 1, 2010, all members of the Plan who do not have Medicare as their primary coverage shall be enrolled in the Basic Plan under the Plan's PPO unless the subscriber can attest that the subscriber or any qualifying dependent does not smoke or otherwise use tobacco products. The Plan shall develop a mechanism for verifying that the member does not smoke or use other tobacco products. Tobacco use will be reassessed annually at the time of Plan enrollment. All subscribers who have attested that neither they nor their dependents use tobacco, or whose physician certifies in writing that the member is participating in a smoking cessation program, shall have the choice of remaining in the Basic plan option or enrolling in the Standard plan option. For purposes of the smoking cessation initiative, "member" includes all members covered under the Plan. As used in this section, "smoking cessation program" means active participation in a Plan-approved cessation program to include counseling or use of tobacco cessation medications.

(3) Weight management. – Effective July 1, 2011, all members of the Plan who do not have Medicare as their primary coverage shall be enrolled in the Basic Plan under the Plan's PPO Plan unless the subscriber attests that the weight and height ratio of the member is within a range determined by the Plan based on evidence-based healthy weight clinical guidelines, or unless the member's physician certifies in writing that the member has a medical condition that prevents the attainment of the specified weight range or that the member is actively participating in a Plan-approved weight management program. In either case, the member shall have the option to enroll in the Basic or Standard Plan.

Not later than October 1, 2009, the Executive Administrator shall inform Plan members of the healthy lifestyle initiatives, requirements for compliance, and consequences of noncompliance. The Executive Administrator shall provide to members education and training to assist members in complying with healthy lifestyle initiatives. The Executive Administrator may implement incentive initiatives to further encourage member achievement in smoking cessation, weight management, and other integrated health management programs.

The Executive Administrator shall report to the Committee on Employee Hospital and Medical Benefits recommendations the Plan may have for additional sanctions that may be imposed when the Executive Administrator finds that a member intentionally makes a false statement on a Plan document.

SECTION 2.(c) Prescription drug co-payments. – G.S. 135-45.6(b) reads as rewritten:

"(b) Prescription Drugs. – The Plan's allowable charges for prescription legend drugs to be used outside of a hospital or skilled nursing facility shall be as determined by the Plan's Executive Administrator and Board of Trustees, which determinations are not subject to appeal under Article 3 of Chapter 150B of the General Statutes. Co-payments and other allowable charges or coverage for prescription drugs shall be as follows:

(1) The Plan will pay allowable charges for each outpatient prescription drug less a copayment to be paid by each covered individual equal to the following amounts: pharmacy charges up to ten dollars ($10.00) for each generic prescription, ~~thirty dollars ($30.00)~~ thirty-five dollars ($35.00) for each preferred branded prescription without a generic equivalent, ~~and forty dollars ($40.00) for each preferred branded prescription with a generic equivalent drug,~~ and ~~fifty dollars ($50.00)~~ fifty-five dollars ($55.00) for each nonpreferred branded ~~or generic~~ prescription. For each branded prescription drug with a generic equivalent drug, the member shall pay the generic

co-payment plus the difference between the Plan's gross allowed cost for the generic prescription and the Plan's cost for the branded prescription drug.

(2) The Plan shall provide coverage of nonacute specialty medications under the Plan's pharmacy benefit through a specialty pharmacy vendor under contract with the Plan. The Plan may transfer coverage of specified specialty disease medications covered under the Plan's medical benefit to the contracted specialty pharmacy vendor. Specialty medications are covered biotech medications and other medications designated and classified by the Plan as specialty medications that are typically significantly more expensive than alternative drugs or therapies. Medications classified by the Plan as specialty medications generally have unique uses for the treatment of complex diseases, require special dosing or administration, require special handling, are typically prescribed by a specialist provider, and exceed four hundred dollars ($400.00) cost to the Plan per prescription. The Plan shall impose a co-payment in the amount of Plan per prescription. The Plan shall impose a co-payment in the amount of twenty-five percent (25%) of the Plan's gross allowed cost of the specialty drug not to exceed one hundred dollars ($100.00) per prescription per 30-day supply.

(3) The Plan may exclude coverage of drugs that have therapeutic equivalents that are available over the counter. Before excluding coverage under this subdivision, the Plan shall consult with the Plan's Pharmacy and Therapeutics Committee.

~~These co-paymentsapply to all optional alternative plans available under the Plan.~~

(4) Allowable charges shall not be greater than a pharmacy's usual and customary charge to the general public for a particular prescription. Prescriptions shall be for no more than a ~~34-day~~30-day supply for the purposes of the copayments paid by each covered individual. By accepting the copayments and any remaining allowable charges provided by this subsection, pharmacies shall not balance bill an individual covered by the Plan. A prescription legend drug is defined as an article the label of which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without Prescription." Such articles may not be sold to or purchased by the public without a prescription order. Benefits are provided for insulin even though a prescription is not required. ~~The Plan may use a pharmacy benefit manager to help manage the Plan's outpatient prescription drug coverage. In managing the Plan's outpatient prescription drug benefits, the Plan and its pharmacy benefit manager shall not provide coverage for sexual dysfunction, growth hormone, antiwrinkle, weight loss, and hair growth drugs unless such coverage is medically necessary to the health of the member. The Plan and its pharmacy benefit manager shall not provide coverage for growth hormone and weight loss drugs and antifungal drugs for the treatment of nail fungus and botulinium toxin without approval in advance by the pharmacy benefit manager.~~ The Plan may adopt utilization management procedures for certain drugs, but in no event shall the Plan provide coverage for sexual dysfunction or hair growth drugs or nonmedically necessary drugs used for cosmetic purposes. Any formulary used by the Plan's Executive Administrator and pharmacy benefit manager shall be an open formulary. Plan members shall not be assessed more than two thousand five hundred dollars ($2,500) per person per fiscal year in copayments required by this subsection. The Plan's Pharmacy Benefit

Manager, or any pharmacy or vendor participating in the Plan shall charge the Plan for any prescription legend drug dispensed under the Plan's pharmacy benefit based upon the original National Drug Code (NDC) as established by the manufacturer of the prescription legend drug and published by the United States Food and Drug Administration.

Copayments authorized under this subsection apply to all optional alternative plans available under the Plan."

SECTION 2.(d) Routine eye examinations not covered. – Effective January 1, 2010, G.S. 135-45.8(13) reads as rewritten:

"**§ 135-45.8. General limitations and exclusions.**

The following shall in no event be considered covered expenses nor will benefits described in G.S. 135-45.6 through G.S. 135-45.11 be payable for:

...

(13) Charges for routine eye examinations, eyeglasses or other corrective lenses (except for cataract lenses certified as medically necessary for aphakia persons) and hearing aids or examinations for the prescription or fitting thereof."

SECTION 2.(e) Deductible and co-payment changes. – Effective July 1, 2009, the Executive Administrator shall make the following changes to deductibles, coinsurance maximums, and co-payments under the Basic and Standard PPO Plans:

(1) Basic plan (70/30):

a. Increase the in-network annual deductible to eight hundred dollars ($800.00) for member-only coverage and to one thousand six hundred dollars ($1,600) for the out-of-network annual deductible for member-only coverage.

The aggregate maximum annual deductible for employee-child and employee-family coverage shall be three times the member-only annual deductibles.

b. Increase the in-network coinsurance maximum to three thousand two hundred fifty dollars ($3,250) for member-only coverage and to six thousand five hundred dollars ($6,500) for member-only out-of-network maximum coinsurance. The aggregate maximum coinsurance for employee-child and employee-family coverage shall be three times the member-only coinsurance maximums.

c. Increase the in-network primary care co-payment to thirty dollars ($30.00) per covered individual.

d. Increase the in-network specialist co-payment to seventy dollars ($70.00) per covered individual.

e. Increase the in-network and out-of-network inpatient co-payment to two hundred fifty dollars ($250.00) per covered individual.

f. Increase prescription drug co-pays as required under G.S. 135-45.6(b) as enacted by this act.

g. Except as otherwise provided in this act, co-payments and coinsurance for coverage not otherwise listed in this subdivision shall remain as applicable in the 2008-2009 benefit year.

(2) Standard plan (80/20):

a. Increase the in-network annual deductible to six hundred dollars ($600.00) for member-only coverage and to one thousand two hundred dollars ($1,200) for the member-only out-of-network annual deductible.

The aggregate maximum annual deductible for employee-child and employee-family coverage shall be three times the member-only annual deductibles.

b. Increase the in-network coinsurance maximum to two thousand seven hundred fifty dollars ($2,750) for member-only coverage and to five thousand five hundred dollars ($5,500) for member-only out-of-network maximum coinsurance. The aggregate maximum coinsurance for employee-child and employee-family coverage shall be three times the member-only coinsurance maximums.

c. Increase the in-network urgent care co-payment to seventy-five dollars ($75.00) per covered individual.

d. Increase the in-network primary care co-payment to twenty-five dollars ($25.00) per covered individual.

e. Increase the in-network specialist co-payment to sixty dollars ($60.00) per covered individual.

f. Increase the in-network and out-of-network inpatient co-payment to two hundred dollars ($200.00) per covered individual.

g. Increase prescription drug co-pays as required under G.S. 135-45.6(b) as enacted by this act.

h. Except as otherwise provided in this act, co-payments and coinsurance for coverage not otherwise listed in this subdivision shall remain as applicable in the 2008-2009 benefit year.

SECTION 2.(f) Limitation on authority to change benefits. – G.S. 135-45(g) reads as rewritten:

"(g) The Executive Administrator and Board of Trustees shall not change the Plan's comprehensive health benefit coverage, co-payments, deductibles, out-of-pocket expenditures, and lifetime maximums in effect on ~~July 1, 2008,~~ July 1, 2009, or a later act of the General Assembly, that would result in a net increased cost to the Plan or in a reduction in benefits to Plan members as a whole unless and until the proposed changes are directed to be made in an act of the General Assembly."

SECTION 2.(g) Premium increases. – Premium rates for contributory coverage established in accordance with G.S. 135-44.6 shall be increased to eight and six-tenths percent (8.6%) for contributory coverage for the 2009-2010 fiscal year and shall be increased by an additional eight and six-tenths percent (8.6%) over the premium rate for contributory coverage for the 2010-2011 fiscal year.

SECTION 2.(h) Pharmacy benefit savings. – The Plan shall direct its pharmacy benefit manager (PBM), within the terms of the Plan's PBM contract, to achieve the sum of eighteen million dollars ($18,000,000) in savings in pharmacy benefit costs in the 2009-2010 fiscal year, and the sum of twenty million dollars ($20,000,000) in savings in pharmacy benefit costs in the 2010-2011 fiscal year through reduced reimbursements paid to pharmacies for prescription drugs. If the savings achieved in each six-month period of the fiscal year do not exceed one hundred-five percent (105%) of the savings amount specified in this section for that fiscal year, there shall be no further adjustment to reimbursements paid to pharmacies for that six-month period. If the total savings achieved, by fiscal year, exceeds one hundred five percent (105%) of the specified savings amount in each six month period of the fiscal year, the Plan shall adjust pharmacy reimbursement reductions accordingly. The Plan shall review savings achieved twice annually to ensure compliance with this section. The Plan shall calculate the savings to be achieved based on Plan enrollment and estimated cost and utilization trends incorporated in the Plan's Financial Projections as of March 20, 2009. The total savings by fiscal year achieved in this section may be increased or decreased without adjustment based on a change in total enrollment provided that the rate of savings achieved on a per member per

month basis remains constant. Not later than 60 days immediately following each six-month period, the Plan shall report the amount of savings achieved and any adjustments made for that period to the Committee on Employee Hospital and Medical Benefits."

PART THREE: ELIGIBILITY CLARIFICATION.

SECTION 3.(a) Dependent child clarifications. – G.S. 135-45.1(10) reads as rewritten:

"(10) Dependent child. – A natural, legally adopted, or foster child or children of the employee and or spouse, unmarried, up to the first of the month following his or her 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for such child's maintenance and support. Dependent child also includes a stepchild of the member who is married to the stepchild's natural parent. To be eligible, the stepchild must have his or her primary residence with the member. Dependent child shall also include any child under age 19 who has reached his or her 18th birthday, provided the employee was legally responsible for such child's maintenance and support on his or her 18th birthday. Dependent children of firefighters, rescue squad workers, and members of the national guard are subject to the same terms and conditions as are other dependent children covered by this subdivision. Eligibility of dependent children is subject to the requirements of G.S. 135-45.2(d). The Plan may require documentation from the member confirming a child's eligibility to be covered as the member's dependent."

SECTION 3.(b) Eligibility of full-time students. – G.S. 135-45.2(d) reads as rewritten:

"(d) A foster child is covered as a dependent child (i) if living in a regular parent-child relationship with the expectation that the employee will continue to rear the child into adulthood, (ii) if at the time of enrollment, or at the time a foster child relationship is established, whichever occurs first, the employee applies for coverage for such child and submits evidence of a bona fide foster child relationship, identifying the foster child by name and setting forth all relevant aspects of the relationship, (iii) if the claims processor accepts the foster child as a participant through a separate written document identifying the foster child by name and specifically recognizing the foster child relationship, and (iv) if at the time a claim is incurred, the foster child relationship, as identified by the employee, continues to exist. Children placed in a home by a welfare agency which obtains control of, and provides for maintenance of the child, are not eligible participants.

Coverage of a dependent child may be extended beyond the 19th birthday under the following conditions:

(1) If the dependent is a full-time student, ~~aged 19 years and one month~~ through the end of the month following the student's 26th ~~birthday,~~birthday. As used in this section, a full-time student is a student who is pursuing a course of study that represents at least the normal workload of a full-time student at a school or college accredited by the state of jurisdiction. In accordance with applicable federal law, coverage of a full-time student that loses full-time status due to illness may be extended for one year from the effective date of the loss of full-time status provided that the student was enrolled at the time of the onset of the illness.

(2) The dependent is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and (i) such handicap developed or began to develop before the dependent's 19th birthday, or (ii) such handicap developed or began to develop before the dependent's 26th birthday if the dependent was covered by the Plan in accordance with G.S. 135-45.2(5)a."

SECTION 3.(c) Waiting periods subject to federal law. – G.S. 135-45.3(b) reads as rewritten:

"(b) ~~"Newly~~ Except as otherwise required by applicable federal law, newly acquired dependents (spouse/child) enrolled within 30 days of becoming an eligible dependent will not be subject to the 12-month waiting period for preexisting conditions. A dependent can become qualified due to marriage, adoption, entering a foster child relationship, due to the divorce of a dependent child or the death of the spouse of a dependent child, and at the beginning of each legislative session (applies only to enrolled legislators). Effective date for newly acquired dependents if application was made within the 30 days can be the first day of the following month. Effective date for an adopted child can be date of adoption, or date of placement in the adoptive parents' home, or the first of the month following the date of adoption or placement. Firefighters, rescue squad workers, and members of the national guard, and their eligible dependents, are subject to the same terms and conditions as are new employees and their dependents covered by this subdivision. Enrollments in these circumstances must occur within 30 days of eligibility to enroll."

SECTION 3.(d) G.S. 135-45.4(b)(5) reads as rewritten:

"(5) To administer the 12-month waiting period for preexisting conditions under this that Article, the Plan must give credit against the 12-month period for the time a person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 63 days before the effective date of coverage. As used in this subdivision, a "previous plan" means any policy, certificate, contract, or any other arrangement provided by any accident and health insurer, any hospital or medical service corporation, any health maintenance organization, any preferred provider organization, any multiple employer welfare arrangement, any self-insured health benefit arrangement, any governmental health benefit or health care plan or program, or any other health benefit arrangement. Waiting periods for preexisting conditions administered under this Article are subject to applicable federal law."

SECTION 3.(e) Eligibility audit. – The Executive Administrator shall provide for an audit of dependent eligibility under the Plan. The audit shall be designed to determine whether all dependents currently covered under the Plan are eligible for coverage under current law. Upon identification of an individual who is enrolled as a dependent but not eligible, the Plan shall disenroll the ineligible dependent effective within 10 days of sending written termination notice to the employee. The notice shall state the date upon which disenrollment will become effective and the basis on which the determination of dependent ineligibility is made. Notwithstanding any other provision of law, the Executive Administrator may waive requirements to collect from the member reimbursement for claims paid for the ineligible covered individual.

SECTION 3.(f) Cessation of coverage of ineligible individuals. – G.S. 135-45.12 is amended by adding the following new subdivision to read:

"(8) The last day of the month in which a covered individual is found to be ineligible for coverage."

SECTION 3.(g) Documentation of dependent eligibility. – G.S. 135-45.3 is amended by adding the following new subsection to read:

"(c) When an eligible or enrolled member applies to enroll the member's eligible dependent child or spouse, the member shall provide the documentation required by the Plan to verify the dependent's eligibility for coverage."

PART FOUR: NC HEALTH CHOICE CHANGES.

SECTION 4.(a) Over-the-counter medications. – Coverage of over-the-counter medication authorized under G.S. 108A-70.21(d) for the NC Health Choice Program shall

become effective on the later of July 1, 2010, or the date upon which the Department of Health and Human Services assumes full responsibility for administration and processing of claims under the NC Health Choice Program.

SECTION 4.(b) Subrogation. – For the period authorized under subsection (a) of this section, the right of subrogation under G.S. 108A-57 applies to the State Health Plan for payments made by the Plan under the NC Health Choice Program. This subsection expires on the later of July 1, 2010, or the date upon which the Department of Health and Human Services assumes full responsibility for administration, processing, and payment of claims under the NC Health Choice Program.

SECTION 4.(c) DHHS Subrogation under NC Health Choice. – G.S. 108A-57 is amended by adding the following new subsection to read:

"(c) This section applies to the administration of and claims payments made by the Department of Health and Human Services under the NC Health Choice Program established under Part 8 of this Article."

SECTION 4.(d) G.S. 108A-70.21(g) reads as rewritten:

"(g) Purchase of Extended Coverage. – An enrollee in the Program who loses eligibility due to an increase in family income above two hundred ~~fifty percent (250%)~~percent (200%) of the federal poverty level and up to and including two hundred ~~seventy-five percent (275%)~~ twenty-five percent (225%) of the federal poverty level may purchase at full premium cost continued coverage under the Program for a period not to exceed one year beginning on the date the enrollee becomes ineligible under the income requirements for the Program. The benefits, copayments, and other conditions of enrollment under the Program applicable to extended coverage purchased under this subsection shall be the same as those applicable to an NC Kids' Care enrollee whose family income equals two hundred ~~fifty percent (250%)~~ percent (200%) of the federal poverty level."

PART FIVE: OTHER CHANGES.

SECTION 5.(a) G.S. 135-45.4(b)(2) reads as rewritten:

"(2) Employees not enrolling or not adding dependents when first eligible may enroll later on the first of any following month, but will be subject to a twelve-month waiting period for preexisting conditions except as provided in subdivision (a)(3) of this section. The waiting period under this subdivision is subject to applicable federal law."

SECTION 5.(b) Utilization management functions. – G.S. 135-44.4 is amended by adding the following new subdivisions to read:

"(13a) The Plan and its pharmacy benefit manager may implement and administer pharmacy and medical utilization management programs and programs to detect and address utilization abuse of benefits.

...

(29) For transplant and bariatric medical procedures, the Plan may restrict coverage to certain in-network providers that are designated by the Plan's claims processing contractor."

SECTION 5.(c) G.S. 135-44.1(b) reads as rewritten:

"(b) ~~Six~~ A majority of the members of the Board of Trustees in office shall constitute a quorum. Decisions of the Board of Trustees shall be made by a majority vote of the Trustees present, except as otherwise provided in this Part."

SECTION 5.(d) G.S. 135-45.9(b) reads as rewritten:

"(b) Notwithstanding any other provision of this Part, the following necessary services for the care and treatment of chemical dependency and mental illness shall be covered as provided in this section: allowable institutional and professional charges for inpatient care, outpatient care, intensive outpatient program services, partial hospitalization treatment, and residential care and treatment:

(1) For mental illness treatment:
a. Licensed psychiatric ~~hospitals;~~ hospitals or State psychiatric hospitals accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
b. Licensed psychiatric beds in licensed general hospitals;
c. Licensed residential treatment facilities that have 24-hour on-site care provided by a registered nurse who is physically located at the facility at all times and that hold current accreditation by a national accrediting body approved by the Plan's mental health case manager;
d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities or County Programs in accordance with G.S. 122C-141;
e. Licensed intensive outpatient treatment programs; and
f. Licensed partial hospitalization programs.

(2) For chemical dependency treatment:
a. Licensed chemical dependency units in licensed psychiatric ~~hospitals;~~ hospitals or in State psychiatric hospitals accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
b. Licensed chemical dependency hospitals;
c. Licensed chemical dependency treatment facilities;
d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities or County Programs in accordance with G.S. 122C-141;
e. Licensed intensive outpatient treatment programs;
f. Licensed partial hospitalization programs; and
g. Medical detoxification facilities or units."

SECTION 5.(e) Section 28.22A(k) of S.L. 2007-323 reads as rewritten:

"**SECTION 28.22A.(k)** Subsection (j) of this section expires ~~June 30, 2009.~~ June 30, 2011."

SECTION 5.(f) G.S. 135-43(b) reads as rewritten:

"(b) Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees may contract with providers of institutional and professional medical care and services to establish preferred provider networks.

~~The terms pertaining to reimbursement rates or other terms of consideration of any contract between hospitals, hospital authorities, doctors, or other medical providers, or a pharmacy benefit manager and the Plan, or contracts pertaining to the provision of any medical benefit offered under the Plan, including its optional alternative comprehensive benefit plans, and programs available under the optional alternative plans, shall not be a public record under Chapter 132 of the General Statutes for a period of 30 months after the date of the expiration of the contract.~~ The terms of a contract between the Plan and its third party administrator or between the Plan and its pharmacy benefit manager are a public record except that the terms in those contracts that contain trade secrets or proprietary or competitive information are not a public record under Chapter 132 of the General Statutes and any such proprietary or competitive information and trade secrets contained in the contract shall be redacted by the Plan prior to making it available to the public. ~~Provided, however, nothing in this subsection shall be deemed to~~This subsection shall not be construed to prevent or restrict the release of any information made not a public record under this subsection to the State Auditor, the Attorney General, the Director of the State Budget, the Plan's Executive Administrator, ~~the Department of Health and Human Services solely for the purpose of implementing the transition of NC Health Choice from the Plan to the Department of Health and Human Services,~~ and the

Committee on Employee Hospital and Medical Benefits solely and exclusively for their use in the furtherance of their duties and ~~responsibilities.~~responsibilities, and to the Department of Health and Human Services solely for the purpose of implementing the transition of NC Health Choice from the Plan to the Department of Health and Human Services. The design, adoption, and implementation of the preferred provider contracts, networks, and optional alternative comprehensive health benefit plans, and programs available under the optional alternative plans, as authorized under G.S. 135-45 are not subject to the requirements of Chapter 143 of the General Statutes. The Executive Administrator and Board of Trustees shall make reports as requested to the President of the Senate, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Committee on Employee Hospital and Medical Benefits."

PART SIX: SALARY-RELATED CONTRIBUTIONS.

SECTION 6.(a) Effective for the 2009-2011 fiscal biennium, required employer salary-related contributions for employees whose salaries are paid from department, office, institution, or agency receipts shall be paid from the same source as the source of the employees' salary. If an employee's salary is paid in part from the General Fund or Highway Fund and in part from department, office, institution, or agency receipts, required employer salary-related contributions may be paid from the General Fund or Highway Fund only to the extent of the proportionate part paid from the General Fund or Highway Fund in support of the salary of the employee, and the remainder of the employer's requirements shall be paid from the source that supplies the remainder of the employee's salary. The requirements of this section as to source of payment are also applicable to payments on behalf of the employee for hospital-medical benefits, longevity pay, unemployment compensation, accumulated leave, workers' compensation, severance pay, separation allowances, and applicable disability income benefits.

Notwithstanding any other provision of law, an employing unit that is subject to Part 3A of Article 3A of Chapter 135 of the General Statutes and that hires or has hired as an employee a retiree that is in receipt of monthly retirement benefits from any retirement system supported in whole or in part by contributions of the State shall enroll the retiree in the active group and pay the cost for the hospital-medical benefits if that retiree is employed in a position that would require the employer to pay hospital-medical benefits if the individual had not been retired.

SECTION 6.(b) Effective July 1, 2009, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2009-2010 fiscal year are: (i) eight and forty-four hundredths percent (8.44%) – Teachers and State Employees; (ii) thirteen and forty-four hundredths percent (13.44%) – State Law Enforcement Officers; (iii) eleven and seventy-six hundredths percent (11.76%) – University Employees' Optional Retirement System; (iv) eleven and seventy-six hundredths percent (11.76%) – Community College Optional Retirement Program; (v) seventeen and sixty-one hundredths percent (17.61%) – Consolidated Judicial Retirement System; and (vi) four and forty hundredths percent (4.40%) – Legislative Retirement System. Each of the foregoing contribution rates includes four and forty hundredths percent (4.40%) for hospital and medical benefits. The rate for Teachers and State Employees, State Law Enforcement Officers, Community College Optional Retirement Program, and for the University Employees' Optional Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

SECTION 6.(c) Effective July 1, 2010, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2010-2011 fiscal year are: (i) eight and eighty-four hundredths percent (8.84%) – Teachers and State

Employees; (ii) thirteen and eighty-four hundredths percent (13.84%) – State Law Enforcement Officers; (iii) twelve and sixteen hundredths percent (12.16%) – University Employees' Optional Retirement System; (iv) twelve and sixteen hundredths percent (12.16%) – Community College Optional Retirement Program; (v) eighteen and one hundredths percent (18.01%) – Consolidated Judicial Retirement System; and (vi) four and eighty hundredths percent (4.80%) – Legislative Retirement System. Each of the foregoing contribution rates includes four and eighty hundredths percent (4.80%) for hospital and medical benefits. The rate for Teachers and State Employees, State Law Enforcement Officers, Community College Optional Retirement Program, and for the University Employees' Optional Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

SECTION 6.(d) Effective July 1, 2009, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2009-2010 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand four hundred thirty-eight dollars ($3,438) and (ii) non-Medicare-eligible employees and retirees – four thousand five hundred fifteen dollars ($4,515).

SECTION 6.(e) Effective July 1, 2010, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2010-2011 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand seven hundred thirty-five dollars ($3,735) and (ii) non-Medicare-eligible employees and retirees – four thousand nine hundred five dollars ($4,905).

PART SEVEN: EFFECTIVE DATE.

SECTION 7. Sections 1(b), 1(c), 1(d), 2(c) through (e), 2(g), and 2(h) of this act become effective July 1, 2009. Section 4(d) of this act applies to applications for the purchase of extended coverage made on and after July 1, 2008. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 287
Select Committee on Employee Hospital and Medical Benefits Committee Substitute Adopted 3/10/09
Third Edition Engrossed 3/24/09
PROPOSED HOUSE COMMITTEE SUBSTITUTE S287-PCS85190-RD-16

Short Title: State Hlth Plan $/Good Health Initiatives. (Public)

Sponsors:

Referred to:

February 25, 2009

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES AND TO MAKE OTHER CHANGES RELATED TO THE STATE HEALTH PLAN.

Whereas, the General Assembly must act quickly and prudently to maintain a financially stable State Health Plan to ensure that all members of the Plan have affordable access to medically necessary health benefits and services within available resources; and

Whereas, in order to meet current fiscal obligations the General Assembly must appropriate $250,000,000 for the 2008-2009 fiscal year to cover the current year shortfall in funds; and

Whereas, estimates indicate that a substantially larger appropriation will be necessary to maintain the fiscal integrity of the Plan in the next and ensuing fiscal periods; and

Whereas, in order to ensure continued access to medically necessary health care to Plan members, the Plan must implement measures to contain costs through premium increases, benefit changes, and healthy lifestyle programs that not only reduce costs but improve member health; and

Whereas, the Plan estimates that over 70,000 Plan members use tobacco, resulting in a cost to the Plan of $2,000 per member per year more than the cost of providing coverage for nonusers of tobacco; and

Whereas, over 60% of North Carolina adults are obese or overweight; and

Whereas, obesity is linked to an over 37% increase in health care spending at a cost of $2,445 per member per year; and

Whereas, weight management and cessation of tobacco use have been demonstrated to result in improved member health and substantial savings in health care costs making it fiscally prudent to implement smoking cessation and weight management incentives and initiatives with mechanisms to verify member compliance with smoking cessation and weight management requirements; Now, therefore,

The General Assembly of North Carolina enacts:

PART ONE: APPROPRIATIONS, DEFINITIONS, AND SCOPE.

SECTION 1.(a) Appropriation for 2008-2009 fiscal year. – There is appropriated from the Savings Reserve Account established in G.S. 143C-4-2 to the Health Benefit Reserve

Fund established in G.S. 135-44.5 the sum of two hundred fifty million dollars ($250,000,000) for the 2008-2009 fiscal year. These funds shall be used to address the shortfall in funds available for the payment of health care and administrative costs under the State Health Plan for Teachers and State Employees ("Plan") for the 2008-2009 fiscal year.

SECTION 1.(b) General Fund appropriation for 2009-2011 fiscal biennium. – Notwithstanding G.S. 143C-5-2, there is appropriated from the General Fund to the Reserve for the State Health Plan in the Office of State Budget and Management the sum of one hundred thirty-four million eight hundred ten thousand nine hundred forty-seven dollars ($134,810,947) for the 2009-2010 fiscal year and the sum of two hundred eighty-one million eight hundred thirty-eight thousand eighty-eight dollars ($281,838,088) for the 2010-2011 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2009-2011 fiscal biennium.

SECTION 1.(c) Highway Fund appropriation for the 2009-2011 fiscal biennium. – Notwithstanding G.S. 143C-5-2, there is appropriated from the Highway Fund to the Reserve for the State Health Plan in the Office of State Budget and Management the sum of six million two hundred ninety-one thousand one hundred seventy-eight dollars ($6,291,178) for the 2009-2010 fiscal year and the sum of thirteen million one hundred fifty-two thousand four hundred forty-four dollars ($13,152,444) for the 2010-2011 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2009-2011 fiscal biennium.

SECTION 1.(d) All other agency funds required to fund the premium increase enacted in this act, other than funds appropriated in subsections (b) and (c) of this section, are appropriated for the 2009-2011 fiscal biennium.

SECTION 1.(e) Definitions. – As used in this act unless the context clearly requires otherwise:

(1) "Plan." – The State Health Plan for Teachers and State Employees.

(2) "Basic plan." – The Plan's PPO option providing for 70/30 in-network coverage after deductibles and co-payments.

(3) "Smoking" or "Smoking cessation." – Includes cessation of the use of all tobacco products.

(4) "Standard plan." – The Plan's PPO option providing for 80/20 in-network coverage after deductibles and co-payments.

SECTION 1.(f) Scope. – In the event of a conflict between the provisions of this act and Article 3A of Chapter 135 of the General Statutes, this act prevails.

PART TWO: HEALTH BENEFIT CHANGES.

SECTION 2.(a) Eliminate PPO Plus Option. – Effective July 1, 2009, the PPO Plus option (90/10 in-network coverage) under the State Health Plan for Teachers and State Employees ("Plan") is eliminated. The Executive Administrator shall provide notice to all members of the Plan that this option will no longer be available as of July 1, 2009. Employees enrolled in the Plan's Plus option shall have the choice of enrolling in the Basic or Standard plan options for the 2009-2010 benefit year.

SECTION 2.(b) Implement Comprehensive Wellness Initiative.

(1) Program development. – The Plan shall develop a Comprehensive Wellness Initiative that includes a focus on smoking cessation and weight management and that is designed to be implemented effective July 1, 2010, for smoking cessation and July 1, 2011, for weight management. Benefit levels shall be determined by the Plan based upon tobacco use or the inability of the member to meet national, evidence-based healthy weight clinical guidelines. For purposes of the Comprehensive Wellness Initiative, "member" includes all State Health Plan primary subscribers and their covered dependents. The Plan shall develop a process whereby a Plan member may appeal the Plan's basis for action it takes due to the member's

failure or refusal to comply with the Plan's smoking cessation or weight management requirements.

(2) Smoking cessation. – Effective July 1, 2010, all members of the Plan who do not have Medicare as their primary coverage shall be enrolled in the Basic Plan under the Plan's PPO unless the subscriber can attest that the subscriber or any qualifying dependent does not smoke or otherwise use tobacco products. The Plan shall develop a mechanism for verifying that the member does not smoke or use other tobacco products. Tobacco use will be reassessed annually at the time of Plan enrollment. All subscribers who have attested that neither they nor their dependents use tobacco, or whose physician certifies in writing that the member is participating in a smoking cessation program, shall have the choice of remaining in the Basic plan option or enrolling in the Standard plan option. For purposes of the smoking cessation initiative, "member" includes all members covered under the Plan. As used in this section, "smoking cessation program" means active participation in a Plan-approved cessation program to include counseling or use of tobacco cessation medications.

(3) Weight management. – Effective July 1, 2011, all members of the Plan who do not have Medicare as their primary coverage shall be enrolled in the Basic Plan under the Plan's PPO Plan unless the subscriber attests that the weight and height ratio of the member is within a range determined by the Plan based on evidence-based healthy weight clinical guidelines, or unless the member's physician certifies in writing that the member has a medical condition that prevents the attainment of the specified weight range or that the member is actively participating in a Plan-approved weight management program. In either case, the member shall have the option to enroll in the Basic or Standard Plan.

Not later than October 1, 2009, the Executive Administrator shall inform Plan members of the healthy lifestyle initiatives, requirements for compliance, and consequences of noncompliance. The Executive Administrator shall provide to members education and training to assist members in complying with healthy lifestyle initiatives. The Executive Administrator may implement incentive initiatives to further encourage member achievement in smoking cessation, weight management, and other integrated health management programs.

The Executive Administrator shall report to the Committee on Employee Hospital and Medical Benefits recommendations the Plan may have for additional sanctions that may be imposed when the Executive Administrator finds that a member intentionally makes a false statement on a Plan document.

SECTION 2.(c) Prescription drug co-payments. – G.S. 135-45.6(b) reads as rewritten:

"(b) Prescription Drugs. – The Plan's allowable charges for prescription legend drugs to be used outside of a hospital or skilled nursing facility shall be as determined by the Plan's Executive Administrator and Board of Trustees, which determinations are not subject to appeal under Article 3 of Chapter 150B of the General Statutes. Co-payments and other allowable charges or coverage for prescription drugs shall be as follows:

(1) The Plan will pay allowable charges for each outpatient prescription drug less a copayment to be paid by each covered individual equal to the following amounts: pharmacy charges up to ten dollars ($10.00) for each generic prescription, ~~thirty dollars ($30.00)~~ thirty-five dollars ($35.00) for each preferred branded prescription without a generic equivalent, ~~and forty dollars ($40.00) for each preferred branded prescription with a generic equivalent drug,~~ and ~~fifty dollars ($50.00)~~ fifty-five dollars ($55.00) for each

nonpreferred branded ~~or generic~~ prescription. For each branded prescription drug with a generic equivalent drug, the member shall pay the generic co-payment plus the difference between the Plan's gross allowed cost for the generic prescription and the Plan's cost for the branded prescription drug.

(2) The Plan shall provide coverage of nonacute specialty medications, excluding cancer medications, under the Plan's pharmacy benefit through a specialty pharmacy vendor under contract with the Plan. The Plan may transfer coverage of specified specialty disease medications covered under the Plan's medical benefit to the contracted specialty pharmacy vendor, provided that the Plan shall continue to allow any retail pharmacy to dispense any specialty drug at the same price as determined by the specialty drug vendor. Specialty medications are covered biotech medications and other medications designated and classified by the Plan as specialty medications that are significantly more expensive than alternative drugs or therapies. Medications classified by the Plan as specialty medications shall meet all of the following conditions:

a. Have unique uses for the treatment of complex diseases.
b. Require special dosing or administration.
c. Require special handling.
d. Are typically prescribed by a specialist provider.
e. Exceed four hundred dollars ($400.00) cost to the Plan per prescription.

The Plan shall impose a co-payment in the amount of twenty-five percent (25%) of the Plan's gross allowed cost of the specialty drug not to exceed one hundred dollars ($100.00) per prescription per 30-day supply.

(3) The Plan may exclude coverage of drugs that have therapeutic equivalents that are available over the counter. Before excluding coverage under this subdivision, the Plan shall consult with the Plan's Pharmacy and Therapeutics Committee.

~~These co-paymentsapply to all optional alternative plans available under the Plan.~~

(4) Allowable charges shall not be greater than a pharmacy's usual and customary charge to the general public for a particular prescription. Prescriptions shall be for no more than a ~~34-day~~30-day supply for the purposes of the copayments paid by each covered individual. By accepting the copayments and any remaining allowable charges provided by this subsection, pharmacies shall not balance bill an individual covered by the Plan. A prescription legend drug is defined as an article the label of which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without Prescription." Such articles may not be sold to or purchased by the public without a prescription order. Benefits are provided for insulin even though a prescription is not required. ~~The Plan may use a pharmacy benefit manager to help manage the Plan's outpatient prescription drug coverage. In managing the Plan's outpatient prescription drug benefits, the Plan and its pharmacy benefit manager shall not provide coverage for sexual dysfunction, growth hormone, antiwrinkle, weight loss, and hair growth drugs unless such coverage is medically necessary to the health of the member. The Plan and its pharmacy benefit manager shall not provide coverage for growth hormone and weight loss drugs and antifungal drugs for the treatment of nail fungus and botulinium toxin without approval in advance by the pharmacy benefit manager.~~ The Plan may adopt utilization

management procedures for certain drugs, but in no event shall the Plan provide coverage for sexual dysfunction or hair growth drugs or nonmedically necessary drugs used for cosmetic purposes. Any formulary used by the Plan's Executive Administrator and pharmacy benefit manager shall be an open formulary. Plan members shall not be assessed more than two thousand five hundred dollars ($2,500) per person per fiscal year in copayments required by this subsection. The Plan's Pharmacy Benefit Manager, or any pharmacy or vendor participating in the Plan shall charge the Plan for any prescription legend drug dispensed under the Plan's pharmacy benefit based upon the original National Drug Code (NDC) as established by the manufacturer of the prescription legend drug and published by the United States Food and Drug Administration.

Copayments authorized under this subsection apply to all optional alternative plans available under the Plan."

SECTION 2.(d) Routine eye examinations not covered. – Effective January 1, 2010, G.S. 135-45.8(13) reads as rewritten:

"**§ 135-45.8. General limitations and exclusions.**

The following shall in no event be considered covered expenses nor will benefits described in G.S. 135-45.6 through G.S. 135-45.11 be payable for:

...

(13) Charges for routine eye examinations, eyeglasses or other corrective lenses (except for cataract lenses certified as medically necessary for aphakia persons) and hearing aids or examinations for the prescription or fitting thereof."

SECTION 2.(e) Deductible and co-payment changes. – Effective July 1, 2009, the Executive Administrator shall make the following changes to deductibles, coinsurance maximums, and co-payments under the Basic and Standard PPO Plans:

(1) Basic plan (70/30):

a. Increase the in-network annual deductible to eight hundred dollars ($800.00) for member-only coverage and to one thousand six hundred dollars ($1,600) for the out-of-network annual deductible for member-only coverage.

The aggregate maximum annual deductible for employee-child and employee-family coverage shall be three times the member-only annual deductibles.

b. Increase the in-network coinsurance maximum to three thousand two hundred fifty dollars ($3,250) for member-only coverage and to six thousand five hundred dollars ($6,500) for member-only out-of-network maximum coinsurance. The aggregate maximum coinsurance for employee-child and employee-family coverage shall be three times the member-only coinsurance maximums.

c. Increase the in-network primary care co-payment to thirty dollars ($30.00) per covered individual. This co-payment applies to chiropractic services.

d. Increase the in-network specialist co-payment to seventy dollars ($70.00) per covered individual. This co-payment does not apply to chiropractic services.

e. Increase the in-network and out-of-network inpatient co-payment to two hundred fifty dollars ($250.00) per covered individual.

f. Increase prescription drug co-pays as required under G.S. 135-45.6(b) as enacted by this act.

g. The in-network co-payment for physical therapy, occupational therapy, and speech therapy shall be thirty dollars ($30.00) per therapy type per covered individual.

h. Except as otherwise provided in this act, co-payments and coinsurance for coverage not otherwise listed in this subdivision shall remain as applicable in the 2008-2009 benefit year.

(2) Standard plan (80/20):

a. Increase the in-network annual deductible to six hundred dollars ($600.00) for member-only coverage and to one thousand two hundred dollars ($1,200) for the member-only out-of-network annual deductible.

The aggregate maximum annual deductible for employee-child and employee-family coverage shall be three times the member-only annual deductibles.

b. Increase the in-network coinsurance maximum to two thousand seven hundred fifty dollars ($2,750) for member-only coverage and to five thousand five hundred dollars ($5,500) for member-only out-of-network maximum coinsurance. The aggregate maximum coinsurance for employee-child and employee-family coverage shall be three times the member-only coinsurance maximums.

c. Increase the in-network urgent care co-payment to seventy-five dollars ($75.00) per covered individual.

d. Increase the in-network primary care co-payment to twenty-five dollars ($25.00) per covered individual. This co-payment applies to chiropractic services.

e. Increase the in-network specialist co-payment to sixty dollars ($60.00) per covered individual. This co-payment does not apply to chiropractic services.

f. Increase the in-network and out-of-network inpatient co-payment to two hundred dollars ($200.00) per covered individual.

g. Increase prescription drug co-pays as required under G.S. 135-45.6(b) as enacted by this act.

h. The in-network co-payment for physical therapy, occupational therapy, and speech therapy shall be twenty-five dollars ($25.00) per therapy type per covered individual.

i. Except as otherwise provided in this act, co-payments and coinsurance for coverage not otherwise listed in this subdivision shall remain as applicable in the 2008-2009 benefit year.

SECTION 2.(f) Limitation on authority to change benefits. – G.S. 135-45(g) reads as rewritten:

"(g) The Executive Administrator and Board of Trustees shall not change the Plan's comprehensive health benefit coverage, co-payments, deductibles, out-of-pocket expenditures, and lifetime maximums in effect on ~~July 1, 2008,~~ July 1, 2009, or a later act of the General Assembly, that would result in a net increased cost to the Plan or in a reduction in benefits to Plan members as a whole unless and until the proposed changes are directed to be made in an act of the General Assembly."

SECTION 2.(g) Premium increases. – Premium rates for contributory coverage established in accordance with G.S. 135-44.6 shall be increased to nine and one-tenth percent (9.1%) for contributory coverage for the 2009-2010 fiscal year and shall be increased by an additional nine and one-tenth percent (9.1%) over the premium rate for contributory coverage for the 2010-2011 fiscal year.

SECTION 2.(h) Pharmacy benefit savings. – The Plan shall direct its pharmacy benefit manager (PBM), within the terms of the Plan's PBM contract, to achieve the sum of eighteen million dollars ($18,000,000) in savings in pharmacy benefit costs in the 2009-2010 fiscal year, and the sum of twenty million dollars ($20,000,000) in savings in pharmacy benefit costs in the 2010-2011 fiscal year through reduced reimbursements paid to pharmacies for prescription drugs. If the savings achieved in each six-month period of the fiscal year do not exceed one hundred-five percent (105%) of the savings amount specified in this section for that fiscal year, there shall be no further adjustment to reimbursements paid to pharmacies for that six-month period. If the total savings achieved, by fiscal year, exceeds one hundred five percent (105%) of the specified savings amount in each six month period of the fiscal year, the Plan shall adjust pharmacy reimbursement reductions accordingly. The Plan shall review savings achieved twice annually to ensure compliance with this section. The Plan shall calculate the savings to be achieved based on Plan enrollment and estimated cost and utilization trends incorporated in the Plan's Financial Projections as of March 20, 2009. The total savings by fiscal year achieved in this section may be increased or decreased without adjustment based on a change in total enrollment provided that the rate of savings achieved on a per member per month basis remains constant. Not later than 60 days immediately following each six-month period, the Plan shall report the amount of savings achieved and any adjustments made for that period to the Committee on Employee Hospital and Medical Benefits."

SECTION 2.(i) Required disclosure. – The Plan's pharmacy benefit manager (PBM) shall disclose to the Plan the amount actually paid or to be paid to the pharmacy for each prescription, including the drug name, dose, and quantity. This information and the corresponding information of the amount the Plan is charged or will be charged by the PBM for each prescription shall be available to the Committee on Employee Hospital and Medical Benefits.

PART THREE: ELIGIBILITY CLARIFICATION.

SECTION 3.(a) Dependent child clarifications. – G.S. 135-45.1(10) reads as rewritten:

"(10) Dependent child. – A natural, legally adopted, or foster child or children of the employee and or spouse, unmarried, up to the first of the month following his or her 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for such child's maintenance and support. Dependent child also includes a stepchild of the member who is married to the stepchild's natural parent. To be eligible, the stepchild must have his or her primary residence with the member. Dependent child shall also include any child under age 19 who has reached his or her 18th birthday, provided the employee was legally responsible for such child's maintenance and support on his or her 18th birthday. Dependent children of firefighters, rescue squad workers, and members of the national guard are subject to the same terms and conditions as are other dependent children covered by this subdivision. Eligibility of dependent children is subject to the requirements of G.S. 135-45.2(d). The Plan may require documentation from the member confirming a child's eligibility to be covered as the member's dependent."

SECTION 3.(b) Eligibility of full-time students. – G.S. 135-45.2(d) reads as rewritten:

"(d) A foster child is covered as a dependent child (i) if living in a regular parent-child relationship with the expectation that the employee will continue to rear the child into adulthood, (ii) if at the time of enrollment, or at the time a foster child relationship is established, whichever occurs first, the employee applies for coverage for such child and submits evidence of a bona fide foster child relationship, identifying the foster child by name

and setting forth all relevant aspects of the relationship, (iii) if the claims processor accepts the foster child as a participant through a separate written document identifying the foster child by name and specifically recognizing the foster child relationship, and (iv) if at the time a claim is incurred, the foster child relationship, as identified by the employee, continues to exist. Children placed in a home by a welfare agency which obtains control of, and provides for maintenance of the child, are not eligible participants.

Coverage of a dependent child may be extended beyond the 19th birthday under the following conditions:

(1) If the dependent is a full-time student, ~~aged 19 years and one month~~ through the end of the month following the student's 26th ~~birthday,~~birthday. As used in this section, a full-time student is a student who is pursuing a course of study that represents at least the normal workload of a full-time student at a school or college accredited by the state of jurisdiction. In accordance with applicable federal law, coverage of a full-time student that loses full-time status due to illness may be extended for one year from the effective date of the loss of full-time status provided that the student was enrolled at the time of the onset of the illness.

(2) The dependent is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and (i) such handicap developed or began to develop before the dependent's 19th birthday, or (ii) such handicap developed or began to develop before the dependent's 26th birthday if the dependent was covered by the Plan in accordance with G.S. 135-45.2(5)a."

SECTION 3.(c) Waiting periods subject to federal law. – G.S. 135-45.3(b) reads as rewritten:

"(b) ~~"Newly~~ Except as otherwise required by applicable federal law, newly acquired dependents (spouse/child) enrolled within 30 days of becoming an eligible dependent will not be subject to the 12-month waiting period for preexisting conditions. A dependent can become qualified due to marriage, adoption, entering a foster child relationship, due to the divorce of a dependent child or the death of the spouse of a dependent child, and at the beginning of each legislative session (applies only to enrolled legislators). Effective date for newly acquired dependents if application was made within the 30 days can be the first day of the following month. Effective date for an adopted child can be date of adoption, or date of placement in the adoptive parents' home, or the first of the month following the date of adoption or placement. Firefighters, rescue squad workers, and members of the national guard, and their eligible dependents, are subject to the same terms and conditions as are new employees and their dependents covered by this subdivision. Enrollments in these circumstances must occur within 30 days of eligibility to enroll."

SECTION 3.(d) G.S. 135-45.4(b)(5) reads as rewritten:

"(5) To administer the 12-month waiting period for preexisting conditions under this that Article, the Plan must give credit against the 12-month period for the time a person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 63 days before the effective date of coverage. As used in this subdivision, a "previous plan" means any policy, certificate, contract, or any other arrangement provided by any accident and health insurer, any hospital or medical service corporation, any health maintenance organization, any preferred provider organization, any multiple employer welfare arrangement, any self-insured health benefit arrangement, any governmental health benefit or health care plan or program, or any other health benefit arrangement. Waiting periods for preexisting conditions administered under this Article are subject to applicable federal law."

SECTION 3.(e) Eligibility audit. – The Executive Administrator shall provide for an audit of dependent eligibility under the Plan. The audit shall be designed to determine whether all dependents currently covered under the Plan are eligible for coverage under current law. Upon identification of an individual who is enrolled as a dependent but not eligible, the Plan shall disenroll the ineligible dependent effective within 10 days of sending written termination notice to the employee. The notice shall state the date upon which disenrollment will become effective and the basis on which the determination of dependent ineligibility is made. Notwithstanding any other provision of law, the Executive Administrator may waive requirements to collect from the member reimbursement for claims paid for the ineligible covered individual.

SECTION 3.(f) Cessation of coverage of ineligible individuals. – G.S. 135-45.12 is amended by adding the following new subdivision to read:

"(8) The last day of the month in which a covered individual is found to be ineligible for coverage."

SECTION 3.(g) Documentation of dependent eligibility. – G.S. 135-45.3 is amended by adding the following new subsection to read:

"(c) When an eligible or enrolled member applies to enroll the member's eligible dependent child or spouse, the member shall provide the documentation required by the Plan to verify the dependent's eligibility for coverage."

PART FOUR: NC HEALTH CHOICE CHANGES.

SECTION 4.(a) Over-the-counter medications. – Coverage of over-the-counter medication authorized under G.S. 108A-70.21(d) for the NC Health Choice Program shall become effective on the later of July 1, 2010, or the date upon which the Department of Health and Human Services assumes full responsibility for administration and processing of claims under the NC Health Choice Program.

SECTION 4.(b) Subrogation. – For the period authorized under subsection (a) of this section, the right of subrogation under G.S. 108A-57 applies to the State Health Plan for payments made by the Plan under the NC Health Choice Program. This subsection expires on the later of July 1, 2010, or the date upon which the Department of Health and Human Services assumes full responsibility for administration, processing, and payment of claims under the NC Health Choice Program.

SECTION 4.(c) DHHS Subrogation under NC Health Choice. – G.S. 108A-57 is amended by adding the following new subsection to read:

"(c) This section applies to the administration of and claims payments made by the Department of Health and Human Services under the NC Health Choice Program established under Part 8 of this Article."

SECTION 4.(d) G.S. 108A-70.21(g) reads as rewritten:

"(g) Purchase of Extended Coverage. – An enrollee in the Program who loses eligibility due to an increase in family income above two hundred ~~fifty percent (250%)~~percent (200%) of the federal poverty level and up to and including two hundred ~~seventy-five percent (275%)~~ twenty-five percent (225%) of the federal poverty level may purchase at full premium cost continued coverage under the Program for a period not to exceed one year beginning on the date the enrollee becomes ineligible under the income requirements for the Program. The benefits, copayments, and other conditions of enrollment under the Program applicable to extended coverage purchased under this subsection shall be the same as those applicable to an NC Kids' Care enrollee whose family income equals two hundred ~~fifty percent (250%)~~ percent (200%) of the federal poverty level."

PART FIVE: OTHER CHANGES.

SECTION 5.(a) G.S. 135-45.4(b)(2) reads as rewritten:

"(2) Employees not enrolling or not adding dependents when first eligible may enroll later on the first of any following month, but will be subject to a

twelve-month waiting period for preexisting conditions except as provided in subdivision (a)(3) of this section. The waiting period under this subdivision is subject to applicable federal law."

SECTION 5.(b) Utilization management functions. – G.S. 135-44.4 is amended by adding the following new subdivisions to read:

"(13a) The Plan and its pharmacy benefit manager may implement and administer pharmacy and medical utilization management programs and programs to detect and address utilization abuse of benefits.

...

(29) For transplant and bariatric medical procedures, the Plan may restrict coverage to certain in-network providers that are designated by the Plan's claims processing contractor."

SECTION 5.(c) G.S. 135-44.1(b) reads as rewritten:

"(b) ~~Six~~ A majority of the members of the Board of Trustees in office shall constitute a quorum. Decisions of the Board of Trustees shall be made by a majority vote of the Trustees present, except as otherwise provided in this Part."

SECTION 5.(d) G.S. 135-45.9(b) reads as rewritten:

"(b) Notwithstanding any other provision of this Part, the following necessary services for the care and treatment of chemical dependency and mental illness shall be covered as provided in this section: allowable institutional and professional charges for inpatient care, outpatient care, intensive outpatient program services, partial hospitalization treatment, and residential care and treatment:

(1) For mental illness treatment:
   a. Licensed psychiatric ~~hospitals;~~ hospitals or State psychiatric hospitals accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
   b. Licensed psychiatric beds in licensed general hospitals;
   c. Licensed residential treatment facilities that have 24-hour on-site care provided by a registered nurse who is physically located at the facility at all times and that hold current accreditation by a national accrediting body approved by the Plan's mental health case manager;
   d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities or County Programs in accordance with G.S. 122C-141;
   e. Licensed intensive outpatient treatment programs; and
   f. Licensed partial hospitalization programs.

(2) For chemical dependency treatment:
   a. Licensed chemical dependency units in licensed psychiatric ~~hospitals;~~ hospitals or in State psychiatric hospitals accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
   b. Licensed chemical dependency hospitals;
   c. Licensed chemical dependency treatment facilities;
   d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities or County Programs in accordance with G.S. 122C-141;
   e. Licensed intensive outpatient treatment programs;
   f. Licensed partial hospitalization programs; and
   g. Medical detoxification facilities or units."

SECTION 5.(e) Section 28.22A(k) of S.L. 2007-323 reads as rewritten:

"**SECTION 28.22A.(k)** Subsection (j) of this section expires ~~June 30, 2009.~~ June 30, 2011."

SECTION 5.(f) G.S. 135-43(b) reads as rewritten:

"(b) Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees may contract with providers of institutional and professional medical care and services to establish preferred provider networks.

~~The terms pertaining to reimbursement rates or other terms of consideration of any contract between hospitals, hospital authorities, doctors, or other medical providers, or a pharmacy benefit manager and the Plan, or contracts pertaining to the provision of any medical benefit offered under the Plan, including its optional alternative comprehensive benefit plans, and programs available under the optional alternative plans, shall not be a public record under Chapter 132 of the General Statutes for a period of 30 months after the date of the expiration of the contract.~~ The terms of a contract between the Plan and its third party administrator or between the Plan and its pharmacy benefit manager are a public record except that the terms in those contracts that contain trade secrets or proprietary or competitive information are not a public record under Chapter 132 of the General Statutes and any such proprietary or competitive information and trade secrets contained in the contract shall be redacted by the Plan prior to making it available to the public. ~~Provided, however, nothing in this subsection shall be deemed to~~This subsection shall not be construed to prevent or restrict the release of any information made not a public record under this subsection to the State Auditor, the Attorney General, the Director of the State Budget, the Plan's Executive Administrator, ~~the Department of Health and Human Services solely for the purpose of implementing the transition of NC Health Choice from the Plan to the Department of Health and Human Services,~~ and the Committee on Employee Hospital and Medical Benefits solely and exclusively for their use in the furtherance of their duties and ~~responsibilities.~~responsibilities, and to the Department of Health and Human Services solely for the purpose of implementing the transition of NC Health Choice from the Plan to the Department of Health and Human Services. The design, adoption, and implementation of the preferred provider contracts, networks, and optional alternative comprehensive health benefit plans, and programs available under the optional alternative plans, as authorized under G.S. 135-45 are not subject to the requirements of Chapter 143 of the General Statutes. The Executive Administrator and Board of Trustees shall make reports as requested to the President of the Senate, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Committee on Employee Hospital and Medical Benefits."

SECTION 5.(g) Effective January 1, 2011, G.S. 135-45.1(21) reads as rewritten:

"(21) Plan year. – The period beginning ~~July 1~~ January 1 and ending on ~~June 30~~ December 31 of the succeeding calendar year."

PART SIX: SALARY-RELATED CONTRIBUTIONS.

SECTION 6.(a) Effective for the 2009-2011 fiscal biennium, required employer salary-related contributions for employees whose salaries are paid from department, office, institution, or agency receipts shall be paid from the same source as the source of the employees' salary. If an employee's salary is paid in part from the General Fund or Highway Fund and in part from department, office, institution, or agency receipts, required employer salary-related contributions may be paid from the General Fund or Highway Fund only to the extent of the proportionate part paid from the General Fund or Highway Fund in support of the salary of the employee, and the remainder of the employer's requirements shall be paid from the source that supplies the remainder of the employee's salary. The requirements of this section as to source of payment are also applicable to payments on behalf of the employee for hospital-medical benefits, longevity pay, unemployment compensation, accumulated leave, workers' compensation, severance pay, separation allowances, and applicable disability income benefits.

Notwithstanding any other provision of law, an employing unit that is subject to Part 3A of Article 3A of Chapter 135 of the General Statutes and that hires or has hired as an employee a retiree that is in receipt of monthly retirement benefits from any retirement system supported in whole or in part by contributions of the State shall enroll the retiree in the active group and pay the cost for the hospital-medical benefits if that retiree is employed in a position that would require the employer to pay hospital-medical benefits if the individual had not been retired.

SECTION 6.(b) Effective July 1, 2009, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2009-2010 fiscal year are: (i) eight and forty-four hundredths percent (8.44%) – Teachers and State Employees; (ii) thirteen and forty-four hundredths percent (13.44%) – State Law Enforcement Officers; (iii) eleven and seventy-six hundredths percent (11.76%) – University Employees' Optional Retirement System; (iv) eleven and seventy-six hundredths percent (11.76%) – Community College Optional Retirement Program; (v) seventeen and sixty-one hundredths percent (17.61%) – Consolidated Judicial Retirement System; and (vi) four and forty hundredths percent (4.40%) – Legislative Retirement System. Each of the foregoing contribution rates includes four and forty hundredths percent (4.40%) for hospital and medical benefits. The rate for Teachers and State Employees, State Law Enforcement Officers, Community College Optional Retirement Program, and for the University Employees' Optional Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

SECTION 6.(c) Effective July 1, 2010, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2010-2011 fiscal year are: (i) eight and eighty-four hundredths percent (8.84%) – Teachers and State Employees; (ii) thirteen and eighty-four hundredths percent (13.84%) – State Law Enforcement Officers; (iii) twelve and sixteen hundredths percent (12.16%) – University Employees' Optional Retirement System; (iv) twelve and sixteen hundredths percent (12.16%) – Community College Optional Retirement Program; (v) eighteen and one hundredths percent (18.01%) – Consolidated Judicial Retirement System; and (vi) four and eighty hundredths percent (4.80%) – Legislative Retirement System. Each of the foregoing contribution rates includes four and eighty hundredths percent (4.80%) for hospital and medical benefits. The rate for Teachers and State Employees, State Law Enforcement Officers, Community College Optional Retirement Program, and for the University Employees' Optional Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

SECTION 6.(d) Effective July 1, 2009, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2009-2010 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand four hundred thirty-eight dollars ($3,438) and (ii) non-Medicare-eligible employees and retirees – four thousand five hundred fifteen dollars ($4,515).

SECTION 6.(e) Effective July 1, 2010, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2010-2011 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand seven hundred thirty-five dollars ($3,735) and (ii) nonMedicare-eligible employees and retirees – four thousand nine hundred five dollars ($4,905).

PART SEVEN: EFFECTIVE DATE.

SECTION 7. Sections 1(b), 1(c), 1(d), 2(c) through (e), 2(g), and 2(h) of this act become effective July 1, 2009. Section 4(d) of this act applies to applications for the purchase of extended coverage made on and after July 1, 2008. The remainder of this act is effective when it becomes law.

SUMMARY
S287 – 3d Edition
STATE HEALTH PLAN

FUNDS (Part One, pages 1-2)
Appropriate $250,000,000 for 2008-2009 [from Savings Reserve]
Appropriate $128.4 million 2009-2010; $267.9 million 2010-2011

BENEFIT changes:
Eliminate PPO Plus effective July 1, 2009 (Section 2(a), p. 2)
Healthy Lifestyles Initiative: (Section 2(b), pp. 2-3)
Smoking cessation:
July 1, **2010,** all members are enrolled in 70/30 plan. If at the time of enrollment the member attests that the member and the member's adult covered dependents are nonsmokers then, upon attestation, the member may enroll in the 80/20 plan.
Weight management:
July 1, **2011,** all members are enrolled in the 70/30 plan. If at the time of enrollment the member is a nonsmoker and meets the weight management requirements the member may choose to enroll in the 80/20 plan. If the member is a nonsmoker but does not meet the weight requirements the member may enroll in the 80/20 plan **if** the member is enrolled in a Plan-approved weight management program, or, **if** the member's physician certifies in writing that the member has a condition that prevents the member from attaining the weight requirement.

The Plan must provide education and training to assist members in complying with smoking cessation and weight management requirements.

Prescription drug co-payments (Section 2(c) pp. 3-4)
No increase for generics ($10)
$35 for preferred brand **w/o generic** ($5 increase)
$55 for non-preferred branded ($5 increase)
Branded w/generic – members pays generic co-pay ($10) **plus** the difference between the Plan's cost for the generic and the Plan's cost for the branded drug.
No coverage for drugs for sexual dysfunction, hair growth, and non-medically necessary drugs used for cosmetic purposes. (Section 2(c), p. 4, lines 36-39)
Prohibits re-packaging by the vendor. (Section 2(c), pp. 4, lines 43-48)

Specialty drugs (Section 2(c) p4.) Specialty medications are covered biotech medications and other medications designated by the Plan that generally have unique uses for the treatment of complex diseases, require special dosing or administration, require special handling, are typically prescribed by a specialist provider, and exceed $400 cost to the Plan. Examples of these medications are those prescribed for such conditions as Hemophilia, or are Growth Hormone drugs or certain drugs prescribed for rheumatoid arthritis.
The member will be required to:
a. Purchase the drug from a "specialty pharmacy vendor" under contract with the Plan, and

b. Pay a co-payment in the amount of 25% of the Plan's cost of the drug but not more than $100. For example, if the Plan's cost of the drug is $1,000, 25% of $1,000 is $250 but the member would only be required to pay $100.

Deductibles/co-pays/coinsurance changes (Section 2(e), pages 5-6)
These amounts go into effect July 1, 2009. They differ in the Basic and Standard plans. Deductibles and coinsurance listed are for member-only coverage. Dependent coverage is 3x the member-only amounts.

Basic Plan (70/30)		**Standard Plan (80/20)**
$800	in-network annual deductible	$600
$1,600	out-of-network annual deductible	$1,200
$3,250	in-network coinsurance	$2,750
$6,500	out-of-network coinsurance	$5,500
$30	in-network primary care	$25
$70	for in-network specialist care	$60
$250	for inpatient co-pay (in-network and out-of-network)	$200
$75 (no change)	urgent care	$75 (increased from $50)

Premium increase for **contributory** (dependent) coverage – 8.6%. (Sec. 2(g), p.6)
The Plan does not charge a premium for member-only coverage.
Eliminate coverage for routine eye exams – Effective 1/1/2010 (Sec.2(d), p. 5.)
Extend sunset on no-limitation on occupational, physical, and speech therapies. (Sec. 5(e), p.10)

Pharmacy benefit savings. (Sec. 2(h), pp. 6-7)
The language in this section replaces that in the 2nd edition pertaining to retail pharmacy networks and mail-order. Under this section there would be reductions in pharmacy reimbursements expected to yield $18,000,000 in savings to the Plan in the first year (2009-2010) and $20,000,000 in savings in the second year (2010-2011). If the savings are greater than these amounts the Plan will adjust the reimbursements accordingly. If the savings do not reach 105% of the savings specified, the pharmacy reimbursement reduction will remain. The Plan will review the savings achieved every six months. Within 60 days of determining the savings achieved, the Plan will report the results to the Committee on Employee Hospital and Medical Benefits. Members will not be required to choose between a network pharmacy and mail-order.

TECHNICAL and conforming changes:(pp. 7-12)
Clarifies dependent coverage (p. 7-8)
Requires eligibility audit to ensure all covered dependents are eligible for coverage (p. 8)
Authorizes programs to address utilization abuse (p. 9)
Changes to employer contribution rates (pp. 11-12)
NC Health Choice (pp 8-9):
Delays effective date of coverage for over-the-counter meds

Authorizes subrogation

Technical correction re purchase of extended coverage

Makes the contracts between the Plan and BC/BS and its pharmacy benefit manager a public record except that information that is competitive, proprietary, or trade secret shall be redacted from the contract before releasing it. (pp. 10-11).

EFFECTIVE DATE.

3/14/gw

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: Senate Bill 287 (Third Edition)

SHORT TITLE: State Hlth Plan $/Good Health Initiatives.

SPONSOR(S): Senator Rand

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY: The third edition of Senate Bill 287, as passed by the Senate, appropriates funds from various sources, authorizes annual premium rate increases, makes various benefit and provider related changes to achieve financial savings, and directs other various changes to the Plan.

EFFECTIVE DATE: Sections 1(b), 1(c), 1(d), 2(c) through (e), 2(g), and 2(h) of this act become effective July 1, 2009. The benefit changes in Section 2(b)(2) become effective July 1, 2010, in Section 2(b)(3) on July 1, 2011, and in Section 2(d) on January 1, 2010. The remainder of this act is effective when it becomes law.

ESTIMATED IMPACT ON STATE:

Current FY 2008-2009

Appropriated Funds

Section 1(a) appropriates the sum of $250 million from the Savings Reserve Account ("Rainy Day Fund") of the General Fund for the 2008-09 fiscal year. These funds are to be used to finance a shortfall in funds available to pay health care benefits, administrative costs, and adequately fund the Plan's beginning cash balance on July 1, 2009.

2009-2011 Biennium

Increased Premium Contributions

Appropriated Funds

Sections 1(b), (c), and (d) appropriate the estimated required funds to support increased employer contributions to continue non-contributory benefit coverage for eligible employees and retired employees enrolled in the Plan for the 2009-2011 Biennium. These appropriations correspond to an annual 8.6% premium increase in non-contributory premium rates for the fiscal year beginning July 1, 2009, and an

additional annual premium increase of 8.6% for the fiscal year beginning July 1, 2010. Historically, the Plan has applied a premium increase in October of the first fiscal year of a biennium; however, the premium increases in the bill propose to change that methodology to an annual increase at the beginning of each fiscal year of a biennium. The table below reflects the allocation of appropriated funds by fund source:

Additional Employer Contributions
Appropriated Funds

Fund Source	FY 2009-10	FY 2010-11	Biennium
General Fund	$128,410,208	$267,904,114	$396,314,322
Highway Fund	$5,992,476	$12,502,192	$18,494,668
Other Funds	$26,491,180	$55,268,941	$81,760,121
Total	$160,893,864	$335,675,247	$496,569,111

Employee Funds

Section 2(g) of the proposed bill authorizes an annual 8.6% premium increase in contributory premium rates for the fiscal year beginning July 1, 2009, and an additional annual premium increase of 8.6% for the fiscal year beginning July 1, 2010. The estimated additional premium contributions from this proposed change is listed below:

Additional Employee Contributions
For Contributory Dependent Coverage

Fund Source	FY 2009-10	FY 2010-11	Biennium
Employee Contributions	$32,939,207	$68,721,555	$101,660,762

Total Increased Premium Contributions From Appropriated and Employee Funds

The table below reflects the total additional premium contributions projected to be received by the Plan over the 2009-2011 Biennium as a result of the proposed rate increase of premium increase:

Total Additonal Premium Contributions
From Appropriated and Employee Funds

Fund Source	FY 2009-10	FY 2010-11	Biennium
Appropriated			
General Fund	$128,410,208	$267,904,114	$396,314,322
Highway Fund	$5,992,476	$12,502,192	$18,494,668
Other Funds	$26,491,180	$55,268,941	$81,760,121
Sub-total	$160,893,864	$335,675,247	$496,569,111
Employee Contributions	$32,939,207	$68,721,555	$101,660,762
Total	$193,833,071	$404,396,802	$598,229,873

Financial Savings for the 2009 Biennium

Per the requirements of Senate Rule 42.2, House Rule 36.2, and G.S. 120-114 actuarial analyses have been prepared with respect to the bill's proposed benefit and other changes that are estimated to affect the financial condition of the Plan. A summary of the proposed changes are described below including the estimated actuarial impact of these changes.

Sections 2(c), (d), and (e) of the bill propose various benefit changes to include increased annual deductibles, annual co-insurance maximums, increased office visit co-pays, increased outpatient prescription drug co-pays, a new specialty drug co-pay and utilization of a specialty drug vendor. Effective January 1, 2010, the proposed bill also eliminates the current in-network routine eye examination benefit offered under the Plan.

A summary of the out-of-pocket changes for medical benefit related services are summarized in the table below:

Medical Benefits	**PPO Basic**		**PPO Standard**	
Plan Member Co-pays (per visit)	**Current**	**New Co-pay**	**Current**	**New Co-pay**
Primary Care	$25	$30	$20	$25
Specialty Care	$50	$70	$40	$60
Urgent Care	$75	$75	$50	$75
Inpatient Hospital	$200	$250	$150	$200
Annual Deductible				
In-network	$600	$800	$300	$600
Out-of-network	$1,200	$1,600	$600	$1,200
Coinsurance Maximum				
In-network	$2,500	$3,250	$1,750	$2,750
Out-of-network	$5,000	$6,500	$3,500	$5,500

For acute and maintenance prescription drugs, the co-pay for brand drugs increases from $30 per script to $35 per script, brand drugs with a generic equivalent from $40 per script to $10 plus the difference in the Plan's gross allowed cost of the brand drug and the Plan's cost of the generic equivalent drug, and from $50 per script to $55 per script for non-preferred brand drugs.

The proposed bill authorizes a new co-pay tier for specialty prescription drugs determined to be "biotech" medications or other select costly medications that cost the Plan in excess of $400 per prescription. The new per script co-pay will be equal to 25% of the Plan's cost for the drug or a maximum of $100. The current co-pays for specialty drugs range from $30 to $50 per script. The bill also authorizes the Plan to contract with a specialty drug vendor through which to channel plan member purchases of specialty drugs on an outpatient basis or in a professional office or institution setting.

Aon Consulting, the consulting actuary for the State Health Plan for Teachers and State Employees, estimates that the implementation of the bill's proposed benefit changes will yield the following projected savings:

Aon Consulting
Projected Financial Savings
Benefit and Provider Related Changes

Category	FY 2009-10	FY 2010-11	Biennium
Medical Benefits	$118,866,918	$139,542,217	$258,409,135
Outpatient Prescription Drugs (acute drugs)	$22,162,147	$24,092,234	$46,254,381
Specialty Drugs	$3,086,315	$3,396,887	$6,483,202
Total	$144,115,380	$167,031,338	$311,146,718

Hartman & Associates, the consulting actuary for the General Assembly's Fiscal Research Division, estimates that estimates that the implementation of the bill's proposed benefit changes will yield the following projected savings:

Hartman & Associates
Projected Financial Savings
Benefit and Provider Related Changes

Category	FY 2009-10	FY 2010-11	Biennium
Medical Benefits	$118,684,000	$143,713,000	$262,397,000
Outpatient Prescription Drugs (acute drugs)	$24,015,000	$24,225,000	$48,240,000
Specialty Drugs	$3,136,000	$3,417,000	$6,553,000
Total	$145,835,000	$171,355,000	$317,190,000

Provided below is a comparison table reflecting the specific results of each consulting actuary by the type of benefit and provider change proposed in the bill:

Projected Financial Savings by Type

Category	Aon Consulting (Plan) FY 2009-10	FY 2010-11	Biennium	Hartman & Assoc. (General Assembly) FY 2009-10	FY 2010-11	Biennium
Medical Benefits						
Primary Care Co-pay (Increase)	$8,518,038	$9,571,177	$18,089,215	$8,116,000	$9,257,000	$17,373,000
Specialist Co-pay (Increase)	$29,077,025	$32,672,003	$61,749,028	$27,125,000	$31,713,000	$58,838,000
Urgent Care Co-pay (Increase)	$739,560	$830,997	$1,570,557	$854,000	$994,000	$1,848,000
Inpatient Co-pay (Increase)	$2,158,037	$2,424,849	$4,582,886	$1,970,000	$2,247,000	$4,217,000
Routine Eye Exam (Eliminate Benefit) {Eff. 1/2010}	$2,158,693	$7,193,591	$9,352,284	$2,540,000	$7,039,000	$9,579,000
Deductible and Coinsurance Max (Increase)	$76,215,565	$86,849,600	$163,065,165	$78,079,000	$92,463,000	$170,542,000
Sub-total	$118,866,918	$139,542,217	$258,409,135	$118,684,000	$143,713,000	$262,397,000
Outpatient Prescription Drugs (acute drugs)						
Brand Drug Co-pay (Increase)	$11,734,884	$12,173,684	$23,908,568	$12,010,000	$11,741,000	$23,751,000
Brand Drug with Generic Equivalent (Increase)	$4,632,720	$5,644,491	$10,277,211	$6,285,000	$6,536,000	$12,821,000
Non-Preferred Brand Drug Co-pay (Increase	$3,089,092	$3,204,602	$6,293,694	$3,530,000	$3,671,000	$7,201,000
Reduce from 34-Day supply to 30-Day Supply	$2,705,451	$3,069,457	$5,774,908	$2,190,000	$2,277,000	$4,467,000
Sub-total	$22,162,147	$24,092,234	$46,254,381	$24,015,000	$24,225,000	$48,240,000
Specialty Drugs						
Establish a Specialty Drug vendor	$1,682,177	$1,835,102	$3,517,279	$1,665,000	$1,887,000	$3,552,000
Specialty Drug Copay (Establish)	$1,404,138	$1,561,785	$2,965,923	$1,471,000	$1,530,000	$3,001,000
Sub-total	$3,086,315	$3,396,887	$6,483,202	$3,136,000	$3,417,000	$6,553,000
Grand Total	$144,115,380	$167,031,338	$311,146,718	$145,835,000	$171,355,000	$317,190,000

Other Proposed Changes Affecting the Plan

Section 2(a) of the proposed bill eliminates the PPO Plus benefit alternative for plan members effective July 1, 2009. Employees currently in this plan will be provided the option to enroll in the remaining PPO Basic or PPO Standard plans. The PPO Plus alternative currently offers 90/10 coverage for an additional premium charge paid by the plan member.

Section 2(b) of the proposed bill implements a "Comprehensive Wellness Initiative" to focus on smoking cessation and weight management efforts.

The smoking cessation program will commence July 1, 2010 and will require all non-Medicare plan members to be enrolled in the PPO Basic plan unless the subscribing employee or retired employee can attest that they or any enrolled dependent do not smoke or otherwise use tobacco products. For eligible employees or retired employees who have attested that neither they nor their enrolled dependents use tobacco products, or if their medical provider certifies that a plan member is in a smoking cessation program, they will have the option to enroll in the PPO Standard plan.

Aon Consulting, consulting actuary for the Plan, estimates the smoking cessation program will save approximately $3.4 million in claims cost for the FY 2010-11. However, the administrative costs to begin implementation are estimated by Aon to offset any first year savings. Aon consulting noted that until further administrative costs and program implementation issues are determined, estimating future savings to the Plan is not possible at this time. Hartman and Associates, consulting actuary for the General Assembly's Fiscal Research Division, does not project any financial impact to the Plan from the proposed smoking cessation program. According to Hartman and Associates, the lack of program parameters and specific administrative costs prevents any reasonable analysis to be conducted.

The weight management program authorized in the proposed bill will begin effective July 1, 2011. Under this program all non-Medicare plan members will be enrolled in the PPO Basic plan unless the subscribing employee or retired employee attests that the ratio of weight and height of the employee or retired employee, or for any of their enrolled dependents, meets certain evidence-based healthy weight clinical guidelines. A plan member who cannot meet the Plan's weight and height ratio guidelines will remain in

the PPO Basic plan unless a medical provider certifies the plan member has a medical condition that prevents them from attaining a specified ration of weight and height, or if the member is actively participating in a Plan-approved weight management program.

Neither the Plan's consulting actuary, Aon Consulting, nor the General Assembly's consulting actuary, Hartman and Associates, have estimated any financial impact due to the weight management program. The July 1, 2011 implementation date and yet to be developed administrative costs and program implementation requirements do not allow for any reliable financial projection at this time.

Section 2(h) of the bill directs the Plan to achieve a reduction of $18 million in FY 2009-10 and $20 million in FY 2010-11 in pharmacy provider costs through its existing contract authority with the Plan's Pharmacy Benefit Manager. These savings are based on the Plan's actuarial projection dated March 20, 2009 which makes specific assumptions about enrollment, estimated costs and utilization trends. Total savings under this authority may increase or decrease without adjustment based on a change in total enrollment provided that the rate of savings achieved on a per member per month basis remains constant. Adjustments to total savings may be made within 60-days after each six-month period of a fiscal year if savings exceed 105% of the specified savings.

Reconciliation of Plan's Financial Requirements

According to available information from the Executive Administrator of the Plan, the Plan needs an immediate appropriation of $250 million for the current 2008-2009 fiscal year to operate through June 30, 2009, and to provide for an adequate beginning cash balance to begin operations for the new fiscal year commencing July 1, 2009. In addition, for the new biennium beginning July 1, 2009 the Plan is estimated to require over $1.2 billion in additional financial support to remain solvent and maintain minimum claim stabilization reserves for the 2009-2011 biennium. If the Plan were to maintain current benefit levels and assuming a 9% per capita claims trend, the Plan would require an estimated 30.8% premium increase for the biennium (effective October 1, 2009).

The proposed bill addresses this projected shortfall by authorizing the following changes:

1. Proposing a 8.6% annual premium increase on July 1 of each fiscal year of the biennium for non-contributory and contributory premium rates; this change moves the historical date to increase premium rates from October 1 in the first year of a biennium, and moves to an annual premium increase;

2. Eliminating the current PPO Plus option benefit alternative;

3. Increase plan member out-of-pocket requirements for certain medical and prescription drug benefits; and

4. Directing the Plan to achieve a reduction of $18 million in FY 2009-10 and $20 million in FY 2010-11 in pharmacy provider costs through its existing contract authority with the Plan's Pharmacy Benefit Manager.

A financial summary table provided below provides a projected reconciliation of the financial related changes authorized under the bill assuming the Plan's consulting actuary's estimate of projected financial need for the 2009-2011 biennium, their projected financial savings due to benefit and other provider related changes, and their estimate of additional premium contributions:

State Health Plan
Summary of Financial Changes
Amendment to Senate Bill 287 (3rd Edition)
($ Million)

	FY 2009-10	FY 2010-11	Biennium
1) Projected Financial Support Required Before Any Adjustments	$528.1	$704.2	$1,232.3
2) Adjust for Proposed FY 2008-09 Special Appropriation of $250M	($107.1)	($142.9)	($250.0)
3) Adjust for Elimination of PPO Plus (Net Adjustment)	($14.4)	($24.4)	($38.8)
4) Adjusted Financial Support Required for the 2009-11 Biennium	$406.6	$536.9	$943.5
5) Benefit Reductions Effective July 1, 2009			
Medical			
Primary Care Co-pay (Increase)	($8.5)	($9.6)	($18.1)
Specialist Co-pay (Increase)	($29.1)	($32.7)	($61.8)
Urgent Care Co-pay (Increase)	($0.7)	($0.8)	($1.5)
Inpatient Co-pay (Increase)	($2.2)	($2.4)	($4.6)
Deductible and Coinsurance Maximum (Increase)	($76.2)	($86.9)	($163.1)
Routine Eye Exam (Eliminate Benefit) {Effective January 1, 2010}	($2.2)	($7.2)	($9.4)
Sub-total	($118.9)	($139.6)	($258.5)
Outpatient Acute and Specialty Prescription Drugs			
Brand Drug Co-pay (Increase)	($11.8)	($12.2)	($24.0)
Brand Drug with Generic Equivalent (Increase)	($4.6)	($5.6)	($10.2)
Non-Preferred Brand Drug Co-pay (Increase	($3.1)	($3.2)	($6.3)
Reduce from 34-Day supply to 30-Day Supply per script	($2.7)	($3.1)	($5.8)
Specialty Drug Copay (Establish)	($1.4)	($1.6)	($3.0)
Establish a Specialty Drug vendor	($1.7)	($1.8)	($3.5)
Sub-total	($25.3)	($27.5)	($52.8)
Total -- Benefit Reductions	($144.2)	($167.1)	($311.3)
6) Additional Pharmacy Discounts to be Implemented by the Plan	($18.0)	($20.0)	($38.0)
7) Appropriations by the General Assembly			
Premium increase for Employing Agencies (July 1, 2009 = 8.6%, July 1, 2010 = 8.6%)			
General Fund	($128.4)	($267.9)	($396.3)
Highway Fund	($6.0)	($12.5)	($18.5)
Other Employer Funds	($26.5)	($55.3)	($81.8)
Total Employer Funds	($160.9)	($335.7)	($496.6)
8) Premium increases for Dependent Coverage (July 1, 2009 = 8.6%, July 1, 2010 = 8.6%) Paid by Employees and Retirees for Enrolled Spouses and Dependent Children			
Total Employee Funds	($32.9)	($68.7)	($101.6)
9) Plan's Other Operating Adjustments	($0.2)	$6.6	$6.4
10) Balance	$50.4	($48.0)	$2.4

Note: The $2.4 balance remaining at the end of the biennium is a product of rounding error and a $2.1 million difference in projected ending cash balances between financial projections estimating total financial requirements and final requirements after the proposed premium increases, benefit changes, and other program changes. This difference is not expected to have an adverse effect on the Plan's finances.

ASSUMPTIONS AND METHODOLOGY:

The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2008, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.6 billion for FY 2008-09. The Plan's PPO benefit design includes three alternative benefit levels offered to plan members. The three alternative benefit levels include the following:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums;

2) The "Standard" 80/20 plan; and

3) The "Plus" 90/10 plan with enhanced benefits via lower out-of pocket requirements as compared to the other PPO plan alternatives offered.

Employees and retired employees electing coverage under the Plus alternative must make a partially contributory premium contribution for their own coverage. The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under all plans is offered on a fully contributory basis.

Financial Condition

Financial Projection (Revised) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year are projected to be $2.3 billion from premium collections, $53.9 million from Medicare Part D subsidies, and $2.7 million from investment earnings, for a total of slightly over $2.3 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.4 billion in claim-payment expenses and $168.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating loss is projected to be approximately $264.4 million for the fiscal year, assuming a 9% annual claims growth trend.

Projected operating losses are expected to deplete the Plan's cash balance of $139.8 million and leave it without sufficient operating resources to continue operations for the fiscal year. It is currently estimated by the Plan's Executive Administrator that the Plan will not be able to pay claims on a timely basis by March 31, 2009.

Consequently, the reforecast of Plan finances now indicates that the Plan will require up to $300 million in additional resources to operate for the balance of the 2008-09 fiscal year. This amount represents the estimated funds necessary to pay claims and administrative expenses through June 30, 2009, plus funding a minimum stabilization reserve equal to 7.5% of projected claims, and assuming a future premium rate increase effective October 1, 2009.

Other Information

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment Data as of December 31, 2008

I. No. of Participants	Basic	Standard	Plus	Total	Percent of Total
Actives					
Employees	11,623	271,243	47,687	330,553	49.6%
Dependents	20,454	115,875	28,156	164,485	24.7%
Sub-total	32,077	387,118	75,843	495,038	74.2%
Retired					
Employees	1,726	127,081	17,967	146,774	22.0%
Dependents	1,117	14,935	3,476	19,528	2.9%
Sub-total	2,843	142,016	21,443	166,302	24.9%
Former Employees with Continuation Coverage					
Employees	60	1,349	344	1,753	0.3%
Dependents	61	501	182	744	0.1%
Sub-total	121	1,850	526	2,497	0.4%
Firefighters, Rescue Squad & National Guard					
Employees	-	3	2	5	0.0%
Dependents	-	3	-	3	0.0%
Sub-total	-	6	2	8	0.0%
Local Governments					
Employees	72	1,577	319	1,968	0.3%
Dependents	141	637	218	996	0.1%
Sub-total	213	2,214	537	2,964	0.4%
Total					
Employees	13,481	401,253	66,319	481,053	72.1%
Dependents	21,773	131,951	32,032	185,756	27.9%
Grand Total	**35,254**	**533,204**	**98,351**	**666,809**	**100%**
Percent of Total	**5.3%**	**80.0%**	**14.7%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	2,684	328,635	49,246	380,565
Employee Child(ren)	4,958	36,903	8,589	50,450
Employee Spouse	2,274	18,145	4,469	24,888
Employee Family	3,565	17,570	4,015	25,150
Total	**13,481**	**401,253**	**66,319**	**481,053**

Percent Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	19.9%	81.9%	74.3%	79.1%
Employee Child(ren)	36.8%	9.2%	13.0%	10.5%
Employee Spouse	16.9%	4.5%	6.7%	5.2%
Employee Family	26.4%	4.4%	6.1%	5.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Enrollment Data Continued

III. Enrollment by Sex	Basic	Standard	Plus	Total
Female	18,837	334,917	61,752	415,506
Male	16,417	198,287	36,599	251,303
Total	35,254	533,204	98,351	666,809

Percent Enrollment by Sex	Basic	Standard	Plus	Total
Female	53.4%	62.8%	62.8%	62.3%
Male	46.6%	37.2%	37.2%	37.7%
Total	100.0%	100.0%	100.0%	100.0%

IV. Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	17,390	136,277	27,211	180,878
30 to 44	8,125	107,375	17,315	132,815
45 to 54	5,164	94,548	18,277	117,989
55 to 64	3,195	102,901	23,452	129,548
65 & Over	1,380	92,103	12,096	105,579
Total	35,254	533,204	98,351	666,809

Percent Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	49.3%	25.6%	27.7%	27.1%
30 to 44	23.0%	20.1%	17.6%	19.9%
45 to 54	14.6%	17.7%	18.6%	17.7%
55 to 64	9.1%	19.3%	23.8%	19.4%
65 & Over	3.9%	17.3%	12.3%	15.8%
Total	100.0%	100.0%	100.0%	100.0%

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	49,534	12,080	61,614
Medicare Eligible	97,240	7,448	104,688
Total	146,774	19,528	166,302

Percent by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.7%	61.9%	37.0%
Medicare Eligible	66.3%	38.1%	63.0%
Total	100.0%	100.0%	100.0%

SOURCES OF DATA:

Aon Consulting, North Carolina State Health Plan, Financial Projections – October 2008, Total For All Plans – 9% Trend, October 10, 2008.

Aon Consulting, North Carolina State Health Plan, Financial Projections – October 2008, Total For All Plans – 9% Trend, July 2009 & 2010 Rate Increases, $250 Million Grant, No Plus Option – July 2009, Benefit Option, Pharmacy Initiatives, March 20, 2009.

Medco Health Solutions, various outpatient acute, specialty, and maintenance drug data and discount assumptions, March 2009.

State Health Plan, various summarized claims reports for medical claims by category and purpose and time period, December 2008, January 2009.

-Actuarial Note, Hartman & Associates, " Senate Bill 287 (Third Edition): An Act to Appropriate Funds for the State Health Plan and to Make Other Changes to the State Health Plan", March 25, 2009, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "Senate Bill 287 Proposed Committee Substitute S287 [v.3], State Health Plan $/Good Health Initiatives", March, 25 2009, original of which is on file with the Comprehensive Major Medical Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Marilyn Chism, Director
Fiscal Research Division

DATE: March 26, 2009

Signed Copy Located in the NCGA Principal Clerk's Offices

NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

SENATE BILL 287
PROPOSED COMMITTEE SUBSTITUTE
S287 [V.3]

State Health Plan $/Good Health Initiatives

Prepared by:

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Atlanta, Georgia 30305

March 2009

ACTUARIAL STATEMENT

The North Carolina State Health Plan for Teachers and State Employees has requested that Aon Consulting prepare an Actuarial Note in response to Senate Bill 287 proposed committee substitute S287 [v.3] entitled "An Act To Appropriate Funds For The State Health Plan For Teachers And State Employees And To Make Other Changes Related To The State Health Plan."

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

March 25, 2009

Kenneth C. Vieira, F.S.A., M.A.A.A.
Senior Vice President

Date

March 25, 2009

Kirsten R. Schatten, A.S.A., M.A.A.A.
Assistant Vice President

Date

STATE HEALTH PLAN $/GOOD HEALTH INITIATIVES

PLAN CHANGES

The proposed legislation is divided into seven sections. The full text of the bill is attached to this actuarial note. Below is brief summary of the key components of each section.

PART ONE: APPROPRIATIONS, DEFINITIONS, AND SCOPE

This section primarily deals with the appropriations required to fund the program for the next biennium. Section (a) details the appropriation of $250 million from the Savings Reserve Account. Sections (b) & (c) are appropriations needed by the general and highway funds.

The amounts set forth in this section were determined based on a financial projection provided by Aon Consulting.

PART TWO: HEALTH BENEFIT CHANGES

This section encompasses the bulk of the financial impact on to State Health Plan related to benefit changes effective July 1, 2009. Each component is summarized below with details of our key assumptions in the "Pricing Approach and Comments" section of this actuarial note.

SECTION 2.(a) Eliminate PPO Plus Option

Effective July 1, 2009, the PPO Plus option (90/10 in-network coverage) under the State Health Plan for Teachers and State Employees ("Plan") is eliminated. The Executive Administrator shall provide notice to all members of the Plan that this option will no longer be available as of July 1, 2009. Employees enrolled in the Plan's Plus option shall have the choice of enrolling in the Basic or Standard plan options for the 2009-2010 benefit year.

SECTION 2.(b) Implement Comprehensive Wellness Initiative

The first section allows the Plan to develop a Comprehensive Wellness Initiative that starts with a focus on smoking cessation and weight management. It is designed to be implemented effective July 1, 2010, for smoking cessation and July 1, 2011, for weight management.

The second and third sections detail how certain members who do not meet the program requirements will be enrolled into the Basic plan. Further details of the program are being developed. The program is assumed to be cost neutral.

SECTION 2.(c) Prescription drug co-payments

The legislation will alter the co-payments for the prescription drug program depending on the category of drug. Below are the major components:

The first section changes the current copays:

1. Formulary brand drugs will increase from $30 to $35
2. Non-Formulary brand drugs will increase from $50 to $55
3. For each branded prescription drug with a generic equivalent drug, the member shall pay the generic co-payment plus the difference between the Plan's gross allowed cost for the generic prescription and the Plan's cost for the branded prescription drug.

The second section allows the plan to provide coverage of nonacute specialty medications under the Plan's pharmacy benefit through a specialty pharmacy vendor under contract with the Plan. The Plan may transfer coverage of specified specialty disease medications covered under the Plan's medical benefit to the contracted specialty pharmacy vendor. The Plan shall impose a co-payment in the amount of twenty-five percent (25%) of the Plan's gross allowed cost of the specialty drug not to exceed one hundred dollars ($100.00) per prescription per 30-day supply.

The third section allows the plan to exclude coverage of certain over the counter medications.

The fourth section reduces the day supply to 30 days from 34 days. It also addresses utilization management procedures and options for the plan.

2.(d) Routine eye examinations not covered

Routine eye exams will no longer be a covered benefit as of January 1, 2010.

2.(e) Deductible and co-payment changes

There were a number of changes made to the Basic (70/30) and Standard (80/20) plans. These involved increased deductibles, coinsurance maximums, primary and specialty physician office visit co-payments, urgent care co-payments and inpatient co-payments. Details of each change can be found in the attached bill.

2.(f) Limitation on authority to change benefits

This section limits the authority of The Executive Administrator and Board of Trustees to make changes, requiring them to be made by the General Assembly.

2.(g) Premium increases

This section sets the premium increase to 8.6% for each July in the next biennium. This is consistent with the financial projections.

2.(h) Pharmacy Benefit Savings

This section directs the Plan to reduce pharmaceutical costs by $18 million in FY2010 and $20 million in FY 2011 through reduced reimbursements paid to pharmacies within the terms of the Plan's PBM contract. Achieved savings will be reviewed twice annually to adjust the PBM contract terms so actual savings will be within 105% of the savings amounts specified above.

PART THREE: ELIGIBILITY CLARIFICATION.

This section contains clarifications on various dependent categories. It also contains a section that allows the Plan to perform a dependent eligibility audit. The savings resulting from the audit should exceed the cost of performing the audit.

PART FOUR: NC HEALTH CHOICE CHANGES.

This section is related to NC Health Choice and has no financial impact on the State Health Plan.

PART FIVE: OTHER CHANGES

This section contains miscellaneous changes and clarification that have no financial impact on the State Health Plan.

PART SIX: SALARY-RELATED CONTRIBUTIONS

This section sets the funding percentages of the various groups and has no additional cost to the State Health Plan. The percentages are designed to be consistent with the financial projections.

PART SEVEN: EFFECTIVE DATE

Sections 1(b), 1(c), 1(d), 2(c), 2(e), 2(g), and 2(h) of this act become effective July 1, 2009. Section 2(d) becomes effective January 1, 2010. The remainder of this act is effective when it becomes law.

PROJECTED SAVINGS

				Based on "Midpoint" Increase		
Section	Plan Design Change			2009-2010 Fiscal Year Cost	2010-2011 Fiscal Year Cost	Total Biennium Cost
Part 1 – Appropriations, Definitions & Scope						
1(a)	$250 million appropriation from savings reserve account			Included in baseline projection		
1(b) - 1(c)	General Fund and Highway Appropriations			Included in baseline projection		
1(d) - 1(f)	Other funds, definition & scope			Included in baseline projection		
Part 2 - Health Benefit Changes						
2(a)	Eliminate PPO Plus Option			Included in baseline projection. Details of savings summarized in pricing		
2(b)	Implement Comprehensive Wellness			Administrative cost assumed to be offset by future savings. No net impact to the plan in the biennium		
2(c)	Prescription Drug Co-payment					
(1)	Preferred Brand	$30 to $35		($11.8)	($12.2)	($24.0)
	Brand with Generic Available	Pay as generic		($4.6)	($5.6)	($10.2)
	Non-Preferred Brand	$50 to $55		($3.1)	($3.2)	($6.3)
(2)	Specialty Drugs	25% coinsurance, $100 max		($1.4)	($1.6)	($3.0)
		Specialty Vendor		($1.7)	($1.8)	($3.5)
(3)	OTC drugs may be excluded			No Cost Impact		
(4)	Day Supply	Reduce from 34 to 30		($2.7)	($3.1)	($5.8)
2(d)	Routine eye exams not covered			($2.1)	($7.2)	($9.3)
2(e)	Deductible and co-payment changes					
		Basic	Standard			
	Deductible to	$800/1600	$600/$1200	($51.8)	($57.6)	($109.4)
	Coinsurance to	$3250/$6500	$2750/$5500	($24.4)	($29.2)	($53.6)
	Primary care copay to	$30	$25	($8.5)	($9.6)	($18.1)
	Specialty care copay to	$70	$60	($29.1)	($32.7)	($61.8)
	Urgent care copay to	$75	$75	($0.7)	($0.8)	($1.5)
	Inpatient copay to	$250	$200	($2.2)	($2.4)	($4.6)
2(f)	Limitation on authority to change benefits			No Cost Impact		
2(g)	Premium Increase of 8.6% for FY10 & FY11			Included in baseline projection		
2(h)	Pharmacy benefit savings			Included in baseline projection		
Part 3 - Eligibility Clarification						
3(a)	Dependent child clarifications			No Cost Impact		
3(b)	Eligibility of full-time students			No Cost Impact		
3(c) - 3(d)	Waiting periods subject to federal law			No Cost Impact		
3(e)	Executive administrator shall provide for an audit of the dependent eligibility under the plan			Savings from the audit should be greater than the cost to provide it		
3(f)	Cessation of coverage of ineligible individuals			No Cost Impact		
3(g)	Documentation of dependent eligibility			No Cost Impact		

		Based on "Midpoint" Increase		
Section	Plan Design Change	2009-2010 Fiscal Year Cost	2010-2011 Fiscal Year Cost	Total Biennium Cost
Part 4 - NC Health Choice Changes				
4(a) - 4(c)	Changes to NC Health Choice have no cost impact on the Plan			
Part 5 - Other Changes				
5(a) - 5(e)	Minor clarifications or changes that have no cost impact			
Part 6 - Salary Related Contributions				
6(a) - 6(f)	Required contribution rates for various entities. These amounts are developed from the baseline projections.			
Total cost of health benefit changes		($144.1)	($167.0)	($311.1)

The baseline projections produced total projected expenses of $2,687,502,073 and $2,919,5 07,795 for the 2010 and 2011 fiscal years respectively.

PRICING APPROACH AND COMMENTS

The following information was compiled and utilized in determining the projected costs or savings of each benefit component addressed in this actuarial note. Due to the inclusion of multiple benefit changes incorporated with imperfect data, all projected savings incorporate a 10% risk factor:

Eliminate PPO Plus Option

- Information was collected from the Plan's data warehouse, EinfoNow. It included detailed eligibility and claims data by plan for Fiscal Year 2008. From this information we were able to develop experience rates specifically for the PPO plus option.
- The claims were then trended at 9% per year and adjusted for the most recent membership levels. We also reviewed the elections effective 7/1/2008 and adjusted our projected expenditures by plan for FY 2010 and 2011 to reflect the experience of the members who moved. These would include prior CMMP members who moved to the Plus option, adjusting their experience accordingly.
- It was then assumed that a benefit reduction of 11.5% would be applied to the medical claims only. Assuming a one month lag produced FY 2010 savings of $56 million and FY 2011 savings of $66 million.
- The savings from lower claims is offset by reduced dependent contributions. Based on the current contribution levels, $41.6 million would not be received as revenue by the Plan. In order to accurately measure the net impact of this benefit you would need to adjust the premium levels appropriately and maintain a consistent reference point.

Implement Comprehensive Wellness Initiative

- Information was provided by the Plan that detailed the administrative costs for implementing the smoking cessation and weight management programs. The costs were projected to be $3,384,308 in FY 2010 and $7,253,282 in FY2011.
- Through conversation with the Plan and the IHM vendors it was assumed that the future savings from these programs would more than offset current expenditures.
- There is currently no net impact to the Plan at this point until further administrative costs and program implementations are determine in the future.

Brand Prescription Drug Copay Changes (Increase Preferred and Non-Preferred Brand $5; Change Brand with Generic Equivalent to Generic Copay and Member pay Cost Difference between Brand and Generic)

- Claims data was received from the Plan's Pharmacy Benefit Manager (PBM) for the period April 5, 2008 through June 27,2008.

- For this period annualized, active employees, non-Medicare retirees and Medicare retirees generated $143,999,486 of paid Brand copayments with 4,069,848 scripts.

- The annualized Brand claims data was projected forward with -4% utilization trend per year and 10% cost trend 1st year/11% cost trend per year thereafter.

- Brand prescription drugs with generic equivalents were assumed to have the same AWP for Brand or Generic with a Generic discount applied.

- The projected claims data was used to quantify the impact of the copay changes.

- Based on an effective date of July 1, 2009, the FY 2010 projected savings for Brand Prescription Drug copays is $19,456,696. The FY 2011 projected savings for Brand Prescription Drug copays is $21,022,777.

Specialty Drug Copay and Exclusive Vendor Changes (Increase Copay to 25% with $100 Max/script and Create Specialty Vendor for all Specialty Drugs)

- Claims data was received from the Plan's Pharmacy Benefit Manager (PBM) for the period July 1, 2007 through June 30,2008.

- For this period, active employees, non-Medicare retirees and Medicare retirees generated $2,232,086 of paid Brand copayments with 46,389 scripts.

- The specialty claims data was used to quantify the impact of the benefit design changes with $2,500 out-of-pocket max applied to total projected prescription drug spend. Trend levels starting at 8.3% were reduced in savings projections to recognize anti-leveraging associated with the benefit design maximums.

- The specialty Vendor network savings projections are provided by Medco and are based on enhanced discounts for a list of specialty drugs that will only be covered in the specialty network by implementing a retail lockout. The list of drugs with retail lockout does not include specialty drugs that may be required on an acute basis. Medco's analysis is based only on ingredient cost with discounts and estimates 4,755 impacted members based on 2008 data.

- Based on an effective date of July 1, 2009, the FY 2010 projected savings for Specialty Prescription Drug changes is $3,086,315. The FY 2011 projected savings for Specialty Prescription Drug changes is $3,396,887.

Prescription Drug Day Supply (Reduce to 30)

- Claims data was received from the Plan's Pharmacy Benefit Manager (PBM) for the period July 1, 2007 through June 30, 2008.

- For this period, active employees, non-Medicare retirees and Medicare retirees generated $25,474,207 of paid co-payments with 1,210,194 scripts for scripts with 1 month fills of 31 to 34 days, 2 month fills of 61 to 68 days and 3 month fills of 91 to 102 days.

- The detailed claims data (FY 2008) was projected forward with 4% utilization trend per year.

- The claims data for these scripts was used to quantify the copay impact of limiting a 1 month fill to 30 days, a 2 month fill to 60 days and a 3 month fill to 90 days.

- Based on an effective date of July 1, 2009, the FY 2010 projected savings for Day Supply changes is $2,705,451. The FY 2011 projected savings for Day Supply changes is $3,069,457.

Routine Eye Coverage Eliminated

- Claims data was received from the Plan's Claims Processing Contractor (CPC) showing Routine Eye office visit claims experience for the period January 1, 2008 through March 31,2008 for all PPO plans separately. The claims experience was also separated for active employees, non-Medicare retirees and Medicare retirees.

- For this period annualized, active employees, non-Medicare retirees and Medicare retirees generated $6,557,857 of Plan paid claims with 109,573 visits.

- The annualized claims data was projected forward with 3% utilization trend per year and 6% cost trend per year.

- Based on an effective date of January 1, 2010, the FY 2010 projected savings for eliminating Routine Eye coverage is $2,158,693. The FY 2011 projected savings for eliminating Routine Eye coverage is $7,193,591.

Deductible and Coinsurance Maximum Changes (Increase Basic Deductible $200/$400 and Coinsurance Maximum $750/$1,500; Increase Standard Deductible $300/$600 and Coinsurance Maximum $1,000/$2,000)

- Claims data was received from the Plan's Claims Processing Contractor (CPC) showing claims experience for all claims subject to deductible and coinsurance for the period July 1, 2007 through June 30,2008 (FY 2008) for the CMM and all PPO plans separately. The claims experience was also separated for active employees, non-Medicare retirees and Medicare retirees.

- For this 12 month period, active employees, non-Medicare retirees and Medicare retirees generated $91,954,962 of paid deductible and $116,899,421 of paid coinsurance.

- The detailed claims data (FY 2008) was projected forward with 3% utilization trend per year and 6% cost trend per year.

- The projected claims data was used to quantify the impact of the deductible and coinsurance maximum changes.

- Based on an effective date of July 1, 2009, the FY 2010 projected savings for deductible and coinsurance maximum changes is $76,215,565. The FY 2011 projected savings for deductible and coinsurance maximum changes is $86,849,600.

Office Visit Copay Change (Increase PCP $5 and Specialty $20)

- Claims data was received from the Plan's Claims Processing Contractor (CPC) showing PCP and Specialty claims experience for the period July 1, 2007 through June 30,2008 (FY 2008) for the CMM and all PPO plans separately. The claims experience was also separated for active employees, non-Medicare retirees and Medicare retirees.

- For this 12 month period, active employees, non-Medicare retirees and Medicare retirees generated $40,327,380 of paid PCP copayments with 2,082,505 visits.

- For this 12 month period, active employees, non-Medicare retirees and Medicare retirees generated $61,139,448 of paid Specialty copayments with 2,109,138 visits.

- The detailed claims data (FY 2008) was projected forward with 3% utilization trend per year and 6% cost trend per year. An additional 10% utilization trend was included for the CMM plan in FY 2009 assuming a first year spike in utilization for all members moving to PPO.

- The projected claims data was used to quantify the impact of the copay changes.

- An adjustment for Specialty copays was applied for Medicare retirees assuming the plan would recover 25% of the savings based on Coordination of Benefits with Medicare.

- Based on an effective date of July 1, 2009, the FY 2010 projected savings for PCP copays is $8,518,038. The FY 2011 projected savings for PCP copays is $9,571,177.

- Based on an effective date of July 1, 2009, the FY 2010 projected savings for Specialty copays is $29,077,025. The FY 2011 projected savings for Specialty copays is $32,672,003

Urgent Care Copay Change (Increase Standard $25)

- Claims data was received from the Plan's Claims Processing Contractor (CPC) showing Urgent Care claims experience for the period July 1, 2007 through June 30,2008 (FY 2008) for the CMM and all PPO plans separately. The claims experience was also separated for active employees, non-Medicare retirees and Medicare retirees.

- For this 12 month period, active employees, non-Medicare retirees and Medicare retirees generated $1,671,386 of paid Urgent Care copayments with 35,753 visits.

- The detailed claims data (FY 2008) was projected forward with 3% utilization trend per year and 6% cost trend per year. An additional 10% utilization trend was included for the CMM plan in FY 2009 assuming a first year spike in utilization for all members moving to PPO.

- The projected claims data was used to quantify the impact of the copay changes.

- An adjustment for Urgent Care copays was applied for Medicare retirees assuming the plan would recover 40% of the savings based on Coordination of Benefits with Medicare.

- Based on an effective date of July 1, 2009, the FY 2010 projected savings for Urgent Care copays is $739,560. The FY 2011 projected savings for PCP copays is $830,997.

Inpatient Copay Change (Increase $50)

- Claims data was received from EinfoNow showing Inpatient claims experience for the period July 1, 2007 through June 30,2008 (FY 2008) for the CMM and all PPO plans separately. The claims experience was also separated for active employees, non-Medicare retirees and Medicare retirees.

- For this 12 month period, active employees, non-Medicare retirees and Medicare retirees generated $6,699,263 of paid Inpatient copayments with 51,076 admissions.

- The detailed claims data (FY 2008) was projected forward with 3% utilization trend per year and 6% cost trend per year.

- The projected claims data was used to quantify the impact of the copay changes.

- An adjustment for Inpatient copays was applied for Medicare retirees assuming the plan would recover 91% of the savings based on Coordination of Benefits with Medicare.

- Based on an effective date of July 1, 2009, the FY 2010 projected savings for Inpatient copays is $2,158,037. The FY 2011 projected savings for Inpatient copays is $2,424,849.

Pharmacy Benefit Savings

- March 20, 2009 financial projections include $38 million of savings over the biennium to reflect the improved contract terms guaranteed by the Plan's PBM.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 3

SENATE BILL 287

Select Committee on Employee Hospital and Medical Benefits Committee Substitute Adopted 3/10/09
Third Edition Engrossed 3/24/09

Short Title: State Hlth Plan $/Good Health Initiatives. (Public)

Sponsors:

Referred to:

February 25, 2009

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES AND TO MAKE OTHER CHANGES RELATED TO THE STATE HEALTH PLAN.

Whereas, the General Assembly must act quickly and prudently to maintain a financially stable State Health Plan to ensure that all members of the Plan have affordable access to medically necessary health benefits and services within available resources; and

Whereas, in order to meet current fiscal obligations the General Assembly must appropriate $250,000,000 for the 2008-2009 fiscal year to cover the current year shortfall in funds; and

Whereas, estimates indicate that a substantially larger appropriation will be necessary to maintain the fiscal integrity of the Plan in the next and ensuing fiscal periods; and

Whereas, in order to ensure continued access to medically necessary health care to Plan members, the Plan must implement measures to contain costs through premium increases, benefit changes, and healthy lifestyle programs that not only reduce costs but improve member health; and

Whereas, the Plan estimates that over 70,000 Plan members use tobacco, resulting in a cost to the Plan of $2,000 per member per year more than the cost of providing coverage for nonusers of tobacco; and

Whereas, over 60% of North Carolina adults are obese or overweight; and

Whereas, obesity is linked to an over 37% increase in health care spending at a cost of $2,445 per member per year; and

Whereas, weight management and cessation of tobacco use have been demonstrated to result in improved member health and substantial savings in health care costs making it fiscally prudent to implement smoking cessation and weight management incentives and initiatives with mechanisms to verify member compliance with smoking cessation and weight management requirements; Now, therefore,

The General Assembly of North Carolina enacts:

PART ONE: APPROPRIATIONS, DEFINITIONS, AND SCOPE.

SECTION 1.(a) Appropriation for 2008-2009 fiscal year. – There is appropriated from the Savings Reserve Account established in G.S. 143C-4-2 to the Health Benefit Reserve Fund established in G.S. 135-44.5 the sum of two hundred fifty million dollars ($250,000,000) for the 2008-2009 fiscal year. These funds shall be used to address the shortfall in funds

available for the payment of health care and administrative costs under the State Health Plan for Teachers and State Employees ("Plan") for the 2008-2009 fiscal year.

SECTION 1.(b) General Fund appropriation for 2009-2011 fiscal biennium. – Notwithstanding G.S. 143C-5-2, there is appropriated from the General Fund to the Reserve for the State Health Plan in the Office of State Budget and Management the sum of one hundred twenty-eight million four hundred ten thousand two hundred eight dollars ($128,410,208) for the 2009-2010 fiscal year and the sum of two hundred sixty-seven million nine hundred four thousand one hundred fourteen dollars ($267,904,114) for the 2010-2011 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2009-2011 fiscal biennium.

SECTION 1.(c) Highway Fund appropriation for the 2009-2011 fiscal biennium. – Notwithstanding G.S. 143C-5-2, there is appropriated from the Highway Fund to the Reserve for the State Health Plan in the Office of State Budget and Management the sum of five million nine hundred ninety-two thousand four hundred seventy-six dollars ($5,992,476) for the 2009-2010 fiscal year and the sum of twelve million five hundred two thousand one hundred ninety-two dollars ($12,502,192) for the 2010-2011 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2009-2011 fiscal biennium.

SECTION 1.(d) All other agency funds required to fund the premium increase enacted in this act, other than funds appropriated in subsections (b) and (c) of this section, are appropriated for the 2009-2011 fiscal biennium.

SECTION 1.(e) Definitions. – As used in this act unless the context clearly requires otherwise:

(1) "Plan." – The State Health Plan for Teachers and State Employees.

(2) "Basic plan." – The Plan's PPO option providing for 70/30 in-network coverage after deductibles and co-payments.

(3) "Smoking" or "Smoking cessation." – Includes cessation of the use of all tobacco products.

(4) "Standard plan." – The Plan's PPO option providing for 80/20 in-network coverage after deductibles and co-payments.

SECTION 1.(f) Scope. – In the event of a conflict between the provisions of this act and Article 3A of Chapter 135 of the General Statutes, this act prevails.

PART TWO: HEALTH BENEFIT CHANGES.

SECTION 2.(a) Eliminate PPO Plus Option. – Effective July 1, 2009, the PPO Plus option (90/10 in-network coverage) under the State Health Plan for Teachers and State Employees ("Plan") is eliminated. The Executive Administrator shall provide notice to all members of the Plan that this option will no longer be available as of July 1, 2009. Employees enrolled in the Plan's Plus option shall have the choice of enrolling in the Basic or Standard plan options for the 2009-2010 benefit year.

SECTION 2.(b) Implement Comprehensive Wellness Initiative.

(1) Program development. – The Plan shall develop a Comprehensive Wellness Initiative that includes a focus on smoking cessation and weight management and that is designed to be implemented effective July 1, 2010, for smoking cessation and July 1, 2011, for weight management. Benefit levels shall be determined by the Plan based upon tobacco use or the inability of the member to meet national, evidence-based healthy weight clinical guidelines. For purposes of the Comprehensive Wellness Initiative, "member" includes all State Health Plan primary subscribers and their covered dependents. The Plan shall develop a process whereby a Plan member may appeal the Plan's basis for action it takes due to the member's failure or refusal to comply with the Plan's smoking cessation or weight management requirements.

(2) Smoking cessation. – Effective July 1, 2010, all members of the Plan who do not have Medicare as their primary coverage shall be enrolled in the Basic Plan under the Plan's PPO unless the subscriber can attest that the subscriber or any qualifying dependent does not smoke or otherwise use tobacco products. The Plan shall develop a mechanism for verifying that the member does not smoke or use other tobacco products. Tobacco use will be reassessed annually at the time of Plan enrollment. All subscribers who have attested that neither they nor their dependents use tobacco, or whose physician certifies in writing that the member is participating in a smoking cessation program, shall have the choice of remaining in the Basic plan option or enrolling in the Standard plan option. For purposes of the smoking cessation initiative, "member" includes all members covered under the Plan. As used in this section, "smoking cessation program" means active participation in a Plan-approved cessation program to include counseling or use of tobacco cessation medications.

(3) Weight management. – Effective July 1, 2011, all members of the Plan who do not have Medicare as their primary coverage shall be enrolled in the Basic Plan under the Plan's PPO Plan unless the subscriber attests that the weight and height ratio of the member is within a range determined by the Plan based on evidence-based healthy weight clinical guidelines, or unless the member's physician certifies in writing that the member has a medical condition that prevents the attainment of the specified weight range or that the member is actively participating in a Plan-approved weight management program. In either case, the member shall have the option to enroll in the Basic or Standard Plan.

Not later than October 1, 2009, the Executive Administrator shall inform Plan members of the healthy lifestyle initiatives, requirements for compliance, and consequences of noncompliance. The Executive Administrator shall provide to members education and training to assist members in complying with healthy lifestyle initiatives. The Executive Administrator may implement incentive initiatives to further encourage member achievement in smoking cessation, weight management, and other integrated health management programs.

The Executive Administrator shall report to the Committee on Employee Hospital and Medical Benefits recommendations the Plan may have for additional sanctions that may be imposed when the Executive Administrator finds that a member intentionally makes a false statement on a Plan document.

SECTION 2.(c) Prescription drug co-payments. – G.S. 135-45.6(b) reads as rewritten:

"(b) Prescription Drugs. – The Plan's allowable charges for prescription legend drugs to be used outside of a hospital or skilled nursing facility shall be as determined by the Plan's Executive Administrator and Board of Trustees, which determinations are not subject to appeal under Article 3 of Chapter 150B of the General Statutes. Co-payments and other allowable charges or coverage for prescription drugs shall be as follows:

(1) The Plan will pay allowable charges for each outpatient prescription drug less a copayment to be paid by each covered individual equal to the following amounts: pharmacy charges up to ten dollars ($10.00) for each generic prescription, ~~thirty dollars ($30.00)~~ thirty-five dollars ($35.00) for each preferred branded prescription without a generic equivalent, ~~and forty dollars ($40.00) for each preferred branded prescription with a generic equivalent drug,~~ and ~~fifty dollars ($50.00)~~ fifty-five dollars ($55.00) for each nonpreferred branded ~~or generic~~ prescription. For each branded prescription drug with a generic equivalent drug, the member shall pay the generic

co-payment plus the difference between the Plan's gross allowed cost for the generic prescription and the Plan's cost for the branded prescription drug.

(2) The Plan shall provide coverage of nonacute specialty medications under the Plan's pharmacy benefit through a specialty pharmacy vendor under contract with the Plan. The Plan may transfer coverage of specified specialty disease medications covered under the Plan's medical benefit to the contracted specialty pharmacy vendor. Specialty medications are covered biotech medications and other medications designated and classified by the Plan as specialty medications that are typically significantly more expensive than alternative drugs or therapies. Medications classified by the Plan as specialty medications generally have unique uses for the treatment of complex diseases, require special dosing or administration, require special handling, are typically prescribed by a specialist provider, and exceed four hundred dollars ($400.00) cost to the Plan per prescription. The Plan shall impose a co-payment in the amount of Plan per prescription. The Plan shall impose a co-payment in the amount of twenty-five percent (25%) of the Plan's gross allowed cost of the specialty drug not to exceed one hundred dollars ($100.00) per prescription per 30-day supply.

(3) The Plan may exclude coverage of drugs that have therapeutic equivalents that are available over the counter. Before excluding coverage under this subdivision, the Plan shall consult with the Plan's Pharmacy and Therapeutics Committee.

~~These co-paymentsapply to all optional alternative plans available under the Plan.~~

(4) Allowable charges shall not be greater than a pharmacy's usual and customary charge to the general public for a particular prescription. Prescriptions shall be for no more than a ~~34-day~~30-day supply for the purposes of the copayments paid by each covered individual. By accepting the copayments and any remaining allowable charges provided by this subsection, pharmacies shall not balance bill an individual covered by the Plan. A prescription legend drug is defined as an article the label of which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without Prescription." Such articles may not be sold to or purchased by the public without a prescription order. Benefits are provided for insulin even though a prescription is not required. ~~The Plan may use a pharmacy benefit manager to help manage the Plan's outpatient prescription drug coverage. In managing the Plan's outpatient prescription drug benefits, the Plan and its pharmacy benefit manager shall not provide coverage for sexual dysfunction, growth hormone, antiwrinkle, weight loss, and hair growth drugs unless such coverage is medically necessary to the health of the member. The Plan and its pharmacy benefit manager shall not provide coverage for growth hormone and weight loss drugs and antifungal drugs for the treatment of nail fungus and botulinium toxin without approval in advance by the pharmacy benefit manager.~~ The Plan may adopt utilization management procedures for certain drugs, but in no event shall the Plan provide coverage for sexual dysfunction or hair growth drugs or nonmedically necessary drugs used for cosmetic purposes. Any formulary used by the Plan's Executive Administrator and pharmacy benefit manager shall be an open formulary. Plan members shall not be assessed more than two thousand five hundred dollars ($2,500) per person per fiscal year in copayments required by this subsection. The Plan's Pharmacy Benefit

Manager, or any pharmacy or vendor participating in the Plan shall charge the Plan for any prescription legend drug dispensed under the Plan's pharmacy benefit based upon the original National Drug Code (NDC) as established by the manufacturer of the prescription legend drug and published by the United States Food and Drug Administration.

Copayments authorized under this subsection apply to all optional alternative plans available under the Plan."

SECTION 2.(d) Routine eye examinations not covered. – Effective January 1, 2010, G.S. 135-45.8(13) reads as rewritten:

"**§ 135-45.8. General limitations and exclusions.**

The following shall in no event be considered covered expenses nor will benefits described in G.S. 135-45.6 through G.S. 135-45.11 be payable for:

...

(13) Charges for routine eye examinations, eyeglasses or other corrective lenses (except for cataract lenses certified as medically necessary for aphakia persons) and hearing aids or examinations for the prescription or fitting thereof."

SECTION 2.(e) Deductible and co-payment changes. – Effective July 1, 2009, the Executive Administrator shall make the following changes to deductibles, coinsurance maximums, and co-payments under the Basic and Standard PPO Plans:

(1) Basic plan (70/30):

a. Increase the in-network annual deductible to eight hundred dollars ($800.00) for member-only coverage and to one thousand six hundred dollars ($1,600) for the out-of-network annual deductible for member-only coverage.

The aggregate maximum annual deductible for employee-child and employee-family coverage shall be three times the member-only annual deductibles.

b. Increase the in-network coinsurance maximum to three thousand two hundred fifty dollars ($3,250) for member-only coverage and to six thousand five hundred dollars ($6,500) for member-only out-of-network maximum coinsurance. The aggregate maximum coinsurance for employee-child and employee-family coverage shall be three times the member-only coinsurance maximums.

c. Increase the in-network primary care co-payment to thirty dollars ($30.00) per covered individual.

d. Increase the in-network specialist co-payment to seventy dollars ($70.00) per covered individual.

e. Increase the in-network and out-of-network inpatient co-payment to two hundred fifty dollars ($250.00) per covered individual.

f. Increase prescription drug co-pays as required under G.S. 135-45.6(b) as enacted by this act.

g. Except as otherwise provided in this act, co-payments and coinsurance for coverage not otherwise listed in this subdivision shall remain as applicable in the 2008-2009 benefit year.

(2) Standard plan (80/20):

a. Increase the in-network annual deductible to six hundred dollars ($600.00) for member-only coverage and to one thousand two hundred dollars ($1,200) for the member-only out-of-network annual deductible.

The aggregate maximum annual deductible for employee-child and employee-family coverage shall be three times the member-only annual deductibles.

b. Increase the in-network coinsurance maximum to two thousand seven hundred fifty dollars ($2,750) for member-only coverage and to five thousand five hundred dollars ($5,500) for member-only out-of-network maximum coinsurance. The aggregate maximum coinsurance for employee-child and employee-family coverage shall be three times the member-only coinsurance maximums.

c. Increase the in-network urgent care co-payment to seventy-five dollars ($75.00) per covered individual.

d. Increase the in-network primary care co-payment to twenty-five dollars ($25.00) per covered individual.

e. Increase the in-network specialist co-payment to sixty dollars ($60.00) per covered individual.

f. Increase the in-network and out-of-network inpatient co-payment to two hundred dollars ($200.00) per covered individual.

g. Increase prescription drug co-pays as required under G.S. 135-45.6(b) as enacted by this act.

h. Except as otherwise provided in this act, co-payments and coinsurance for coverage not otherwise listed in this subdivision shall remain as applicable in the 2008-2009 benefit year.

SECTION 2.(f) Limitation on authority to change benefits. – G.S. 135-45(g) reads as rewritten:

"(g) The Executive Administrator and Board of Trustees shall not change the Plan's comprehensive health benefit coverage, co-payments, deductibles, out-of-pocket expenditures, and lifetime maximums in effect on ~~July 1, 2008,~~ July 1, 2009, or a later act of the General Assembly, that would result in a net increased cost to the Plan or in a reduction in benefits to Plan members as a whole unless and until the proposed changes are directed to be made in an act of the General Assembly."

SECTION 2.(g) Premium increases. – Premium rates for contributory coverage established in accordance with G.S. 135-44.6 shall be increased to eight and six-tenths percent (8.6%) for contributory coverage for the 2009-2010 fiscal year and shall be increased by an additional eight and six-tenths percent (8.6%) over the premium rate for contributory coverage for the 2010-2011 fiscal year.

SECTION 2.(h) Pharmacy benefit savings. – The Plan shall direct its pharmacy benefit manager (PBM), within the terms of the Plan's PBM contract, to achieve the sum of eighteen million dollars ($18,000,000) in savings in pharmacy benefit costs in the 2009-2010 fiscal year, and the sum of twenty million dollars ($20,000,000) in savings in pharmacy benefit costs in the 2010-2011 fiscal year through reduced reimbursements paid to pharmacies for prescription drugs. If the savings achieved in each six-month period of the fiscal year do not exceed one hundred-five percent (105%) of the savings amount specified in this section for that fiscal year, there shall be no further adjustment to reimbursements paid to pharmacies for that six-month period. If the total savings achieved, by fiscal year, exceeds one hundred five percent (105%) of the specified savings amount in each six month period of the fiscal year, the Plan shall adjust pharmacy reimbursement reductions accordingly. The Plan shall review savings achieved twice annually to ensure compliance with this section. The Plan shall calculate the savings to be achieved based on Plan enrollment and estimated cost and utilization trends incorporated in the Plan's Financial Projections as of March 20, 2009. The total savings by fiscal year achieved in this section may be increased or decreased without adjustment based on a change in total enrollment provided that the rate of savings achieved on a per member per

month basis remains constant. Not later than 60 days immediately following each six-month period, the Plan shall report the amount of savings achieved and any adjustments made for that period to the Committee on Employee Hospital and Medical Benefits."

PART THREE: ELIGIBILITY CLARIFICATION.

SECTION 3.(a) Dependent child clarifications. – G.S. 135-45.1(10) reads as rewritten:

"(10) Dependent child. – A natural, legally adopted, or foster child or children of the employee and or spouse, unmarried, up to the first of the month following his or her 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for such child's maintenance and support. Dependent child also includes a stepchild of the member who is married to the stepchild's natural parent. To be eligible, the stepchild must have his or her primary residence with the member. Dependent child shall also include any child under age 19 who has reached his or her 18th birthday, provided the employee was legally responsible for such child's maintenance and support on his or her 18th birthday. Dependent children of firefighters, rescue squad workers, and members of the national guard are subject to the same terms and conditions as are other dependent children covered by this subdivision. Eligibility of dependent children is subject to the requirements of G.S. 135-45.2(d). The Plan may require documentation from the member confirming a child's eligibility to be covered as the member's dependent."

SECTION 3.(b) Eligibility of full-time students. – G.S. 135-45.2(d) reads as rewritten:

"(d) A foster child is covered as a dependent child (i) if living in a regular parent-child relationship with the expectation that the employee will continue to rear the child into adulthood, (ii) if at the time of enrollment, or at the time a foster child relationship is established, whichever occurs first, the employee applies for coverage for such child and submits evidence of a bona fide foster child relationship, identifying the foster child by name and setting forth all relevant aspects of the relationship, (iii) if the claims processor accepts the foster child as a participant through a separate written document identifying the foster child by name and specifically recognizing the foster child relationship, and (iv) if at the time a claim is incurred, the foster child relationship, as identified by the employee, continues to exist. Children placed in a home by a welfare agency which obtains control of, and provides for maintenance of the child, are not eligible participants.

Coverage of a dependent child may be extended beyond the 19th birthday under the following conditions:

(1) If the dependent is a full-time student, ~~aged 19 years and one month~~ through the end of the month following the student's 26th ~~birthday,~~birthday. As used in this section, a full-time student is a student who is pursuing a course of study that represents at least the normal workload of a full-time student at a school or college accredited by the state of jurisdiction. In accordance with applicable federal law, coverage of a full-time student that loses full-time status due to illness may be extended for one year from the effective date of the loss of full-time status provided that the student was enrolled at the time of the onset of the illness.

(2) The dependent is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and (i) such handicap developed or began to develop before the dependent's 19th birthday, or (ii) such handicap developed or began to develop before the dependent's 26th birthday if the dependent was covered by the Plan in accordance with G.S. 135-45.2(5)a."

SECTION 3.(c) Waiting periods subject to federal law. – G.S. 135-45.3(b) reads as rewritten:

"(b) ~~"Newly~~ Except as otherwise required by applicable federal law, newly acquired dependents (spouse/child) enrolled within 30 days of becoming an eligible dependent will not be subject to the 12-month waiting period for preexisting conditions. A dependent can become qualified due to marriage, adoption, entering a foster child relationship, due to the divorce of a dependent child or the death of the spouse of a dependent child, and at the beginning of each legislative session (applies only to enrolled legislators). Effective date for newly acquired dependents if application was made within the 30 days can be the first day of the following month. Effective date for an adopted child can be date of adoption, or date of placement in the adoptive parents' home, or the first of the month following the date of adoption or placement. Firefighters, rescue squad workers, and members of the national guard, and their eligible dependents, are subject to the same terms and conditions as are new employees and their dependents covered by this subdivision. Enrollments in these circumstances must occur within 30 days of eligibility to enroll."

SECTION 3.(d) G.S. 135-45.4(b)(5) reads as rewritten:

"(5) To administer the 12-month waiting period for preexisting conditions under this that Article, the Plan must give credit against the 12-month period for the time a person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 63 days before the effective date of coverage. As used in this subdivision, a "previous plan" means any policy, certificate, contract, or any other arrangement provided by any accident and health insurer, any hospital or medical service corporation, any health maintenance organization, any preferred provider organization, any multiple employer welfare arrangement, any self-insured health benefit arrangement, any governmental health benefit or health care plan or program, or any other health benefit arrangement. Waiting periods for preexisting conditions administered under this Article are subject to applicable federal law."

SECTION 3.(e) Eligibility audit. – The Executive Administrator shall provide for an audit of dependent eligibility under the Plan. The audit shall be designed to determine whether all dependents currently covered under the Plan are eligible for coverage under current law. Upon identification of an individual who is enrolled as a dependent but not eligible, the Plan shall disenroll the ineligible dependent effective within 10 days of sending written termination notice to the employee. The notice shall state the date upon which disenrollment will become effective and the basis on which the determination of dependent ineligibility is made. Notwithstanding any other provision of law, the Executive Administrator may waive requirements to collect from the member reimbursement for claims paid for the ineligible covered individual.

SECTION 3.(f) Cessation of coverage of ineligible individuals. – G.S. 135-45.12 is amended by adding the following new subdivision to read:

"(8) The last day of the month in which a covered individual is found to be ineligible for coverage."

SECTION 3.(g) Documentation of dependent eligibility. – G.S. 135-45.3 is amended by adding the following new subsection to read:

"(c) When an eligible or enrolled member applies to enroll the member's eligible dependent child or spouse, the member shall provide the documentation required by the Plan to verify the dependent's eligibility for coverage."

PART FOUR: NC HEALTH CHOICE CHANGES.

SECTION 4.(a) Over-the-counter medications. – Coverage of over-the-counter medication authorized under G.S. 108A-70.21(d) for the NC Health Choice Program shall

become effective on the later of July 1, 2010, or the date upon which the Department of Health and Human Services assumes full responsibility for administration and processing of claims under the NC Health Choice Program.

SECTION 4.(b) Subrogation. – For the period authorized under subsection (a) of this section, the right of subrogation under G.S. 108A-57 applies to the State Health Plan for payments made by the Plan under the NC Health Choice Program. This subsection expires on the later of July 1, 2010, or the date upon which the Department of Health and Human Services assumes full responsibility for administration, processing, and payment of claims under the NC Health Choice Program.

SECTION 4.(c) DHHS Subrogation under NC Health Choice. – G.S. 108A-57 is amended by adding the following new subsection to read:

"(c) This section applies to the administration of and claims payments made by the Department of Health and Human Services under the NC Health Choice Program established under Part 8 of this Article."

SECTION 4.(d) G.S. 108A-70.21(g) reads as rewritten:

"(g) Purchase of Extended Coverage. – An enrollee in the Program who loses eligibility due to an increase in family income above two hundred ~~fifty percent (250%)~~percent (200%) of the federal poverty level and up to and including two hundred ~~seventy-five percent (275%)~~ twenty-five percent (225%) of the federal poverty level may purchase at full premium cost continued coverage under the Program for a period not to exceed one year beginning on the date the enrollee becomes ineligible under the income requirements for the Program. The benefits, copayments, and other conditions of enrollment under the Program applicable to extended coverage purchased under this subsection shall be the same as those applicable to an NC Kids' Care enrollee whose family income equals two hundred ~~fifty percent (250%)~~ percent (200%) of the federal poverty level."

PART FIVE: OTHER CHANGES.

SECTION 5.(a) G.S. 135-45.4(b)(2) reads as rewritten:

"(2) Employees not enrolling or not adding dependents when first eligible may enroll later on the first of any following month, but will be subject to a twelve-month waiting period for preexisting conditions except as provided in subdivision (a)(3) of this section. The waiting period under this subdivision is subject to applicable federal law."

SECTION 5.(b) Utilization management functions. – G.S. 135-44.4 is amended by adding the following new subdivisions to read:

"(13a) The Plan and its pharmacy benefit manager may implement and administer pharmacy and medical utilization management programs and programs to detect and address utilization abuse of benefits.

...

(29) For transplant and bariatric medical procedures, the Plan may restrict coverage to certain in-network providers that are designated by the Plan's claims processing contractor."

SECTION 5.(c) G.S. 135-44.1(b) reads as rewritten:

"(b) ~~Six~~ A majority of the members of the Board of Trustees in office shall constitute a quorum. Decisions of the Board of Trustees shall be made by a majority vote of the Trustees present, except as otherwise provided in this Part."

SECTION 5.(d) G.S. 135-45.9(b) reads as rewritten:

"(b) Notwithstanding any other provision of this Part, the following necessary services for the care and treatment of chemical dependency and mental illness shall be covered as provided in this section: allowable institutional and professional charges for inpatient care, outpatient care, intensive outpatient program services, partial hospitalization treatment, and residential care and treatment:

(1) For mental illness treatment:
a. Licensed psychiatric ~~hospitals;~~ hospitals or State psychiatric hospitals accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
b. Licensed psychiatric beds in licensed general hospitals;
c. Licensed residential treatment facilities that have 24-hour on-site care provided by a registered nurse who is physically located at the facility at all times and that hold current accreditation by a national accrediting body approved by the Plan's mental health case manager;
d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities or County Programs in accordance with G.S. 122C-141;
e. Licensed intensive outpatient treatment programs; and
f. Licensed partial hospitalization programs.

(2) For chemical dependency treatment:
a. Licensed chemical dependency units in licensed psychiatric ~~hospitals;~~ hospitals or in State psychiatric hospitals accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
b. Licensed chemical dependency hospitals;
c. Licensed chemical dependency treatment facilities;
d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities or County Programs in accordance with G.S. 122C-141;
e. Licensed intensive outpatient treatment programs;
f. Licensed partial hospitalization programs; and
g. Medical detoxification facilities or units."

SECTION 5.(e) Section 28.22A(k) of S.L. 2007-323 reads as rewritten:

"**SECTION 28.22A.(k)** Subsection (j) of this section expires ~~June 30, 2009.~~ June 30, 2011."

SECTION 5.(f) G.S. 135-43(b) reads as rewritten:

"(b) Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees may contract with providers of institutional and professional medical care and services to establish preferred provider networks.

~~The terms pertaining to reimbursement rates or other terms of consideration of any contract between hospitals, hospital authorities, doctors, or other medical providers, or a pharmacy benefit manager and the Plan, or contracts pertaining to the provision of any medical benefit offered under the Plan, including its optional alternative comprehensive benefit plans, and programs available under the optional alternative plans, shall not be a public record under Chapter 132 of the General Statutes for a period of 30 months after the date of the expiration of the contract.~~ The terms of a contract between the Plan and its third party administrator or between the Plan and its pharmacy benefit manager are a public record except that the terms in those contracts that contain trade secrets or proprietary or competitive information are not a public record under Chapter 132 of the General Statutes and any such proprietary or competitive information and trade secrets contained in the contract shall be redacted by the Plan prior to making it available to the public. ~~Provided, however, nothing in this subsection shall be deemed to~~This subsection shall not be construed to prevent or restrict the release of any information made not a public record under this subsection to the State Auditor, the Attorney General, the Director of the State Budget, the Plan's Executive Administrator, ~~the Department of Health and Human Services solely for the purpose of implementing the transition of NC Health Choice from the Plan to the Department of Health and Human Services,~~ and the

Committee on Employee Hospital and Medical Benefits solely and exclusively for their use in the furtherance of their duties and ~~responsibilities.~~responsibilities, and to the Department of Health and Human Services solely for the purpose of implementing the transition of NC Health Choice from the Plan to the Department of Health and Human Services. The design, adoption, and implementation of the preferred provider contracts, networks, and optional alternative comprehensive health benefit plans, and programs available under the optional alternative plans, as authorized under G.S. 135-45 are not subject to the requirements of Chapter 143 of the General Statutes. The Executive Administrator and Board of Trustees shall make reports as requested to the President of the Senate, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Committee on Employee Hospital and Medical Benefits."

PART SIX: SALARY-RELATED CONTRIBUTIONS.

SECTION 6.(a) Effective for the 2009-2011 fiscal biennium, required employer salary-related contributions for employees whose salaries are paid from department, office, institution, or agency receipts shall be paid from the same source as the source of the employees' salary. If an employee's salary is paid in part from the General Fund or Highway Fund and in part from department, office, institution, or agency receipts, required employer salary-related contributions may be paid from the General Fund or Highway Fund only to the extent of the proportionate part paid from the General Fund or Highway Fund in support of the salary of the employee, and the remainder of the employer's requirements shall be paid from the source that supplies the remainder of the employee's salary. The requirements of this section as to source of payment are also applicable to payments on behalf of the employee for hospital-medical benefits, longevity pay, unemployment compensation, accumulated leave, workers' compensation, severance pay, separation allowances, and applicable disability income benefits.

Notwithstanding any other provision of law, an employing unit that is subject to Part 3A of Article 3A of Chapter 135 of the General Statutes and that hires or has hired as an employee a retiree that is in receipt of monthly retirement benefits from any retirement system supported in whole or in part by contributions of the State shall enroll the retiree in the active group and pay the cost for the hospital-medical benefits if that retiree is employed in a position that would require the employer to pay hospital-medical benefits if the individual had not been retired.

SECTION 6.(b) Effective July 1, 2009, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2009-2010 fiscal year are: (i) eight and forty-four hundredths percent (8.44%) – Teachers and State Employees; (ii) thirteen and forty-four hundredths percent (13.44%) – State Law Enforcement Officers; (iii) eleven and seventy-six hundredths percent (11.76%) – University Employees' Optional Retirement System; (iv) eleven and seventy-six hundredths percent (11.76%) – Community College Optional Retirement Program; (v) seventeen and sixty-one hundredths percent (17.61%) – Consolidated Judicial Retirement System; and (vi) four and forty hundredths percent (4.40%) – Legislative Retirement System. Each of the foregoing contribution rates includes four and forty hundredths percent (4.40%) for hospital and medical benefits. The rate for Teachers and State Employees, State Law Enforcement Officers, Community College Optional Retirement Program, and for the University Employees' Optional Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

SECTION 6.(c) Effective July 1, 2010, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2010-2011 fiscal year are: (i) eight and eighty-four hundredths percent (8.84%) – Teachers and State

Employees; (ii) thirteen and eighty-four hundredths percent (13.84%) – State Law Enforcement Officers; (iii) twelve and sixteen hundredths percent (12.16%) – University Employees' Optional Retirement System; (iv) twelve and sixteen hundredths percent (12.16%) – Community College Optional Retirement Program; (v) eighteen and one hundredths percent (18.01%) – Consolidated Judicial Retirement System; and (vi) four and eighty hundredths percent (4.80%) – Legislative Retirement System. Each of the foregoing contribution rates includes four and eighty hundredths percent (4.80%) for hospital and medical benefits. The rate for Teachers and State Employees, State Law Enforcement Officers, Community College Optional Retirement Program, and for the University Employees' Optional Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

SECTION 6.(d) Effective July 1, 2009, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2009-2010 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand four hundred thirty-eight dollars ($3,438) and (ii) non-Medicare-eligible employees and retirees – four thousand five hundred fifteen dollars ($4,515).

SECTION 6.(e) Effective July 1, 2010, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2010-2011 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand seven hundred thirty-five dollars ($3,735) and (ii) non-Medicare-eligible employees and retirees – four thousand nine hundred five dollars ($4,905).

PART SEVEN: EFFECTIVE DATE.

SECTION 7. Sections 1(b), 1(c), 1(d), 2(c) through (e), 2(g), and 2(h) of this act become effective July 1, 2009. Section 4(d) of this act applies to applications for the purchase of extended coverage made on and after July 1, 2008. The remainder of this act is effective when it becomes law.

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668 Link Road
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March 25, 2009

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Senate Bill 287 (Third Edition): An Act to Appropriate Funds for the State Health Plan and to Make Other Changes to the State Health Plan

Dear Mr. Trogdon:

The third edition of this bill, engrossed March 24, 2009, appropriates funds and makes various changes to the North Carolina State Health Plan for Teachers and State Employees (the "Plan"). Unless otherwise noted, these changes are effective July 1, 2009.

The proposed changes to the Plan are as follows:

1. Increase the member copayments for outpatient prescription drugs

	Rx Copays	
	Current	Revised
Preferred Brand	$30	$35
Brand with Generic Equivalent	$40	Generic copayment plus the difference in the allowed cost of the brand and the allowed cost of the generic
Non-preferred Brand	$50	$55
Specialty Drugs	$30-$50	25% of allowed cost, not to exceed $100

The bill, as amended, defines specialty drugs as covered biotech medications or other medications classified as specialty by the Plan that are significantly more expensive than other therapies. These are to be drugs that have unique uses to treat complex diseases and require special dosing or handling and exceed $400 cost to the Plan per prescription. Specialty drugs under the pharmacy benefit are to be provided through a specialty pharmacy vendor under contract with the Plan.

2. Reduce the maximum prescription drug supply for purposes of member copayments from 34 days to 30 days

3. Increase the member copayments for hospitalization and office visits

	Member Copayments			
	PPO Standard		PPO Basic	
	Current	Revised	Current	Revised
Primary Care	$20	$25	$25	$30
Specialist	$40	$60	$50	$70
Urgent Care	$50	$75	$75	$75
Inpatient	$150	$200	$200	$250

4. Remove coverage for routine eye exams, effective January 1, 2010

5. Increase the member deductible and coinsurance maximums

	Member Deductible and Coinsurance			
	PPO Standard		PPO Basic	
	Current	Revised	Current	Revised
Deductible In/Out Network	$300/$600	$600/$1200	$600/$1200	$800/$1600
Coinsurance Maximum	$1,750/ $3,500	$2,750/ $5,500	$2,500/ $5,000	$3,250/ $6,500

The maximum annual deductible and coinsurance for members with dependent coverage remains at three times the member-only limits.

6. Pharmacy benefit savings
   The Plan is to direct its pharmacy benefit manager to achieve savings of $18,000,000 in the 2009-2010 fiscal year and $20,000,000 in the 2010-2011 fiscal year through reduced reimbursements paid to pharmacies for prescription drugs. Reimbursement rates are to be reviewed twice annually and adjusted if the actual savings exceed 105% of the above targets. Savings are measured from the Plan's Financial Projects as of March 20, 2009.

7. Eliminate the current PPO Plus option

8. Implement two wellness initiatives
   A smoking cessation program, effective July 1, 2010, would require all members who use tobacco and do not have Medicare as their primary coverage to enroll in the PPO Basic option. A weight management program, effective July 1, 2011, would require all members who do not meet healthy weight guidelines and do not have Medicare as their primary coverage to enroll in the PPO Basic option.

9. Make clarifying and technical corrections related to member eligibility, Plan coverage, and approved providers

I have valued the financial impact on the Plan of each benefit change described in items 1 through 5 above, and the estimated savings are itemized in the table below. The level of appropriations to the Plan and the premium increases included in this bill are not part of my analysis, nor is the Plan's ability to achieve the pharmacy benefit savings. Elimination of the

PPO Plus Option has been included by the Plan in determining the baseline funding needs, so I have not included itemization of the impact of that change. No impact is included for the wellness initiatives, since program parameters and administrative costs have not yet been determined. Also, no financial impact is estimated for the clarifying and technical corrections.

The estimated savings to the Plan for each benefit change is shown in the following chart for the next two fiscal years:

	Estimated Savings for Fiscal Year Beginning	
Component	July 1, 2009	July 1, 2010
Primary Care Copay	$ 8,116,000	$ 9,257,000
Specialist Copay	27,125,000	31,713,000
Urgent Care Copay	854,000	994,000
Inpatient Copay	1,970,000	2,247,000
Routine Eye Exam Coverage	2,540,000	7,039,000
Deductible & Coinsurance	78,079,000	92,463,000
Preferred Brand Copay	12,010,000	11,741,000
Brand w/ Generic Equiv. Copay	6,285,000	6,536,000
Non-Preferred Brand Copay	3,530,000	3,671,000
Specialty Drug Copay	1,471,000	1,530,000
Decrease 34-day Supply to 30-days	2,190,000	2,277,000
Specialty Drug Contract Change	1,665,000	1,887,000
Total Savings	$145,835,000	$171,355,000

As noted above, the impact of eliminating the PPO Plus option effective July 1, 2009 was included in the Plan's baseline funding projection. Thus, it is not included in the above table. I have estimated the net impact of removing this option will be cost neutral. This results from a loss of member premiums of approximately $42.1 million per year, and a reduction in net plan benefits of the same amount.

The savings estimates shown above are based on analysis of medical and prescription drug claims information for the Plan. Data was primarily used from fiscal years 2008 and 2009 to date. These projections assume that the members currently covered under the PPO Plus option will elect the PPO Standard option. The data and assumptions used in this analysis are outlined in Attachment #1.

Projected savings include a two-week claim payment lag for prescription drugs and 45-day lag for medical services. The projections also assume the plan membership remains constant at the December 2008 level of 666,809. All projected savings have been discounted with a risk factor, generally 5-10%, as shown in Attachment #1.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, FCA, EA
Consulting Actuary

Actuarial Assumptions and Data

Data Sources: State Health Plan for Teachers and State Employees
- Charge Summary
- Coinsurance and Deductible Levels – Full Population
- Coinsurance and Deductible Levels – Closed Population
- Copay Report
- Financial Reconciliation Report

The above reports were available for Fiscal Year 2008 and Fiscal Year 2009 through January. Reports are on both a paid and an incurred basis.

SHP Distribution of Participants by Age and Gender

State of NC Rx Drug Pull – 1st half FY2009
State of NC Rx Drugs – FY 2007/FY2008

Data Summary:

Distribution of Claims Active Members			
Allowed Charges </=	Percent of Members		
	Standard	Basic	Plus
$0	62.55%	64.71%	40.24%
$100	2.30%	2.71%	2.55%
$200	2.34%	4.07%	2.80%
$300	2.07%	1.58%	2.57%
$400	1.78%	0.90%	2.23%
$500	1.45%	1.36%	1.67%
$600	1.09%	0.90%	1.52%
$700	0.96%	1.36%	1.54%
$800	1.02%	0.90%	1.45%
$900	0.92%	1.58%	1.30%
$1,000	0.85%	0.23%	1.25%
$1,500	3.83%	3.62%	5.16%
$2,000	2.56%	1.58%	4.23%
$2,500	1.73%	2.49%	2.97%
$3,000	1.42%	0.90%	2.49%
$5,000	3.54%	2.94%	6.33%
$10,000	4.91%	4.75%	9.15%
$20,000	3.05%	2.04%	6.18%
$9,999,999	1.64%	1.36%	4.38%
Total	100.00%	100.00%	100.00%

Includes only claims subject to deductible and coinsurance
Separate distributions used for Medicare and non-Medicare retirees

Office Visit Rates PPO Standard FY2008				
Status	Type	Visit Rate Per Member	Copay Increases	Effective Rate
Active Employee	Primary Care	2.87	5	100.0%
	Specialist	2.17	20	98.7%
	Urgent Care	0.08	25	98.4%
	Inpatient	0.05	50	97.7%
	Routine Eye	0.19	n/a	n/a
Medicare Eligible Retiree	Primary Care	3.78	5	70.0%
	Specialist	5.87	20	25.0%
	Urgent Care	0.06	25	15.0%
	Inpatient	0.23	50	65.0%
	Routine Eye	0.04	n/a	n/a
Non-Medicare Retirees	Primary Care	3.24	5	100.0%
	Specialist	3.89	20	98.3%
	Urgent Care	0.06	25	96.7%
	Inpatient	0.06	50	95.7%
	Routine Eye	0.25	n/a	n/a

Separate rates used for PPO Basic and Plus.

Prescription Drug Data Summary July – December 2008			
Category	Rx Count	Gross Cost	Member Copay
Single Source Preferred Brand	1,517,485	$240,708,957	$49,186,024
Single Source Non-Preferred Brand	419,651	69,475,149	20,891,702
Multi Source Brand	167,344	12,811,482	5,690,735
Generic	3,897,258	106,199,847	40,728,123
TOTAL	6,001,738	$429,195,435	$116,496,583

Specialty Drug Data Summary July 2007– June 2008			
Category	Rx Count	Gross Cost	Member Copay
Outpatient Specialty Drugs	43,615	$88,891,916	$2,250,965

Membership:

Distribution by Option and Status				
Status	Standard	Basic	Plus	Total
Active Employee	380,833	31,204	75,109	487,146
Medicare Eligible Retiree	90,918	1,350	11,604	103,872
Non-Medicare Retirees	50.910	1,472	9,667	62,049
Total	522,661	34,026	96,380	653,067

This represents the average membership within each category for the second quarter of Fiscal Year 2009.

Actuarial Assumptions and Methods:

Medical Claim Trends

Office Visit & Inpatient Annual Utilization Trends	
Category	Percent
Primary Care	0.0%
Specialist	2.5%
Urgent Care	1.0%
Inpatient	0.0%

Annual Price Increase: 5.0%

Prescription Drugs

Prescription Drugs Annual Trend Assumptions		
Component	Generic	Brand
Utilization	3.0%	-3.0%
Price	6.0%	9.0%

Maintenance Drugs Percent of Non-Specialty Scripts	
Tier	Percent
Generic	70.4%
Single Source Preferred	92.1%
Other Brand	85.1%
Total	77.3%

Percent of Rx currently at 3-month Supply: 5.0%
Members Meeting $2,500 OOP Max: 5,000
Brand Copay Increase Realization Rate: 92.0%

Specialty Drugs

Savings for the Specialty Drug Contract Change are based on proposed additional discounts the Plan may obtain under an exclusive contract with a specialty pharmacy vendor. While these savings reflect proposed larger discounts, I note that over 60% of the savings is due to six specialty drugs. Thus, this amount could change dramatically with any price or utilization changes in these drugs, and a higher risk factor was applied to this category.

The savings due to the increased member copay on specialty drugs was estimated by analyzing the specialty drug claims from fiscal year 2008. Approximately 85% of these prescriptions are in the non-preferred brand tier. To avoid double counting the effect of the $5 copay increase for that tier and to

account for the $2,500 out of pocket maximum for prescriptions, a 67% realization factor was applied to the increased copayments in this category.

Risk Factors

Estimated savings were reduced by the risk factors shown below. This provides a margin for adverse deviation and reflects data limitations. In particular, both the projection period and the periods of available data contain significant movement of members between plan options, increasing the likelihood that future experience will not follow past patterns. The risk factors also reflect any conservatism inherent in other assumptions.

Risk Factors	
Category	Percent
Medical Copays	5.0%
Deductible/Coinsurance	5.0%
SS Brand Copays	5.0%
Multi Source Rx Copay	10.0%
Specialty Rx Copay	5.0%
Specialty Rx Contract	20.0%
30 Day Supply Limit	10.0%

ATTACHMENT #2

Remarks by Bob Greczyn
House Insurance Committee
April 2, 2009

Thank you, Mr. Chairman, and members of the House Insurance Committee.

Good morning. I'm Bob Greczyn, chief executive officer of Blue Cross and Blue Shield of North Carolina. On behalf of the state of North Carolina, we administer the State Health Plan, which covers teachers, state employees, retirees and their dependents. We've been doing so for more than 20 years.

Including the State Health Plan, we serve more than 3.7 million customers. We are not just the largest health insurer in North Carolina. We're the only major health insurer based in North Carolina.

I've been invited here to comment on our role in the State Health Plan. I'm happy to do that on behalf of our 4,900 employees, including more than 500 of whom work directly on the Plan.

I also appreciate the opportunity to provide our perspective on the financial challenges facing the Plan.

It would have been our preference to let the legislature resolve the State Health Plan matter and for us to focus on serving the 665,000 State Health Plan members who count on us. However, we believe it's time to let you hear directly from us.

With regard to the State Health Plan, we know you face very difficult choices. But these tough choices are not the result of our work. We don't set budgets or make financial projections for the Plan.

And, we don't decide member benefits or set the Plan's premiums – you do.

I'm very proud of the work we've done in administering the plan. North Carolina is our home, and we're pleased to provide outstanding service to the state at a reasonable price.

Let me share some details:

- We processed more than 7.7 million claims for state members last year.
- Our average claims processing time is currently less than a week.
- We answered more than 335,000 state member calls last year.
- Our average call answer time this year is less than 30 seconds.

Here's something you may not have heard: Of every dollar paid out by the State Health Plan, 94 cents pays for hospitals, doctors and other health care providers.

Our profit on the contract amounts to just over one-half of one percent of each dollar of revenue we receive. That amounted to less than $480,000 for the 2008 fiscal year.

Overwhelmingly, state employees value the Blue Cross card in their wallets, along with the stability and reliability it represents. We provide them with great value and great services. We give them access to an unparalleled network of physicians, hospitals and other health care professionals, both inside and outside North Carolina, wherever they might travel.

We have never asked you to take our word for the value and quality of the service we provide. Every self-insured employer that we serve – including the State Health Plan – has audit rights. We are the subject of audits all the time.

We don't claim perfection. We are committed to addressing issues when they occur.

But the real issue facing you is not our contract. It's that the State Health Plan failed to accurately predict the health utilization and the resulting costs of its members. That's not part of our contract. But it is the central issue that must be resolved to ensure the long-term stability of the plan.

Let me say again – we don't set the plan's budget, make financial projections or perform actuarial services for the State Health Plan. We administer the plan based on the state's direction.

We've done all we can within our contract to work with the State Health Plan during this difficult time. Our help to the State Health Plan also includes allowing it to defer $40 million in payments to us last year.

We did not cause this shortfall, but we have been asked to consider reducing our costs to administer the State Health Plan. We have looked at that, and any reduction in costs would result in an unacceptable degradation of services to state employees. Or, we'd have to ask our commercial customers to subsidize the State Health Plan.

We saved you money at the front end by negotiating the best price we could to deliver the service.

A cut right now of 10 percent, for example, would immediately put 120 jobs at risk, increase call times, and slow claims processing. It would jeopardize programs that actually generate savings for the state – like reviewing claims for errors, inappropriate service or fraud. We wouldn't have the money to mail benefits information to Plan members. This would be bad for state employees, bad for North Carolina and bad for your constituents back home.

We will not offer less than acceptable service to state employees or any other customer. If we did, **our** reputation would suffer, not the state's.

Let me state clearly: The leadership of SEANC, our critics and some in the news media clearly don't understand – or don't choose to understand – that revenues aren't profits.

The News & Observer has said erroneously that we would make $121 million per year on the state contract. We actually made less than $480,000 in 2008 – a profit margin of well under a penny per dollar of revenue.

We reject these mischaracterizations, and we particularly regret that the leadership of SEANC has chosen to knowingly provide inaccurate information.

In an effort to be transparent, we even publicly released our contract with the State Health Plan. We could not do it as quickly as we would have liked because of restrictions from the State Health Plan.

Now, let me address the unspoken issue in the room, that of my compensation as CEO of Blue Cross and Blue Shield of North Carolina. We can disagree about executive compensation, but that won't solve the fundamental problems of the Plan.

Corporate executives are an easy target when so many people are having a tough time. That's true even for those of us whose companies are growing, paying our bills and providing thousands of good, stable jobs for North Carolinians.

We are not only North Carolina's largest health insurer; we are a dedicated corporate citizen, working to improve our health care system, increase access to care and build our communities. It would be interesting to ponder if a health insurance company based in Pennsylvania or Minnesota would have that same commitment.

Let me take a moment to address another common misperception – that we are a tax-exempt charity. State law classifies Blue Cross and Blue Shield of North Carolina as a nonprofit hospital and medical services corporation. But we are fully taxed.

That bears repeating – we are fully taxed. Last year, our tax bill was more than $162 million. That was money that supported government programs in places like Chapel Hill, Orange County, Durham County, Forsyth County, Raleigh and Washington.

Here's what's really at stake on our contract. If we no longer serve as administrator of the State Health Plan, we would be forced to eliminate more than 500 jobs of North Carolinians who serve State Health Plan members every day. We shouldn't put their jobs at risk for a problem they did not create.

We've got a valid contract – negotiated in good faith – to serve State Health Plan members until mid-2013. We've lived up to all our responsibilities under the contract, and we know the state will do the same.

We fully expect that contract will be put out to bid in 2013. We are the state's largest health insurer because we know how to successfully compete for and keep customers.

I would like to say a word about our cooperative work with the General Assembly. We've partnered with you not just on the State Health Plan but also on the patients' bill of rights, the high-risk pool and mental health parity.

We look forward to our continued work with you.

Mr. Chairman, if members of the committee have any questions, I would be pleased to answer them.

ATTACHMENT #3

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 287

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

S287-ALN-16 [v.2]

Comm. Sub. [YES]
Amends Title [NO]
Third edition.

Date _____,2009

Representative Howard

moves to amend the bill on page 4, line 3,
by deleting the word "medications" and substituting "medications, excluding cancer medications,".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: Amendment to Senate Bill 287 (Third Edition) S287-ALN-16 [v.2]

SHORT TITLE: State Hlth Plan $/Good Health Initiatives.

SPONSOR(S):

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY: Amends the third edition of Senate Bill 287 by excluding cancer drugs from the provision in Section 2(c) of the bill requiring specialty drugs to be provided through a exclusive specialty pharmacy vendor.

EFFECTIVE DATE: Proposed changes in the amendment, if adopted, will follow the effective dates included in the third edition of SB 287.

ESTIMATED IMPACT ON STATE:

Aon Consulting, the consulting actuary for the State Health Plan for Teachers and State Employees, estimates that implementation of the proposed amendment will reduce the projected savings estimated for SB 287 (Third Edition) by $100,000 in FY 2009-10 and $100,000 in FY 2010-11 for a total amount of $200,000 for the biennium.

Hartman & Associates, the consulting actuary for the General Assembly's Fiscal Research Division, estimates that implementation of the proposed amendment will reduce the projected savings estimated for SB 287 (Third Edition) by $110,000 in FY 2009-10 and $ 125,000 in FY 2010-11 for a total amount of $235,000 for the biennium.

To fund the additional estimated cost of the change proposed in the amendment, the Executive Administrator of the Plan has said that the projected costs can be absorbed without further adjustment to the projected financial changes in Senate Bill 287 (Third Edition).

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2008, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.6 billion for FY 2008-09. The Plan's PPO benefit design includes three alternative benefit levels offered to plan members. The three alternative benefit levels include the following:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums;

2) The "Standard" 80/20 plan; and

3) The "Plus" 90/10 plan with enhanced benefits via lower out-of pocket requirements as compared to the other PPO plan alternatives offered.

Employees and retired employees electing coverage under the Plus alternative must make a partially contributory premium contribution for their own coverage. The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under all plans is offered on a fully contributory basis.

Financial Condition

Financial Projection (Revised) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year are projected to be $2.3 billion from premium collections, $53.9 million from Medicare Part D subsidies, and $2.7 million from investment earnings, for a total of slightly over $2.3 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.4 billion in claim-payment expenses and $168.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating loss is projected to be approximately $264.4 million for the fiscal year, assuming a 9% annual claims growth trend.

Projected operating losses are expected to deplete the Plan's cash balance of $139.8 million and leave it without sufficient operating resources to continue operations for the fiscal year. It is currently estimated by the Plan's Executive Administrator that the Plan will not be able to pay claims on a timely basis by March 31, 2009.

Consequently, the reforecast of Plan finances now indicates that the Plan will require up to $300 million in additional resources to operate for the balance of the 2008-09 fiscal year. This amount represents the estimated funds necessary to pay claims and administrative expenses through June 30, 2009, plus funding a minimum stabilization reserve equal to 7.5% of projected claims, and assuming a future premium rate increase effective October 1, 2009.

Other Information

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment Data as of December 31, 2008

I. No. of Participants	Basic	Standard	Plus	Total	Percent of Total
Actives					
Employees	11,623	271,243	47,687	330,553	49.6%
Dependents	20,454	115,875	28,156	164,485	24.7%
Sub-total	32,077	387,118	75,843	495,038	74.2%
Retired					
Employees	1,726	127,081	17,967	146,774	22.0%
Dependents	1,117	14,935	3,476	19,528	2.9%
Sub-total	2,843	142,016	21,443	166,302	24.9%
Former Employees with Continuation Coverage					
Employees	60	1,349	344	1,753	0.3%
Dependents	61	501	182	744	0.1%
Sub-total	121	1,850	526	2,497	0.4%
Firefighters, Rescue Squad & National Guard					
Employees	-	3	2	5	0.0%
Dependents	-	3	-	3	0.0%
Sub-total	-	6	2	8	0.0%
Local Governments					
Employees	72	1,577	319	1,968	0.3%
Dependents	141	637	218	996	0.1%
Sub-total	213	2,214	537	2,964	0.4%
Total					
Employees	13,481	401,253	66,319	481,053	72.1%
Dependents	21,773	131,951	32,032	185,756	27.9%
Grand Total	**35,254**	**533,204**	**98,351**	**666,809**	**100%**
Percent of Total	**5.3%**	**80.0%**	**14.7%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	2,684	328,635	49,246	380,565
Employee Child(ren)	4,958	36,903	8,589	50,450
Employee Spouse	2,274	18,145	4,469	24,888
Employee Family	3,565	17,570	4,015	25,150
Total	**13,481**	**401,253**	**66,319**	**481,053**

Percent Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	19.9%	81.9%	74.3%	79.1%
Employee Child(ren)	36.8%	9.2%	13.0%	10.5%
Employee Spouse	16.9%	4.5%	6.7%	5.2%
Employee Family	26.4%	4.4%	6.1%	5.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Enrollment Data Continued

III. Enrollment by Sex	Basic	Standard	Plus	Total
Female	18,837	334,917	61,752	415,506
Male	16,417	198,287	36,599	251,303
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Sex	Basic	Standard	Plus	Total
Female	53.4%	62.8%	62.8%	62.3%
Male	46.6%	37.2%	37.2%	37.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	17,390	136,277	27,211	180,878
30 to 44	8,125	107,375	17,315	132,815
45 to 54	5,164	94,548	18,277	117,989
55 to 64	3,195	102,901	23,452	129,548
65 & Over	1,380	92,103	12,096	105,579
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	49.3%	25.6%	27.7%	27.1%
30 to 44	23.0%	20.1%	17.6%	19.9%
45 to 54	14.6%	17.7%	18.6%	17.7%
55 to 64	9.1%	19.3%	23.8%	19.4%
65 & Over	3.9%	17.3%	12.3%	15.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	49,534	12,080	61,614
Medicare Eligible	97,240	7,448	104,688
Total	**146,774**	**19,528**	**166,302**

Percent by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.7%	61.9%	37.0%
Medicare Eligible	66.3%	38.1%	63.0%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

Aon Consulting, North Carolina State Health Plan, Financial Projections – October 2008, Total For All Plans – 9% Trend, July 2009 & 2010 Rate Increases, $250 Million Grant, No Plus Option – July 2009, Benefit Option, Pharmacy Initiatives, March 20, 2009.

Medco Health Solutions, various summarized claims reports for medical claims by category and purpose and time period, March 2009.

-Actuarial Note, Hartman & Associates, "Senate Bill 287 Amendment S287-ALN-16 [v.2]: Amendment to Specialty Pharmacy Medication in the State Health Plan," March 27, 2009, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "Senate Bill 287, Proposed Amendment, S287-ALN-16 [v.2]", March 30, 2009, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY Bob Weiss

:

Bob Weiss
on behalf of Marilyn Chism, Director
Fiscal Research Division

DATE:April 2, 2009

NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

SENATE BILL S287
PROPOSED AMENDMENT
S287-ALN-16 [V.2]

EXCLUDE CANCER MEDICATIONS FROM EXCLUSIVE SPECIALTY VENDOR

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30305

March 2009

ACTUARIAL STATEMENT

The North Carolina State Health Plan for Teachers and State Employees has requested that Aon Consulting prepare an Actuarial Note in response to Amendment S287-ALN-16 [v.2] to Senate Bill 287 which proposes that the State Health Plan shall exclude cancer medications from specialty medications covered exclusively through the contracted specialty pharmacy vendor.

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

March 30, 2009

Kenneth C. Vieira, F.S.A., M.A.A.A. — Date
Senior Vice President

March 30, 2009

Kirsten R. Schatten, A.S.A., M.A.A.A. — Date
Assistant Vice President

EXCLUDE CANCER MEDICATIONS FROM EXCLUSIVE SPECIALTY VENDOR

PLAN CHANGES

The General Assembly of North Carolina:
moves to amend the bill on page 4, line 3,
by deleting the word "medications" and substituting "medications, excluding cancer medications,".

PROJECTED COSTS

	Based on "Midpoint" Increase (in millions)		
Plan Design Change	2009-2010 Fiscal Year Cost	2010-2011 Fiscal Year Cost	Total Biennium Cost
Exclude cancer medications from exclusive specialty vendor	$.1	$.1	$.2

* Based on total projected expenses of $2,687,502,073 and $2,919,507,795 for the 2010 and 2011 fiscal years respectively.

PRICING APPROACH AND COMMENTS

The following information was compiled and utilized in determining the projected costs or savings of each benefit component addressed in this actuarial note:

- The specialty vendor network savings projections are provided by Medco and are based on enhanced discounts for a list of specialty drugs that will only be covered in the specialty network by implementing a retail lockout. The list of drugs with retail lockout does not include specialty drugs that may be required on an acute basis. Medco's analysis is based only on ingredient cost with discounts based on 2008 data.

- The proposed amendment excludes cancer drugs from the list of drugs with retail lockout. Note: as per the amendment, these excluded drugs are only oncology drugs; other drugs that provide adjunctive therapy such as drugs that treat anemia are not included in this projection.

- The cost estimate provided by Medco to exclude cancer drugs from the specialty network is projected to be $.1 million per year.

HARTMAN & ASSOCIATES, LLC

ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

hartman@triad.rr.com

Phone: (336) 731-4038
Fax: (336) 731-2583

668 Link Road
Lexington, NC 27295

March 27, 2009

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Senate Bill 287 Amendment S287-ALN-16 [v.2]: Amendment to Specialty Pharmacy Medication in the State Health Plan

Dear Mr. Trogdon:

This amendment modifies the third edition of this bill. The bill appropriates funds and makes various changes to the North Carolina State Health Plan for Teachers and State Employees (the "Plan"). Included in the bill is a provision for the Plan to provide coverage of nonacute specialty medications under the Plan's pharmacy benefit through a specialty pharmacy vendor under contract with the plan. This amendment excludes cancer medications from the specialty pharmacy vendor requirement.

The amendment eliminates a proposed change to the Plan and does not modify the current Plan provisions. Thus, the amendment does not have an impact on current operations. However, the amendment does eliminate potential savings on cancer medications under the specialty pharmacy vendor provision. The chart below shows the financial impact on the Plan for this provision as included in the bill and with the amendment.

Specialty Pharmacy Vendor Contrac:		
	Estimated Savings for Fiscal Year Beginning	
Version	July 1, 2009	July 1, 2010
Bill Provisions	1,665,000	1,887,000
Bill with Amendment	1,555,000	1,762,000
Net Impact of Amendment	110,000	125,000

The above estimates are based on proposed additional discounts that may be obtained under an exclusive contract with a specialty pharmacy vendor. Specialty cancer medications were identified by the Plan's pharmacy benefits manager.

Projected savings include a two-week claim payment lag and assume plan membership remains constant at the December 2008 level of 666,809. Projected savings have been discounted with a 20% risk factor due to a high concentration of savings in a small number of drugs.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, FCA, EA
Consulting Actuary

MVH/mt

ATTACHMENT #4

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. 3rd

H. B. No. _____ DATE 4/02/09

S. B. No. 287 Amendment No. _____ (to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.) Sen.) Jarvis

effective January 1, 2011

1 moves to amend the bill on page 11, line 11

2 ~~( ) WHICH CHANGES THE TITLE~~

3 by inserting between lines 11 and 12, the following:

4 "SECTION 5.(g) G.S. 135-45.1(21) reads as rewritten:

5 '(21) Plan year. – The period beginning ~~July 1~~ January 1 and ending

6 ~~June 30~~ December 31 of the succeeding calendar year.'"

7

8

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SIGNED _____

ADOPTED ✓ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

Faison - to Suspend rules
~~Rule~~ Blust called for eyes + no's

ROLL CALL VOTE

____ ____ =_____(TOTAL) HB# ____
YES NO SB# ____

HOUSE STANDING COMMITTEE ON INSURANCE

House Subcommittee on _____

YES	NO	MEMBER (last name)	YES	NO	MEMBER (last name)
____	____	GOFORTH, Bruce	✓	____	
____	____	WRAY, Michael H.	✓	____	
____	____	DICKSON, Margaret	✓	____	
____	____	DOCKHAM, Jerry	✓	____	
____	____	SETZER, Mitchell	✓	____	
____	____	BARNHART, Jeff	✓	____	
____	____	BLUST, John	✓	____	
____	____	BRAXTON, R. Van	✓	____	
____	____	BRUBAKER, Harold	✓	____	
____	____	COLE, Nelson	✓	____	
____	____	CURRENT, Bill	✓	____	
____	____	FAISON, Bill	✓	____	
____	____	GIBSON, Pryor	✓	____	
____	____	HOLLIMAN, Hugh	✓	____	
____	____	HOWARD, Julia	✓	____	
____	____	HUGHES, Sandra Spaulding	✓	____	
____	____	PIERCE, Garland	✓	____	
____	____	WAINWRIGHT, William	✓	____	
____	____		____	____	
____	____		____	____	
____	____				
____	____				
____	____				
____	____				

ATTACHMENT #5

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 287

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

S287-ALN-22 [v.2]

Comm. Sub. [YES]
Amends Title [NO]
Third Edition

Date _____,2009

Representative Cole

moves to amend the bill on page 4, line 7,
by rewriting the line to read "specialty pharmacy vendor, provided that the Plan shall continue to allow any retail pharmacy to dispense any specialty drug at the same price as determined by the specialty drug vendor."

SIGNED Nelson Cole
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: Amendment to Senate Bill 287 (Third Edition) S287-ALN-22 [v.1]

SHORT TITLE: State Hlth Plan $/Good Health Initiatives.

SPONSOR(S):

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY: Amends the third edition of Senate Bill 287 by allowing any retail pharmacy to dispense any specialty drug at the same price as determined by a specialty drug vendor authorized under Section 2(c) of the bill.

EFFECTIVE DATE: Proposed changes in the amendment, if adopted, will follow the effective dates included in the third edition of SB 287.

ESTIMATED IMPACT ON STATE:

Aon Consulting, the consulting actuary for the State Health Plan for the Teachers and State Employees, estimates that implementation of the proposed amendment will not have an impact on the projected financial changes in Senate Bill 287 (Third Edition).

Hartman & Associates, the consulting actuary for the General Assembly's Fiscal Research Division, estimates that implementation of the proposed amendment will not have an impact on the projected financial changes in Senate Bill 287 (Third Edition).

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2008, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.6 billion for FY 2008-09. The Plan's PPO benefit design includes three alternative benefit levels offered to plan members. The three alternative benefit levels include the following:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums;

2) The "Standard" 80/20 plan; and

3) The "Plus" 90/10 plan with enhanced benefits via lower out-of pocket requirements as compared to the other PPO plan alternatives offered.

Employees and retired employees electing coverage under the Plus alternative must make a partially contributory premium contribution for their own coverage. The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under all plans is offered on a fully contributory basis.

Financial Condition

Financial Projection (Revised) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year are projected to be $2.3 billion from premium collections, $53.9 million from Medicare Part D subsidies, and $2.7 million from investment earnings, for a total of slightly over $2.3 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.4 billion in claim-payment expenses and $168.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating loss is projected to be approximately $264.4 million for the fiscal year, assuming a 9% annual claims growth trend.

Projected operating losses are expected to deplete the Plan's cash balance of $139.8 million and leave it without sufficient operating resources to continue operations for the fiscal year. It is currently estimated by the Plan's Executive Administrator that the Plan will not be able to pay claims on a timely basis by March 31, 2009.

Consequently, the reforecast of Plan finances now indicates that the Plan will require up to $300 million in additional resources to operate for the balance of the 2008-09 fiscal year. This amount represents the estimated funds necessary to pay claims and administrative expenses through June 30, 2009, plus funding a minimum stabilization reserve equal to 7.5% of projected claims, and assuming a future premium rate increase effective October 1, 2009.

Other Information

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment Data as of December 31, 2008

I. No. of Participants	Basic	Standard	Plus	Total	Percent of Total
Actives					
Employees	11,623	271,243	47,687	330,553	49.6%
Dependents	20,454	115,875	28,156	164,485	24.7%
Sub-total	32,077	387,118	75,843	495,038	74.2%
Retired					
Employees	1,726	127,081	17,967	146,774	22.0%
Dependents	1,117	14,935	3,476	19,528	2.9%
Sub-total	2,843	142,016	21,443	166,302	24.9%
Former Employees with Continuation Coverage					
Employees	60	1,349	344	1,753	0.3%
Dependents	61	501	182	744	0.1%
Sub-total	121	1,850	526	2,497	0.4%
Firefighters, Rescue Squad & National Guard					
Employees	-	3	2	5	0.0%
Dependents	-	3	-	3	0.0%
Sub-total	-	6	2	8	0.0%
Local Governments					
Employees	72	1,577	319	1,968	0.3%
Dependents	141	637	218	996	0.1%
Sub-total	213	2,214	537	2,964	0.4%
Total					
Employees	13,481	401,253	66,319	481,053	72.1%
Dependents	21,773	131,951	32,032	185,756	27.9%
Grand Total	**35,254**	**533,204**	**98,351**	**666,809**	**100%**
Percent of Total	**5.3%**	**80.0%**	**14.7%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	2,684	328,635	49,246	380,565
Employee Child(ren)	4,958	36,903	8,589	50,450
Employee Spouse	2,274	18,145	4,469	24,888
Employee Family	3,565	17,570	4,015	25,150
Total	**13,481**	**401,253**	**66,319**	**481,053**

Percent Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	19.9%	81.9%	74.3%	79.1%
Employee Child(ren)	36.8%	9.2%	13.0%	10.5%
Employee Spouse	16.9%	4.5%	6.7%	5.2%
Employee Family	26.4%	4.4%	6.1%	5.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Enrollment Data Continued

III. Enrollment by Sex	Basic	Standard	Plus	Total
Female	18,837	334,917	61,752	415,506
Male	16,417	198,287	36,599	251,303
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Sex	Basic	Standard	Plus	Total
Female	53.4%	62.8%	62.8%	62.3%
Male	46.6%	37.2%	37.2%	37.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	17,390	136,277	27,211	180,878
30 to 44	8,125	107,375	17,315	132,815
45 to 54	5,164	94,548	18,277	117,989
55 to 64	3,195	102,901	23,452	129,548
65 & Over	1,380	92,103	12,096	105,579
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	49.3%	25.6%	27.7%	27.1%
30 to 44	23.0%	20.1%	17.6%	19.9%
45 to 54	14.6%	17.7%	18.6%	17.7%
55 to 64	9.1%	19.3%	23.8%	19.4%
65 & Over	3.9%	17.3%	12.3%	15.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	49,534	12,080	61,614
Medicare Eligible	97,240	7,448	104,688
Total	**146,774**	**19,528**	**166,302**

Percent by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.7%	61.9%	37.0%
Medicare Eligible	66.3%	38.1%	63.0%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

Aon Consulting, North Carolina State Health Plan, Financial Projections – October 2008, Total For All Plans – 9% Trend, July 2009 & 2010 Rate Increases, $250 Million Grant, No Plus Option – July 2009, Benefit Option, Pharmacy Initiatives, March 20, 2009.

Medco Health Solutions, various summarized claims reports for medical claims by category and purpose and time period, March 2009.

-Actuarial Note, Hartman & Associates, "Senate Bill 287 Amendment S287-ALN-22 [v.1]: Amendment to Specialty Pharmacy Vendor in the State Health Plan," March 27, 2009, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "Senate Bill 287, Proposed Amendment, S287-ALN-22 [v.1]", March 30, 2009, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Bob Weiss

Bob Weiss
on behalf of Marilyn Chism, Director
Fiscal Research Division

DATE: April 2, 2009

NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

SENATE BILL S287
PROPOSED AMENDMENT
S287-ALN-22 [V.1]

ANY PHARMACY MAY DISPENSE SPECIALTY DRUG AT SPECIALTY VENDOR PRICE

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30305

March 2009

ACTUARIAL STATEMENT

The North Carolina State Health Plan for Teachers and State Employees has requested that Aon Consulting prepare an Actuarial Note in response to Amendment S287-ALN-16 [v.2] to Senate Bill 287 which proposes that the State Health Plan shall allow any retail pharmacy to dispense any specialty drug at the same price as determined by the specialty drug vendor.

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

March 30, 2009

Kenneth C. Vieira, F.S.A., M.A.A.A.
Senior Vice President

Date

March 30, 2009

Kirsten R. Schatten, A.S.A., M.A.A.A.
Assistant Vice President

Date

ANY RETAIL PHARMACY MAY DISPENSE SPECIALTY DRUG AT SPECIALTY VENDOR PRICE

PLAN CHANGES

The General Assembly of North Carolina:

moves to amend the bill on page 4, line 7,

by rewriting the line to read "specialty pharmacy vendor, provided that the Plan shall continue to allow any retail pharmacy to dispense any specialty drug at the same price as determined by the specialty drug vendor."

PROJECTED COSTS

	Based on "Midpoint" Increase (in millions)		
Plan Design Change	2009-2010 Fiscal Year Cost	2010-2011 Fiscal Year Cost	Total Biennium Cost
Any retail pharmacy may dispense specialty drug at specialty vendor price	No financial impact.		

* Based on total projected expenses of $2,687,502,073 and $2,919,507,795 for the 2010 and 2011 fiscal years respectively.

PRICING APPROACH AND COMMENTS

The following information was compiled and utilized in determining the projected costs or savings of each benefit component addressed in this actuarial note:

- We expect no financial impact by allowing any retail pharmacy to dispense specialty drugs with the provision that it is at the same price.

HARTMAN & ASSOCIATES, LLC

ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

hartman@triad.rr.com

Phone: (336) 731-4038
Fax: (336) 731-2583

668 Link Road
Lexington, NC 27295

March 27, 2009

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Senate Bill 287 Amendment S287-ALN-22 [v.1]: Amendment to Specialty Pharmacy Vendor in the State Health Plan

Dear Mr. Trogdon:

This amendment modifies the third edition of this bill. The bill appropriates funds and makes various changes to the North Carolina State Health Plan for Teachers and State Employees (the "Plan").

Included in the bill is a provision for the Plan to provide coverage of nonacute specialty medications under the Plan's pharmacy benefit through a specialty pharmacy vendor under contract with the plan. This amendment adds language to provide that the Plan shall continue to allow any retail pharmacy to dispense any specialty drug at the same price as determined by the specialty vendor.

This amendment is not expected to have a financial impact on the Plan.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, FCA, EA
Consulting Actuary

MVH/mt

ATTACHMENT #6

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 287

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

S287-ALN-24 [v.3]

Comm. Sub. [YES]
Amends Title [NO]
Third Edition

Date _____,2009

Representative Cole

moves to amend the bill on page 4, lines 7 through 16,
by rewriting the lines to read:

"specialty pharmacy vendor. Specialty medications are covered biotech medications and other medications designated and classified by the Plan as specialty medications that are significantly more expensive than alternative drugs or therapies. Medications classified by the Plan as specialty medications shall meet all of the following conditions:

a. Have unique uses for the treatment of complex diseases.
b. Require special dosing or administration.
c. Require special handling.
d. Are typically prescribed by a specialist provider.
e. Exceed four hundred dollars ($400.00) cost to the Plan per prescription.

The Plan shall impose a co-payment in the amount of twenty-five percent (25%) of the Plan's gross".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

ATTACHMENT #7

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 287

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

S287-ALN-25 [v.1]

Comm. Sub. [YES]
Amends Title [NO]
Third Edition

Date _____,2009

Representative Cole

moves to amend the bill on page 7, line 3,
by inserting between lines 3 and 4, the following,

"**SECTION 2.(i)** Required disclosure. – The Plan's pharmacy benefit manager (PBM) shall disclose to the Plan the amount actually paid or to be paid to the pharmacy for each prescription, including the drug name, dose, and quantity. This information and the corresponding information of the amount the Plan is charged or will be charged by the PBM for each prescription shall be available to the Committee on Employee Hospital and Medical Benefits."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

ATTACHMENT #1

VISITOR REGISTRATION SHEET

Insurance Committee
Name of Committee

April 2, 2009
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chuck Stone	SEANC
ANN LORE	DVIC
Jori Alley	BEGINNINGS
Lina McCann	State Health Plan
Carol Orwell	State Health Plan
Tracy Stephenson	State Health Plan
Marci Wilding	Novant Health
Ashley J. Bell	American Cancer Society
Lew Ebert	NC Chamber
Shayna Altschuler	AARP
John McAlister	NC Chamber

VISITOR REGISTRATION SHEET

Insurance Committee
Name of Committee

April 2, 2009
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jim White	Greater Raleigh Chamber of Commerce 800 S. Salisbury St Raleigh, NC 27601
Kim Hanchette	The Diabetes Bus Initiative Nonprofit - 1100 Navaho Dr #108 Ral. 27609
Heather Blackley	Greater Raleigh Chamber of Commerce 800 S. Salisbury st, Raleigh 27601
Ginger Baxley	Greater Raleigh Chamber of Commerce 800 S. Salisbury St. Raleigh, NC 27601
Sarah Gaskill	Greater Raleigh Chamber of Commerce 800 S. Salisbury St. Raleigh NC 27602
Pam Deardorff	NCRSP
Evelyn Hendrickson	ETGR
Joan Siefert Rose	Council for Entrepreneurial Development (CED) 100 Capitola Drive, Durham, NC 27713
Craig Chancellor	Triangle United Way
Jennifer Farmer	Duke University Med Center
Lu-Ann [illegible]	NCPA

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mark Dearmon	SEANC
John Wilke	Durham Chamber
Erica Baldwin	SEANC
Michelle Lindley	NCDOA employee
Susan Yates	↓
Donna Cassell	↓
Lauren Edwards	↓
Ken Melton	K.M.A.
Chip Baggett	NCMS
Robert Soliyson	NCMS
DORANNA ANDERSON	SEANC

VISITOR REGISTRATION SHEET

Insurance Committee
Name of Committee

April 2, 2009
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Art Anthony	SEANC
Mitch Lunard	SEANC
Kristy Kent	BCBSNC
DANA Cope	SEANC
Andy Ellen	NCRMA
CHARLES HAYES	RTRP
Donna Albertone	NCNSP.
Jerry Hardesty	NCPC/FB
Ran Adcock	BCBSNC
Casandra White	AOC
	Bar Asso

VISITOR REGISTRATION SHEET

Insurance Committee — April 2, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Retonda Williams	SEANC
Kisha Robinson	SEANC
Donna Hickman	SEANC
CELIAMARIE WILSON	SEANC
Marge Foreman	NCAE
Cecil BANKS	NCAE
Kevin LeCount	SEANC
Will Cubbison	SEANC
Mary Adelaide Bell	SEANC
GEORGEKAPETANAKIS	SEANC
Shoshana Sorxner	SEANC

VISITOR REGISTRATION SHEET

Insurance Committee — **Name of Committee**

April 2, 2009 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary O'Neill	SEANC
Brenda Hooker	SEANC
Ted Pless	SEANC
Tony E. Smith	SEANC
Larry Presnell	North Carolina Retired School Personnel
[illegible] Dalton	NCRMT
Mike [illegible]	[illegible]
Bill Rusto	AARP
Christy L Simmons	Food Bank of CENC
Allen Reep	Food Bank of Central + Eastern NC
[illegible]	[illegible]

VISITOR REGISTRATION SHEET

Insurance Committee
Name of Committee

April 2, 2009
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dr. MARC GOTTLIEB	chiropractor, NC. Chiro Assoc. Pol. NC.
Anne Burns	State Health Plan
Jake Walker	State Health Plan
Steve Bishop	Carolina Ballet
Sarah Moore	March of Dimes.
Jenny Hutto	American Diabetes Association
Jim Stegall	U.C.P.S.
Katherine Joyce	NCASA
Ed Regan	NCRGEA
Jim Kaylor	Kaylor Law Firm
Dana Simpson	Smith Anderson
Christine Craig	Wakemed

VISITOR REGISTRATION SHEET

Insurance Committee — **Name of Committee**

April 2, 2009 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Alcie Garland	NCEL
Barbara Cansler	BCBS
Mike Mazure	CBNC
[illegible]	NNRS
John Bowditch	AstraZeneca
[illegible]	LNC
[illegible]	NCMS
Holly Blackman	Children's Flight of Hope, Inc.
Bill Stockard	OSBM
Mona Moon	SHP
Lacey Barnes	SHP

House Pages

INSURANCE

Name Of Committee: _____ Date: 4-2-09

1. Name: MOLLY HALL
   County: CUMBERLAND
   Sponsor: REP. BRISSON
2. Name: TYLER ROGERS
   County: PITT
   Sponsor: REP. BRAXTON
3. Name: _____
   County: _____
   Sponsor: _____
4. Name: _____
   County: _____
   Sponsor: _____
5. Name: _____
   County: _____
   Sponsor: _____

Sgt-At-Arms

1. Name: Charles Williams
2. Name: Fred HINES
3. Name: John Brandon
4. Name: Bob Rossi

Mary Capps (Rep. Wray)

m: Ann Jordan (Rep. Goforth)
t: Tuesday, March 31, 2009 9:27 AM
Subject: Meeting Notice 2 Corrected for March 31.doc

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

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

DAY & DATE: **Thursday, April 2, 2009**

TIME: **11:00a.m.**

LOCATION: **Room 1228**

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

(Continued Discussion on SB 287)

287 – STATE HEALTH PLAN $/GOOD HEALTH INITIATIVES – Senator Tony Rand

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at **4:45 pm** on **March 30, 2009**.

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 2, 2009

The House Committee on Insurance met at 2:50 PM on Thursday, April 2, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael H. Wray; Vice Chairs: M. Dickson, J. Dockham and M. Setzer. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Cole, Current, Faison, Gibson, Holliman, Hughes, Pierce and Wainwright.

Chairman Goforth called the meeting to order and stated the committee will continue hearing amendments. He called upon Rep. Cole to explain his amendment (Attachment #8) which amends the third edition of SB 287 by requiring per visit co-payments for chiropractic services to be charged at a rate equivalent to that charged for primary car services. Rep. Cole asked Mr. Trogdon to explain the actuarial note for SB 287. (Attachment #9) A vote was taken and the amendment passed.

Rep. Brubaker was recognized to explain his amendment (Attachment #10), and he asked Mr. Trogdon to explain the actuarial note. The amendment amends the third edition of SB 287 by requiring per visit co-payments for physical therapy, occupational therapy, and speech therapy benefits to be charged at a rate equivalent to that charged for primary care services. Rep. Holliman stated the amendment will add $30 M and money will need to be found in Appropriations or added to the cost for state employees. A vote was taken and the amendment passed.

Rep. Blust came forward to explain his amendment (Attachment 11) which will not fix the immediate problem, but he thinks it is something that needs to be done. The control and administration of the Health Plan seems obviously to be an executive branch function, not a legislative branch function, and he would like to put the Health Plan in executive branch where it belongs. Staff has advised him that the best fit is in the Budget Office where it once was located. He moved that the amendment be adopted. Rep. Holloman stated we need to look at this item in the long range fix of the plan. It is not an item we want to take up in this bill which is needed to pass in the next week or so. He does not object to what Rep. Blust wants to do but not in this bill today. A vote was taken on the amendment and it failed.

Chairman Goforth announced the committee will hear speakers from SEANC and NCAE. He called upon Ms. Artis Watkins, Legislative Affairs Director, State Employees Association of North Carolina, to address the committee. SEANC asks that the committee vote no on SB 287 and that the General Assembly freeze State Health Plan member benefits right where they are until a thorough professional audit done by a firm given full access to the State Health Plan contracts can access where the plan is and where we may be paying for expenses not actually incurred by plan members. SEANC further proposes the General Assembly fund the 2009-10 fiscal year with the general fund money already proposed in SB 287 to complete this audit.

Mr. Cecil Banks, Government Relations Manager, North Carolina Association of Educators, was recognized to speak to the committee. NCAE is concerned with the cost shifts to employees and wants to hold the costs down. The increase in out of pocket cost to the employee is significant. He hopes more money can be found to put into the plan and that additional

savings can be found a year from now. He hopes the North Carolina Association of School Administrators and the North Carolina Retired School Personnel will join him in supporting these remarks and concerns.

Chairman Goforth called for a vote on the bill and it passed. The bill received a favorable report as to the House PCS, unfavorable as to Senate Committee Substitute Bill and recommendation that the House committee substitute bill be re-referred to the Appropriations Committee.

Chairman Goforth adjourned the meeting at 3:45 PM.

_____

Representative Bruce Goforth, Chairman

_____

Mary Capps – Committee Assistant

ATTACHMENT #8

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 287

Cole passes

AMENDMENT NO. _____
(to be filled in by Principal Clerk)

S287-ALN-26 [v.2]

Comm. Sub. [YES]
Amends Title [NO]
Third Edition

Date _____,2009

Representative Cole

Moves to amend the bill on page 5, line 36,
by inserting at the end of the line the following new sentence to read:
"This co-payment applies to chiropractic services."; and

further moves to amend the bill on page 5, line 38,
by inserting at the end of the line the following new sentence to read:
"This co-payment does not apply to chiropractic services."; and

further moves to amend the bill on page 6, line 13,
by inserting at the end of the line the following new sentence to read:
"This co-payment applies to chiropractic services."; and

further moves to amend the bill on page 6, line 15,
by inserting at the end of the line the following new sentence to read:
"This co-payment does not apply to chiropractic services."; and

further moves to amend the bill on page 2, line 6,
by rewriting the line to read:
"thirty-two million, three hundred thousand, sixty-two dollars ($132,300,062) for"; and

further moves to amend the bill on page 2, lines 7 and 8,
by deleting "two hundred sixty-seven million nine hundred four thousand one hundred fourteen dollars ($267,904,114)" and substituting "two hundred seventy-six million three hundred sixty-five thousand four hundred ninety-eight dollars ($276,365,498)"; and

further moves to amend the bill on page 2, lines 13 and 14,
by deleting "five million nine hundred ninety-two thousand four hundred seventy-six dollars ($5,992,476)" and substituting "six million one hundred seventy-four thousand three dollars ($6,174,003)"; and

further moves to amend the bill on page 2, lines 15 and 16,

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 287

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

S287-ALN-26 [v.2]

by deleting "twelve million five hundred two thousand one hundred ninety-two dollars ($12,502,192)" and substituting "twelve million, eight hundred ninety-seven thousand fifty-seven dollars ($12,897,057)" and

further moves to amend the bill on page 6, lines 32 through 34,
by deleting "eight and six-tenths percent (8.6%)" in both places and substituting eight and nine tenths percent (8.9%)" in both places.

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROL

ATTACHMENT #9

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: Amendment to Senate Bill 287 (Third Edition) S287-ALN-26

SHORT TITLE: State Hlth Plan $/Good Health Initiatives.

SPONSOR(S):

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY: Amends the third edition of Senate Bill 287 by requiring per visit co-payments for chiropractic services to be charged at a rate equivalent to that charged for primary care services.

The proposed co-pay rates in the amendment for these services are compared to those proposed in the Third Edition of Senate Bill 287 in the table below:

	PPO Basic		PPO Standard	
Medical Benefits	**Senate Bill 287**	**Proposed**	**Senate Bill 287**	**Proposed**
Plan Member Co-pays (per visit)	**Third Editon**	**Co-Pay**	**Third Editon**	**Co-Pay**
Chiropractic Services	$70	$30	$60	$25

EFFECTIVE DATE: Proposed changes in the amendment, if adopted, will follow the effective dates included in the third edition of SB 287.

ESTIMATED IMPACT ON STATE:

Aon Consulting, the consulting actuary for the State Health Plan for Teachers and State Employees, estimates that implementation of the benefit change proposed in the amendment will reduce the projected savings estimated for SB 287 (Third Edition) by $8.6 million in FY 2009-10 and $9.7 million in FY 2010-11 for a total amount of $18.3 million for the biennium.

Hartman & Associates, the consulting actuary for the General Assembly's Fiscal Research Division, estimates that implementation of the benefit change proposed in the amendment will reduce the projected savings estimated for SB 287 (Third Edition) by $7.5 million in FY 2009-10 and $8.8 million in FY 2010-11 for a total amount of $16.3 million for the biennium.

To fund the additional cost of the proposed benefit change, the amendment increases the rate of premium increase by 0.3% effective July 1, 2009, and then again by another 0.3% increase on July 1, 2010, to put in

effect an annual 8.9% premium increase for each year of the biennium. This rate of annual increase compares to an 8.6% annual increase proposed in the current bill (SB 287, Third Edition).

The estimated funds generated in accord with the proposed rate of premium increase are as follows:

Total Additonal Premium Contributions From Appropriated and Employee Funds

Fund Source	FY 2009-10	FY 2010-11	Biennium
Appropriated			
General Fund	$3,889,854	$8,461,384	$12,351,238
Highway Fund	$181,527	$394,865	$576,392
Other Funds	$802,482	$1,745,594	$2,548,076
Sub-total	$4,873,863	$10,601,843	$15,475,706
Employee Contributions	$997,808	$2,170,476	$3,168,284
Total	$5,871,671	$12,772,319	$18,643,990

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2008, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.6 billion for FY 2008-09. The Plan's PPO benefit design includes three alternative benefit levels offered to plan members. The three alternative benefit levels include the following:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums;

2) The "Standard" 80/20 plan; and

3) The "Plus" 90/10 plan with enhanced benefits via lower out-of pocket requirements as compared to the other PPO plan alternatives offered.

Employees and retired employees electing coverage under the Plus alternative must make a partially contributory premium contribution for their own coverage. The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under all plans is offered on a fully contributory basis.

Financial Condition

Financial Projection (Revised) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year are projected to be $2.3 billion from premium collections, $53.9 million from Medicare Part D subsidies, and $2.7 million from investment earnings, for a total of slightly over $2.3 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.4 billion in claim-payment expenses and $168.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating loss is projected to be approximately $264.4 million for the fiscal year, assuming a 9% annual claims growth trend.

Projected operating losses are expected to deplete the Plan's cash balance of $139.8 million and leave it without sufficient operating resources to continue operations for the fiscal year. It is currently estimated by the Plan's Executive Administrator that the Plan will not be able to pay claims on a timely basis by March 31, 2009.

Consequently, the reforecast of Plan finances now indicates that the Plan will require up to $300 million in additional resources to operate for the balance of the 2008-09 fiscal year. This amount represents the estimated funds necessary to pay claims and administrative expenses through June 30, 2009, plus funding a minimum stabilization reserve equal to 7.5% of projected claims, and assuming a future premium rate increase effective October 1, 2009.

Other Information

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment Data as of December 31, 2008

I. No. of Participants	Basic	Standard	Plus	Total	Percent of Total
Actives					
Employees	11,623	271,243	47,687	330,553	49.6%
Dependents	20,454	115,875	28,156	164,485	24.7%
Sub-total	32,077	387,118	75,843	495,038	74.2%
Retired					
Employees	1,726	127,081	17,967	146,774	22.0%
Dependents	1,117	14,935	3,476	19,528	2.9%
Sub-total	2,843	142,016	21,443	166,302	24.9%
Former Employees with Continuation Coverage					
Employees	60	1,349	344	1,753	0.3%
Dependents	61	501	182	744	0.1%
Sub-total	121	1,850	526	2,497	0.4%
Firefighters, Rescue Squad & National Guard					
Employees	-	3	2	5	0.0%
Dependents	-	3	-	3	0.0%
Sub-total	-	6	2	8	0.0%
Local Governments					
Employees	72	1,577	319	1,968	0.3%
Dependents	141	637	218	996	0.1%
Sub-total	213	2,214	537	2,964	0.4%
Total					
Employees	13,481	401,253	66,319	481,053	72.1%
Dependents	21,773	131,951	32,032	185,756	27.9%
Grand Total	**35,254**	**533,204**	**98,351**	**666,809**	**100%**
Percent of Total	**5.3%**	**80.0%**	**14.7%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	2,684	328,635	49,246	380,565
Employee Child(ren)	4,958	36,903	8,589	50,450
Employee Spouse	2,274	18,145	4,469	24,888
Employee Family	3,565	17,570	4,015	25,150
Total	**13,481**	**401,253**	**66,319**	**481,053**

Percent Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	19.9%	81.9%	74.3%	79.1%
Employee Child(ren)	36.8%	9.2%	13.0%	10.5%
Employee Spouse	16.9%	4.5%	6.7%	5.2%
Employee Family	26.4%	4.4%	6.1%	5.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Enrollment Data Continued

III. Enrollment by Sex	Basic	Standard	Plus	Total
Female	18,837	334,917	61,752	415,506
Male	16,417	198,287	36,599	251,303
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Sex	Basic	Standard	Plus	Total
Female	53.4%	62.8%	62.8%	62.3%
Male	46.6%	37.2%	37.2%	37.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	17,390	136,277	27,211	180,878
30 to 44	8,125	107,375	17,315	132,815
45 to 54	5,164	94,548	18,277	117,989
55 to 64	3,195	102,901	23,452	129,548
65 & Over	1,380	92,103	12,096	105,579
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	49.3%	25.6%	27.7%	27.1%
30 to 44	23.0%	20.1%	17.6%	19.9%
45 to 54	14.6%	17.7%	18.6%	17.7%
55 to 64	9.1%	19.3%	23.8%	19.4%
65 & Over	3.9%	17.3%	12.3%	15.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	49,534	12,080	61,614
Medicare Eligible	97,240	7,448	104,688
Total	**146,774**	**19,528**	**166,302**

Percent by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.7%	61.9%	37.0%
Medicare Eligible	66.3%	38.1%	63.0%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

Aon Consulting, North Carolina State Health Plan, Financial Projections – October 2008, Total For All Plans – 9% Trend, July 2009 & 2010 Rate Increases, $250 Million Grant, No Plus Option – July 2009, Benefit Option, Pharmacy Initiatives, March 20, 2009.

Aon Consulting, North Carolina State Health Plan, Financial Projections – October 2008, Total For All Plans – 9% Trend, July 2009 & 2010 Rate Increases, $250 Million Grant, No Plus Option – July 2009, Benefit Option, Pharmacy Initiatives, PT/OT/ST Copay Change, April 1, 2009.

State Health Plan, various summarized claims reports for medical claims by category and purpose and time period, March 2009.

-Actuarial Note, Hartman & Associates, "Senate Bill 287 Amendment S287-ALN-26 [v.1]: Amendment to Copayment for Chiropractic Services in the State Health Plan, April 1, 2009, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "Senate Bill 287, Proposed Amendment, S287-ALN-26 [v.1]", April 1, 2009, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Bob Weiss

Bob Weiss for Marilyn Chism, Director, Fiscal Research Division

DATE: April 2, 2009

NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

SENATE BILL S287
PROPOSED AMENDMENT
S287-ALN-26 [V.1]

CHANGE CHIROPRACTIC SERVICES COPAY FROM SPECIALTY TO PRIMARY CARE

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30305

March 2009

ACTUARIAL STATEMENT

The North Carolina State Health Plan for Teachers and State Employees has requested that Aon Consulting prepare an Actuarial Note in response to Amendment S287-ALN-26 [v.1] to Senate Bill 287 which proposes that the State Health Plan shall change the Chiropractic Services copay from Specialty Physician to Primary Care Physician.

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

March 30, 2009

Kenneth C. Vieira, F.S.A., M.A.A.A.
Senior Vice President

Date

March 30, 2009

Kirsten R. Schatten, A.S.A., M.A.A.A.
Assistant Vice President

Date

CHANGE CHIROPRACTIC SERVICES COPAY FROM SPECIALTY PHYSICIAN TO PRIMARY CARE PHYSICIAN

PLAN CHANGES

The General Assembly of North Carolina:
Moves to amend the bill on page 5, line 36,
by inserting at the end of the line the following new sentence to read:
"This co-payment applies to chiropractic services."; and

further moves to amend the bill on page 5, line 38,
by inserting at the end of the line the following new sentence to read:
"This co-payment does not apply to chiropractic services."; and

further moves to amend the bill on page 6, line 13,
by inserting at the end of the line the following new sentence to read:
"This co-payment applies to chiropractic services."; and

further moves to amend the bill on page 6, line 15,
by inserting at the end of the line the following new sentence to read:
"This co-payment does not apply to chiropractic services."

PROJECTED COSTS

	Based on "Midpoint" Increase (in millions)		
Plan Design Change	2009-2010 Fiscal Year Cost	2010-2011 Fiscal Year Cost	Total Biennium Cost
Change Chiropractic Services copay to PCP	$5.7	$7.1	$12.8

* Based on total projected expenses of $2,687,502,073 and $2,919,507,795 for the 2010 and 2011 fiscal years respectively.

PRICING APPROACH AND COMMENTS

The following information was compiled and utilized in determining the projected costs or savings of each benefit component addressed in this actuarial note:

- Claims data was received from the Plan's Claims Processing Contractor (CPC) showing Chiropractic claims experience for the period July 1, 2008 through February 28, 2009 for all PPO plans separately. The claims experience was also separated for active employees, non-Medicare retirees and Medicare retirees.

- For this period annualized, active employees, non-Medicare retirees and Medicare retirees generated $9,203,127 of paid Chiropractic copayments with 253,982 visits.
- The detailed claims data was projected forward with 3% utilization trend per year and 6% cost trend per year.
- The projected claims data was used to quantify the impact of the copay changes.
- An adjustment for Chiropractic copays was applied for Medicare retirees assuming the plan would recover similar savings with the new copay based on Coordination of Benefits with Medicare.
- Based on an effective date of July 1, 2009, the FY 2010 projected Plan cost for changing Chirporactic copays from SPC to PCP is $5,654,394. The FY 2011 projected cost is $7,128,788.

HARTMAN & ASSOCIATES, LLC

ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

hartman@triad.rr.com

Phone: (336) 731-4038
Fax: (336) 731-2583

668 Link Road
Lexington, NC 27295

March 28, 2009

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Senate Bill 287 Amendment S287-ALN-26 [v.1]: Amendment to Copayment for Chiropractic Services in the State Health Plan

Dear Mr. Trogdon:

This amendment modifies the third edition of this bill. The bill appropriates funds and makes various changes to the North Carolina State Health Plan for Teachers and State Employees (the "Plan").

The bill includes a provision to increase the member copayments for hospitalization and doctor office visits covered under the Plan. The increases include the following:

	Member Copayments			
	PPO Standard		PPO Basic	
	Current	Revised	Current	Revised
Primary Care	$20	$25	$25	$30
Specialist	$40	$60	$50	$70

Currently, a Plan member pays the Specialist copayment for chiropractic services covered under the Plan. This amendment provides that the Primary Care copayment would apply to chiropractic services.

This amendment will produce a cost to the Plan by reducing the member copayment. The estimated impact is shown below.

Move Chiropractic Services to Primary Care Copayment		
	Estimated Savings for Fiscal Year Beginning	
Version	July 1, 2009	July 1, 2010
Primary Care Copay Increase in Bill	8.116,000	9,257,000
Specialist Copay Increase in Bill	27,125,000	31,713,000
Combined Primary Care/Specialist Copay in Bill	35,241,000	40,970,000
Combined Impact with Chiropractic at Primary	27,730,000	32,188,000
Net Impact of Amendment	(7,511,000)	(8,782,000)

The savings estimates shown above are based on analysis of medical claims information for the Plan. Data was primarily used from fiscal years 2008 and 2009 to date. These projections assume that the members currently covered under the PPO Plus option will elect the PPO Standard option. The data and assumptions used in this analysis are outlined in Attachment #1.

Projected savings include a 45-day lag for medical services. The projections also assume the plan membership remains constant at the December 2008 level of 666,809. All projected savings have been discounted with a 5% risk factor.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, FCA, EA
Consulting Actuary

MVH/mt

Attachment #1

Actuarial Assumptions and Data

Data Sources: State Health Plan for Teachers and State Employees
Charge Summary
Copay Report
Financial Reconciliation Report

The above reports were available for fiscal year 2008 and fiscal year 2009 through February. Reports are on both a paid and an incurred basis.

SHP Distribution of Participants by Age and Gender

Data Summary:

Office Visit Rates PPO Standard FY2008				
Status	Type	Visit Rate Per Member	Copay Increases	Effective Rate
Active Employee	Primary Care	2.87	5	100.0%
	Specialist	2.17	20	98.7%
	Chiropractic	0.36	(35)	98.7%
Medicare Eligible Retiree	Primary Care	3.78	5	70.0%
	Specialist	5.87	20	25.0%
	Chiropractic	0.24	(35)	35.0%
Non-Medicare Retirees	Primary Care	3.24	5	100.0%
	Specialist	3.89	20	98.3%
	Chiropractic	0.56	(35)	98.3%

Separate rates used for PPO Basic and Plus.

Membership:

Distribution by Option and Status				
Status	Standard	Basic	Plus	Total
Active Employee	380,833	31,204	75,109	487,146
Medicare Eligible Retiree	90,918	1,350	11,604	103,872
Non-Medicare Retirees	50.910	1,472	9,667	62,049
Total	522,661	34,026	96,380	653,067

This represents the average membership within each category for the second quarter of fiscal year 2009.

Actuarial Assumptions and Methods:

Medical Claim Trends

Office Visit & Inpatient Annual Utilization Trends	
Category	Percent
Primary Care	0.0%
Specialist	2.5%

Annual Price Increase: 5.0%

Risk Factors

Estimated savings were reduced by the risk factors shown below. This provides a margin for adverse deviation and reflects data limitations. In particular, both the projection period and the periods of available data contain significant movement of members between plan options, increasing the likelihood that future experience will not follow past patterns. The risk factors also reflect any conservatism inherent in other assumptions.

Risk Factors	
Category	Percent
Medical Copays	5.0%

ATTACHMENT #10

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 287

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

S287-ALN-23 [v.3]

Comm. Sub. [YES]
Amends Title [NO]
Third Edition

Date _____,2009

Representative Brubaker

moves to amend the bill on page 5, line 42
by inserting between lines 42 and 43, the following:

"g. The in-network co-payment for physical therapy, occupational therapy, and speech therapy shall be thirty dollars ($30.00) per therapy type per covered individual."; and

on page 5, line 43, by deleting "g." and substituting "h."; and

further moves to amend the bill on page 6, line 19
by inserting between lines 19 and 20, the following:

"h. The in-network co-payment for physical therapy, occupational therapy, and speech therapy shall be twenty-five dollars ($25.00) per therapy type per covered individual."; and

on page 6, line 20, by deleting "h." and substituting "i."; and

further moves to amend the bill on page 2, lines 5 and 6,
by deleting "one hundred twenty-eight million four hundred ten thousand two hundred eight dollars ($128,410,208)" and substituting "one hundred thirty million six hundred ninety-six thousand nine hundred two dollars ($130,696,902)"; and

further moves to amend the bill on page 2, lines 7 and 8,
by deleting "two hundred sixty-seven million nine hundred four thousand one hundred fourteen dollars ($267,904,114)" and substituting two hundred seventy-two million, eight hundred seventy-five thousand seven hundred sixty-nine dollars ($272,875,769)"; and

further moves to amend the bill on page 2, lines 13 and 14,
by deleting "five million one hundred ninety-two thousand four hundred seventy-six dollars ($5,992,476)" and substituting "six million ninety-nine thousand one hundred eighty-nine dollars ($6,099,189)"; and

further moves to amend the bill on page 2, lines 15 and 16,
by deleting "twelve million five hundred two thousand one hundred ninety-two dollars ($12,502,192)" and substituting twelve million seven hundred thirty-four thousand two hundred three dollars ($12,734,203)"; and

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 287

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

S287-ALN-23 [v.3]

further moves to amend the bill on page 6, lines 32-34,
by deleting "eight and six-tenths percent (8.6%)" wherever it appears on the those lines and substituting therefore in both places eight and eight-tenths percent (8.8%)".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: Amendment to Senate Bill 287 (Third Edition) S287-ALN-23 [v.3]

SHORT TITLE: State Hlth Plan $/Good Health Initiatives.

SPONSOR(S):

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY: Amends the third edition of Senate Bill 287 by requiring per visit co-payments for physical therapy, occupational therapy, and speech therapy benefits to be charged at a rate equivalent to that charged for primary care services.

The proposed co-pay rates in the amendment for these services are compared to those proposed in the Third Edition of Senate Bill 287 in the table below:

	PPO Basic		PPO Standard	
Medical Benefits	**Senate Bill 287**	**Proposed**	**Senate Bill 287**	**Proposed**
Plan Member Co-pays (per visit)	**Third Editon**	**Co-Pay**	**Third Editon**	**Co-Pay**
Physical, Occupational & Speech Therapy Services	$70	$30	$60	$25

EFFECTIVE DATE: Proposed changes in the amendment, if adopted, will follow the effective dates included in the third edition of SB 287.

ESTIMATED IMPACT ON STATE:

Aon Consulting, the consulting actuary for the State Health Plan for Teachers and State Employees, estimates that implementation of the benefit change proposed in the amendment will reduce the projected savings estimated for SB 287 (Third Edition) by $5.1 million in FY 2009-10 and $ 5.7 million in FY 2010-11 for a total amount of $10.8 million for the biennium.

Hartman & Associates, the consulting actuary for the General Assembly's Fiscal Research Division, estimates that implementation of the benefit change proposed in the amendment will reduce the projected savings estimated for SB 287 (Third Edition) by $5.0 million in FY 2009-10 and $ 5.9 million in FY 2010-11 for a total amount of $10.9 million for the biennium.

To fund the additional cost of the proposed benefit change, the amendment increases the rate of premium increase by 0.2% effective July 1, 2009, and then again by another 0.2% increase on July 1, 2010, to put in effect an annual 8.8% premium increase for each year of the biennium. This rate of annual increase compares to an 8.6% annual increase proposed in the current bill (SB 287, Third Edition).

The estimated funds generated in accord with the proposed rate of premium increase are as follows:

Total Additonal Premium Contributions From Appropriated and Employee Funds

Fund Source	FY 2009-10	FY 2010-11	Biennium
Appropriated			
General Fund	$2,286,694	$4,971,655	$7,258,349
Highway Fund	$106,713	$232,011	$338,724
Other Funds	$471,748	$1,025,658	$1,497,406
Sub-total	$2,865,155	$6,229,324	$9,094,479
Employee Contributions	$586,573	$1,275,307	$1,861,880
Total	$3,451,728	$7,504,631	$10,956,359

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1; 2008, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.6 billion for FY 2008-09. The Plan's PPO benefit design includes three alternative benefit levels offered to plan members. The three alternative benefit levels include the following:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums;

2) The "Standard" 80/20 plan; and

3) The "Plus" 90/10 plan with enhanced benefits via lower out-of pocket requirements as compared to the other PPO plan alternatives offered.

Employees and retired employees electing coverage under the Plus alternative must make a partially contributory premium contribution for their own coverage. The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under all plans is offered on a fully contributory basis.

Financial Condition

Financial Projection (Revised) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year are projected to be $2.3 billion from premium collections, $53.9 million from Medicare Part D subsidies, and $2.7 million from investment earnings, for a total of slightly over $2.3 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.4 billion in claim-payment expenses and $168.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating loss is projected to be approximately $264.4 million for the fiscal year, assuming a 9% annual claims growth trend.

Projected operating losses are expected to deplete the Plan's cash balance of $139.8 million and leave it without sufficient operating resources to continue operations for the fiscal year. It is currently estimated by the Plan's Executive Administrator that the Plan will not be able to pay claims on a timely basis by March 31, 2009.

Consequently, the reforecast of Plan finances now indicates that the Plan will require up to $300 million in additional resources to operate for the balance of the 2008-09 fiscal year. This amount represents the estimated funds necessary to pay claims and administrative expenses through June 30, 2009, plus funding a minimum stabilization reserve equal to 7.5% of projected claims, and assuming a future premium rate increase effective October 1, 2009.

Other Information

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment Data as of December 31, 2008

I. No. of Participants	Basic	Standard	Plus	Total	Percent of Total
Actives					
Employees	11,623	271,243	47,687	330,553	49.6%
Dependents	20,454	115,875	28,156	164,485	24.7%
Sub-total	32,077	387,118	75,843	495,038	74.2%
Retired					
Employees	1,726	127,081	17,967	146,774	22.0%
Dependents	1,117	14,935	3,476	19,528	2.9%
Sub-total	2,843	142,016	21,443	166,302	24.9%
Former Employees with Continuation Coverage					
Employees	60	1,349	344	1,753	0.3%
Dependents	61	501	182	744	0.1%
Sub-total	121	1,850	526	2,497	0.4%
Firefighters, Rescue Squad & National Guard					
Employees	-	3	2	5	0.0%
Dependents	-	3	-	3	0.0%
Sub-total	-	6	2	8	0.0%
Local Governments					
Employees	72	1,577	319	1,968	0.3%
Dependents	141	637	218	996	0.1%
Sub-total	213	2,214	537	2,964	0.4%
Total					
Employees	13,481	401,253	66,319	481,053	72.1%
Dependents	21,773	131,951	32,032	185,756	27.9%
Grand Total	**35,254**	**533,204**	**98,351**	**666,809**	**100%**
Percent of Total	**5.3%**	**80.0%**	**14.7%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	2,684	328,635	49,246	380,565
Employee Child(ren)	4,958	36,903	8,589	50,450
Employee Spouse	2,274	18,145	4,469	24,888
Employee Family	3,565	17,570	4,015	25,150
Total	**13,481**	**401,253**	**66,319**	**481,053**

Percent Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	19.9%	81.9%	74.3%	79.1%
Employee Child(ren)	36.8%	9.2%	13.0%	10.5%
Employee Spouse	16.9%	4.5%	6.7%	5.2%
Employee Family	26.4%	4.4%	6.1%	5.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Enrollment Data Continued

III. Enrollment by Sex	Basic	Standard	Plus	Total
Female	18,837	334,917	61,752	415,506
Male	16,417	198,287	36,599	251,303
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Sex	Basic	Standard	Plus	Total
Female	53.4%	62.8%	62.8%	62.3%
Male	46.6%	37.2%	37.2%	37.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	17,390	136,277	27,211	180,878
30 to 44	8,125	107,375	17,315	132,815
45 to 54	5,164	94,548	18,277	117,989
55 to 64	3,195	102,901	23,452	129,548
65 & Over	1,380	92,103	12,096	105,579
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	49.3%	25.6%	27.7%	27.1%
30 to 44	23.0%	20.1%	17.6%	19.9%
45 to 54	14.6%	17.7%	18.6%	17.7%
55 to 64	9.1%	19.3%	23.8%	19.4%
65 & Over	3.9%	17.3%	12.3%	15.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	49,534	12,080	61,614
Medicare Eligible	97,240	7,448	104,688
Total	**146,774**	**19,528**	**166,302**

Percent by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.7%	61.9%	37.0%
Medicare Eligible	66.3%	38.1%	63.0%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

Aon Consulting, North Carolina State Health Plan, Financial Projections – October 2008, Total For All Plans – 9% Trend, July 2009 & 2010 Rate Increases, $250 Million Grant, No Plus Option – July 2009, Benefit Option, Pharmacy Initiatives, March 20, 2009.

Aon Consulting, North Carolina State Health Plan, Financial Projections – October 2008, Total For All Plans – 9% Trend, July 2009 & 2010 Rate Increases, $250 Million Grant, No Plus Option – July 2009, Benefit Option, Pharmacy Initiatives, PT/OT.ST Copay Change, March 31, 2009.

State Health Plan, various summarized claims reports for medical claims by category and purpose and time period, March 2009.

-Actuarial Note, Hartman & Associates, "Senate Bill 287 Amendment S287-ALN-23 [v.2]: Amendment to Copayment for Physical, Occupational, and Speech Therapy in the State Health Plan, March 28, 2009, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "Senate Bill 287, Proposed Amendment, S287-ALN-23 [v.2]", March 30, 2009, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Bob Weiss

Bob Weiss
on behalf of Marilyn Chism, Director
Fiscal Research Division

DATE: April 2, 2009

NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

SENATE BILL S287
PROPOSED AMENDMENT
S287-ALN-23 [V.2]

CHANGE PT/OT/ST COPAY FROM SPECIALTY TO PRIMARY CARE

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30305

March 2009

ACTUARIAL STATEMENT

The North Carolina State Health Plan for Teachers and State Employees has requested that Aon Consulting prepare an Actuarial Note in response to Amendment S287-ALN-23 [v.2] to Senate Bill 287 which proposes that the State Health Plan shall change the PT/OT/ST copay from Specialty Physician to Primary Care Physician.

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

March 30, 2009

Kenneth C. Vieira, F.S.A., M.A.A.A.
Senior Vice President

Date

March 30, 2009

Kirsten R. Schatten, A.S.A., M.A.A.A.
Assistant Vice President

Date

CHANGE PT/OT/ST COPAY FROM SPECIALTY PHYSICIAN TO PRIMARY CARE PHYSICIAN

PLAN CHANGES

The General Assembly of North Carolina:
moves to amend the bill on page 5, line 42,
by inserting between lines 42 and 43, the following:
"g. The in-network co-payment for physical therapy, occupational therapy, and speech therapy shall be thirty dollars ($30.00) per therapy type per covered individual."; and
on page 5, line 43, by deleting "g." and substituting "h."; and

further moves to amend the bill on page 6, line19
by inserting between lines 19 and 20, the following:
"h. The in-network co-payment for physical therapy, occupational therapy, and speech therapy shall be twenty-five dollars ($25.00) per therapy type per covered individual."; and
on page 6, line 20, by deleting "h." and substituting "i.".

PROJECTED COSTS

	Based on "Midpoint" Increase (in millions)		
Plan Design Change	2009-2010 Fiscal Year Cost	2010-2011 Fiscal Year Cost	Total Biennium Cost
Change PT/OT/ST copay to PCP	$5.1	$5.7	$10.8

* Based on total projected expenses of $2,687,502,073 and $2,919,507,795 for the 2010 and 2011 fiscal years respectively.

PRICING APPROACH AND COMMENTS

The following information was compiled and utilized in determining the projected costs or savings of each benefit component addressed in this actuarial note:

- Claims data was received from the Plan's Claims Processing Contractor (CPC) showing PT/OT/ST claims experience for the period July 1, 2008 through February 28, 2009 for all PPO plans separately. The claims experience was also separated for active employees, non-Medicare retirees and Medicare retirees.

- For this period annualized, active employees, non-Medicare retirees and Medicare retirees generated $6,403,612 of paid PT/OT/ST copayments with 195,720 visits.

- The detailed claims data was projected forward with 3% utilization trend per year and 6% cost trend per year.

- The projected claims data was used to quantify the impact of the copay changes.

- An adjustment for PT/OT/ST copays was applied for Medicare retirees assuming the plan would recover similar savings with the new copay based on Coordination of Benefits with Medicare.

- Based on an effective date of July 1, 2009, the FY 2010 projected Plan cost for changing PT/OT/ST copays from SPC to PCP is $5,055,300. The FY 2011 projected cost is $5,745,365.

HARTMAN & ASSOCIATES, LLC

ACTUARIAL CONSULTING

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668 Link Road
Lexington, NC 27295

March 28, 2009

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Senate Bill 287 Amendment S287-ALN-23 [v.2]: Amendment to Copayment for Physical, Occupational, and Speech Therapy in the State Health Plan

Dear Mr. Trogdon:

This amendment modifies the third edition of this bill. The bill appropriates funds and makes various changes to the North Carolina State Health Plan for Teachers and State Employees (the "Plan").

The bill includes a provision to increase the member copayments for hospitalization and doctor office visits covered under the Plan. The increases include the following:

	Member Copayments			
	PPO Standard		PPO Basic	
	Current	Revised	Current	Revised
Primary Care	$20	$25	$25	$30
Specialist	$40	$60	$50	$70

Currently, a Plan member pays the Specialist copayment for physical therapy, occupational therapy, and speech therapy services covered under the Plan. This amendment provides that the primary Care copayment would apply to these services.

This amendment will produce a cost to the Plan by reducing the member copayment. The estimated impact is shown below.

Move Physical, Occupational & Speech Therapy to Primary Care Copayment		
	Estimated Savings for Fiscal Year Beginning	
Version	July 1, 2009	July 1, 2010
Primary Care Copay Increase in Bill	8.116,000	9,257,000
Specialist Copay Increase in Bill	27,125,000	31,713,000
Combined Primary Care/Specialist Copay in Bill	35,241,000	40,970,000
Combined Impact with PT/OT/ST at Primary	30,227,000	35,108,000
Net Impact of Amendment	(5,014,000)	(5,862,000)

The savings estimates shown above are based on analysis of medical claims information for the Plan. Data was primarily used from fiscal years 2008 and 2009 to date. These projections assume that the members currently covered under the PPO Plus option will elect the PPO Standard option. The data and assumptions used in this analysis are outlined in Attachment #1.

Projected savings include a 45-day lag for medical services. The projections also assume the plan membership remains constant at the December 2008 level of 666,809. All projected savings have been discounted with a 5% risk factor.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, FCA, EA
Consulting Actuary

MVH/mt

Actuarial Assumptions and Data

Data Sources: State Health Plan for Teachers and State Employees
Charge Summary
Copay Report
Financial Reconciliation Report

The above reports were available for fiscal year 2008 and fiscal year 2009 through February. Reports are on both a paid and an incurred basis.

SHP Distribution of Participants by Age and Gender

Data Summary:

Office Visit Rates PPO Standard FY2008				
Status	Type	Visit Rate Per Member	Copay Increases	Effective Rate
Active Employee	Primary Care	2.87	5	100.0%
	Specialist	2.17	20	98.7%
	PT/OT/ST	0.20	(35)	98.7%
Medicare Eligible Retiree	Primary Care	3.78	5	70.0%
	Specialist	5.87	20	25.0%
	PT/OT/ST	0.49	(35)	35.0%
Non-Medicare Retirees	Primary Care	3.24	5	100.0%
	Specialist	3.89	20	98.3%
	PT/OT/ST	0.43	(35)	98.3%

Separate rates used for PPO Basic and Plus.

Membership:

Distribution by Option and Status				
Status	Standard	Basic	Plus	Total
Active Employee	380,833	31,204	75,109	487,146
Medicare Eligible Retiree	90,918	1,350	11,604	103,872
Non-Medicare Retirees	50.910	1,472	9,667	62,049
Total	522,661	34,026	96,380	653,067

This represents the average membership within each category for the second quarter of fiscal year 2009.

Actuarial Assumptions and Methods:

Medical Claim Trends

Office Visit & Inpatient Annual Utilization Trends	
Category	Percent
Primary Care	0.0%
Specialist	2.5%

Annual Price Increase: 5.0%

Risk Factors

Estimated savings were reduced by the risk factors shown below. This provides a margin for adverse deviation and reflects data limitations. In particular, both the projection period and the periods of available data contain significant movement of members between plan options, increasing the likelihood that future experience will not follow past patterns. The risk factors also reflect any conservatism inherent in other assumptions.

Risk Factors	
Category	Percent
Medical Copays	5.0%

ATTACHMENT #11

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 287

AMENDMENT NO. _____
(to be filled in by Principal Clerk)

S287-ALN-38 [v.3]

Comm. Sub. [YES]
Amends Title [NO]
Third Edition

Date _____,2009

Representative Blust

moves to amend the bill on page 12. line 25,
by inserting between lines 25 and 26, the following:
"PART 7. TRANSFER STATE HEALTH PLAN ADMINISTRATION TO THE OFFICE OF STATE BUDGET AND MANAGEMENT.

SECTION 7.(a) The administration and management of the North Carolina State Health Plan for Teachers and State Employees is transferred to the Office of State Budget and Management by a Type 1 transfer as defined in G.S. 143A-6.

SECTION 7.(b). G.S. 135-43.1 and G.S. 135-43.2 are repealed.

SECTION 7.(c) G.S. 135-43.3 reads as rewritten:

'**§ 135-43.3. Oversight team.**

(a) ~~The Committee on Employee Hospital and Medical Benefits may use employees of the Legislative Services Office and may employ contractual services as approved by the Legislative Services Commission to monitor the Executive Administrator and Board of Trustees, the Claims Processor, and the Comprehensive Major Medical Plan [State Health Plan for Teachers and State Employees].~~ The Director of the Budget may use employees of the Office of State Budget and Management to monitor the Executive Administrator and Board of Trustees, the Claims Processor, and the State Health Plan for Teachers and State Employees. Employees authorized by ~~the Legislative Services Commission and~~ the Director of the Budget to provide assistance to the ~~Committee on Employee Hospital and Medical Benefits and to the~~ Director of the Budget shall comprise an oversight team.

(b) The oversight team shall, jointly or individually, have access to all records of the Board of Trustees, the Executive Administrator, the Claims Processor, and the Plan. The oversight team shall, jointly or individually, be entitled to attend all meetings of the Board of Trustees.

~~(c) The oversight team shall report to the Committee on Employee Hospital and Medical Benefits when requested by the Committee.~~'

SECTION 7.(d) G.S. 135-43(a) reads as rewritten:

'**§ 135-43. Confidentiality of information and medical records; provider contracts.**

(a) Any information as herein described in this section which is in the possession of the Executive Administrator and the Board of Trustees of the State Health Plan for Teachers and State Employees or its Claims Processor under the Plan or the Predecessor Plan shall be confidential and shall be exempt from the provisions of Chapter 132 of the General Statutes or any other provision requiring information and records held by State agencies to be made public

or accessible to the public. This section shall apply to all information concerning individuals, including the fact of coverage or noncoverage, whether or not a claim has been filed, medical information, whether or not a claim has been paid, and any other information or materials concerning a plan participant. Provided, however, such information may be released to the Office of State Budget and Management, the State Auditor, or to the Attorney General, or to the persons designated under G.S. 135-43.3 in furtherance of their statutory duties and responsibilities, or to such persons or organizations as may be designated and approved by the Executive Administrator and Board of Trustees of the Plan, but any information so released shall remain confidential as stated above and any party obtaining such information shall assume the same level of responsibility for maintaining such confidentiality as that of the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees.

SECTION 7.(e) G.S. 135-45(b), as amended by section 5(f) of this act, reads as rewritten:

'(b) Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees may contract with providers of institutional and professional medical care and services to establish preferred provider networks. The terms of a contract between the Plan and its third party administrator or between the Plan and its pharmacy benefit manager are a public record except that the terms in those contracts that contain trade secrets or proprietary or competitive information are not a public record under Chapter 132 of the General statutes and any such proprietary or competitive information and trade secrets contained in the contract shall be redacted by the Plan prior to making it available to the public. This subsection shall not be construed to prevent or restrict the release of any information made not a public record under this subsection to the Office of State Budget and Management, the State Auditor, the Attorney General, the Director of the State Budget, the Plan's Executive Administrator, ~~the Committee on Employee Hospital and Medical Benefits~~ solely and exclusively for their use in the furtherance of their duties and responsibilities, and to the Department of Health and Human Services solely for the purpose of implementing the transition of NC Health Choice from the Plan to the Department of Health and Human Services. The design, adoption, and implementation of the preferred provider contracts, networks, and optional alternative comprehensive health benefit plans, and programs available under the optional alternative plans, as authorized under G.S. 135-45 are not subject to the requirements of Chapter 143 of the General Statutes. The Executive Administrator and Board of Trustees shall make reports as requested to the President of the Senate, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Committee on Employee Hospital and Medical Benefits.'

SECTION 7.(f). G.S. 135-44.2 reads as rewritten:

'§ 135-44.2. Executive Administrator.

(a) The Plan shall have an Executive Administrator and a Deputy Executive Administrator. The Executive Administrator and the Deputy Executive Administrator positions are exempt from the provisions of Chapter 126 of the General Statutes as provided in G.S. 126-5(c1).

(b) The Executive Administrator shall be appointed by the ~~State Health Plan Administrative Commission.~~ Governor upon the recommendation of the Office of State Budget and Management. The term of employment and salary of the Executive Administrator shall be set by the ~~State Health Plan Administrative Commission upon the advice of an executive committee of the Committee on Employee Hospital and Medical Benefits.~~ Governor upon the recommendation of the Office of State Budget and Management. The Executive Administrator may be removed from office by the ~~State Health Plan Administrative Commission, upon the advice of an executive committee of the Committee on Employee Hospital and Medical Benefits,~~ Governor upon the advice of the Office of State Budget and Management, and any vacancy in the office of Executive Administrator may be filled by the ~~State Health Plan Administrative Commission with the term of employment and salary set upon the advice of an executive committee of the Committee on Employee Hospital and Medical Benefits.~~ Governor upon the advice of the Office of State Budget and Management.

(c) The Executive Administrator shall appoint the Deputy Executive Administrator and may employ such clerical and professional staff, and such other assistance as may be necessary to assist the Executive Administrator and the Board of Trustees in carrying out their duties and responsibilities under this Article. The Executive Administrator may designate managerial, professional, or policy-making positions as exempt from the State Personnel Act. The Executive Administrator may also negotiate, renegotiate and execute contracts with third parties in the performance of the Executive Administrator's duties and responsibilities under this ~~Article; provided any contract negotiations, renegotiations and execution with a Claims Processor, with an optional alternative comprehensive health benefit plan, or program thereunder, authorized under G.S. 135-45, with a preferred provider of institutional or professional hospital and medical care, or with a pharmacy benefit manager shall be done only after consultation with the Committee on Employee Hospital and Medical Benefits.~~Article.

(d) The Executive Administrator shall be responsible for:

(1) Cost management programs;
(2) Education and illness prevention programs;
(3) Training programs for Health Benefit Representatives;
(4) Membership functions;
(5) Long-range planning;
(6) Provider and participant relations; and
(7) Communications.

Managed care practices used by the Executive Administrator in cost management programs are subject to the requirements of G.S. 58-3-191, 58-3-221, 58-3-223, 58-3-235, 58-3-240, 58-3-245, 58-3-250, 58-3-265, 58-67-88, and 58-50-30.

(e) The Executive Administrator shall make reports and recommendations on the Plan to the Governor, the Office of State Budget and Management, the President of the Senate, the Speaker of the House of Representatives and the Committee on Employee Hospital and Medical Benefits.'

SECTION 7.(g). G.S. 135-44.4(8) and (9) read as rewritten:

'§ 135-44.4. Powers and duties of the Executive Administrator and Board of Trustees.

The Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan shall have the following powers and duties:

...

(8) Preparing and submitting to the ~~Governor~~ Governor, the Office of State Budget and Management, and the General Assembly cost estimates for the Plan, including those required by Article 15 of Chapter 120 of the General Statutes.

(9) Recommending to the ~~Governor~~ Governor, the Office of State Budget and Management, and the General Assembly changes or additions to the health benefits programs and health care cost containment programs offered under the Plan, together with statements of financial and actuarial effects as required by Article 15 of Chapter 120 of the General Statutes.

...'; and

SECTION 7.(h) G.S. 135-45.11 reads as rewritten:

'**§ 135-45.11. Cost-savings initiatives and incentive programs authorized.**

(a) Cost-Saving Initiatives. – Coverage of Over-the-Counter Medications. – The Executive Administrator and Board of Trustees may authorize coverage for over-the-counter medications as recommended by the Plan's pharmacy and therapeutics committee. In approving for coverage one or more over-the-counter medications, the Executive Administrator and Board of Trustees shall ensure that each recommended over-the-counter medication has been analyzed to ensure medical effectiveness and Plan member safety. The analysis shall also address the financial impact on the Plan. The Executive Administrator and Board of Trustees may impose a co-payment to be paid by each covered individual for each packaged over-the-counter medication. The Executive Administrator and Board of Trustees may adopt policies establishing limits on the amount of coverage available for over-the-counter medications for each covered individual over a 12-month period. Prior to implementing policy and co-payment changes authorized under this section, the Executive Administrator and Board of Trustees shall submit the proposed policies and co-payments to the ~~Committee on Employee Hospital and Medical Benefits for its review.~~Office of State Budget and Management for review.

(b) Incentive Programs. – For the purposes of helping Plan members to achieve and maintain a healthy lifestyle without impairing patient care, and to increase cost effectiveness in Plan coverage, the Executive Administrator and Board of Trustees may adopt programs offering incentives to Plan members to encourage changes in member behavior or lifestyle designed to improve member health and promote cost-efficiency in the Plan. Participation in one or more incentive programs is voluntary on the part of the Plan member. Before adopting an incentive program, the Executive Administrator and Board of Trustees shall conduct an impact analysis on the proposed incentive program to determine (i) whether the program is likely to result in significant member satisfaction, (ii) that it will not adversely affect quality of care, and (iii) whether it is likely to result in significant cost savings to the Plan. The impact analysis may be conducted by a committee of the Plan, in conjunction with the Plan's consulting actuary, provided that the Plan's medical director participates in the analysis. An approved incentive plan may provide for a waiver of deductibles, co-payments, and coinsurance required under this Article in order to determine the effectiveness of the incentive

program in promoting the health of members and increasing cost-effectiveness to the Plan. The Executive Administrator and Board of Trustees shall, before implementing incentive programs authorized under this section, submit the proposed programs to the ~~Committee on Employee Hospital and Medical Benefits for review.~~Office of State Budget and Management for review.'

SECTION 7.(h) This section becomes effective July 1, 2010."; and

Further moves to amend the bill on page 12, lines 26 and 27, by deleting "**SEVEN:**" on line 26 and substituting "**EIGHT:**" and on line 27 by deleting "**SECTION 7.**" and substituting "**SECTION 8.**".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☒Committee Substitute for

SB 287 A BILL TO BE ENTITLED AN ACT TO APPROPRIATE FUNDS FOR THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES AND TO MAKE OTHER CHANGES RELATED TO THE STATE HEALTH PLAN.

☒ With a favorable report as to the House committee substitute bill, unfavorable as to Senate Committee Substitute Bill and recommendation that the House 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/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.

VISITOR REGISTRATION SHEET

House Committee on Insurance — 4-2-09 PM

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cecil S Bonds	NCAE
Marge Foreman	NCAE
Katherine Joyce	NCASA
Pam Deardorff	NCRSP
Sheyna Altervilz	AARP
DAVID BARNES	Poyner Spruill
Ardis Watkins	SEANC
MIKE MANN	CNC
Erin Schaettpelz	UNC
Chris Hollis	K&L Gates
Joel Maynard	GPM & Assoc

VISITOR REGISTRATION SHEET

House Committee on Insurance — 4-2-09 PM

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Andy Ellen	NCRMA
Elizabeth Dalton	NCRMA
Carol Siebert	NCOTA
Emilyn Hendrickson	EHGR
[signature]	NPOTA & NCDS
[signature]	[signature]
Carrie Brodwell	NCSBA
Joseph Qubain	SEANC
Farah Qubain	Needham Broughton Highschool
Annette Newkirk	Governor's Office
[signature]	Media
Ben Nicolet	NAO
Mary Addaide Bell	NAO

VISITOR REGISTRATION SHEET

House Committee on Insurance — 4-2-09 PM

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ken Melton	Ken Melton & Assoc.

VISITOR REGISTRATION SHEET

House Committee on Insurance — 4-2-09 PM

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kevin LeCount	SEANC
Erica Baldwin	SEANC
Lynn Cote	SEANC
Will Gibbison	SEANC
Willie Dunn	SEANC
Dr. Marc Gottlieb	NC Chiro Assoc.
Anne Rogers	State Health Plan
Lacey Barnes	SHP
Linda McCrudden	State Health Plan
Tracy P Stephens	State Health Plan
Josie Grasse	state Health Plan

VISITOR REGISTRATION SHEET

House Committee on Insurance — 4-2-09 pm

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jim Stegall	U.C.P.S.
Dorianna Anderson	SEANC
Michelle Thrower	SEANC
Cheryl Perkins	D.O.C Seanc
Belinda C. Williams	SEANC
CELIAMARIE WILSON	SEANC
Tony Baze	SEANC
Brenda Hooker	SEANC
Joe Trostel	SEANC
Ernest Honeycutt	SEANC
Cheryl P. Gill	SEANC
Bill Kustin	Def

VISITOR REGISTRATION SHEET

House Committee on Insurance — 4-2-09 PM

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kathryn Mullican	BCBSNC
Mitch Lunard	SGANC
Van Lindley	Steel Smyth
April Graham	SEANC
[signature]	WCPSS
Alice Garland	NCEL

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 9, 2009

The House Committee on Insurance met at 11:00 AM on Thursday, April 9, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael Wray; Vice Chairs: M. Dickson and M. Setzer. Members attending were Reps. Blust, Braxton, Brubaker, Cole, Current, Faison, Holliman, Howard and Hughes.

Chairman Wray called the meeting to order and welcomed visitors. He recognized Sgt-At Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachments)

Chairman Wray recognized Rep. Phil Haire to explain HB 889 – Structured Settlement Annuities/Insurance Guaranty Association. The bill was co-sponsored by Reps. Love, Blue and Faison. Rep. Goforth made a motion for the Proposed Committee Substitute to be before the committee. Rep. Haire explained that the bill would expand the protection against defaulting insurers under the Life and Health Insurance Guaranty Association Act to include NC residents who settle claims for personal injury, or illness under an agreement funded at least in part by an annuity, regardless of whether the owner of the annuity contract is a State resident. It also offered some additional protections to non-residents. Rep. Haire said he know of no opposition to the bill. Rep. Holliman made a motion to move the $300,000 to $1 million. Motion carried. The bill passed with a favorable motion to the PCS as amended, unfavorable to the original and the bill would be sent to the Judiciary III committee.

Chairman Wray recognized Rep. Bordsen to explain HB 989 – DOC Liability Insurance. The bill was also co-sponsored by Rep. Love. The bill would enact a new provision in Chapter 148 (State Prison System) to explicitly authorize the Department of Correction to provide medical liability insurance coverage of up to $1,000,000 for employees and contractual service providers licensed to practice medicine or dentistry at correctional institutions or other Department facilities. Rep. Goforth made a motion for a favorable report to the PCS, unfavorable to the original and the bill would be sent to the Appropriations Committee. Motion carried.

The meeting adjourned at 11:30 AM.

Representative Michael Wray, Chairman

Ann Jordan – Committee Assistant

HOUSE INSURANCE COMMITTEE

April 9, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

HB 889 – STRUCT. SETTLEMENT ANNUNITIES/INS. GUAR. ASSN. – Reps. Haire, Love, Blue & Faison

HB 989 – DOC LIABILITY INSURANCE – Reps. Bordsen & Love

Adjourn

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 889*
PROPOSED COMMITTEE SUBSTITUTE H889-CSTG-8 [v.2]

4/8/2009 8:08:36 PM

Short Title: Struc. Settlement Annuities/Ins. Guar. Assn. (Public)

Sponsors:

Referred to:

March 31, 2009

A BILL TO BE ENTITLED

AN ACT TO EXPAND COVERAGE UNDER THE INSURANCE GUARANTY ASSOCIATION WITH RESPECT TO STRUCTURED SETTLEMENT ANNUITIES FOR MATTERS INVOLVING PERSONAL INJURY OR ILLNESS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-62-16 is amended by adding a new subdivision to read:

"(17a) 'Structured settlement annuities' means any contracts or certificates for annuities issued to fund, in whole or in part, a settlement agreement for a matter involving personal injury or illness, including any settlement agreement permitted under Chapter 97 of the General Statutes."

SECTION 2. G.S. 58-62-21(a) reads as rewritten:

"**§ 58-62-21. Coverage and limitations.**

(a) This Article provides coverage for the policies and contracts specified in subsection (b) of this section:

(1) To persons other than persons specified in subdivisions (3) and (4) of this subsection who, regardless of where they reside (except for nonresident certificate holders under group policies), are the beneficiaries, assignees, or payees of the persons covered under subdivision (2) of this ~~subsection, and~~subsection;

(2) To persons other than persons specified in subdivisions (3) and (4) of this subsection who are owners or certificate holders under the policies, or in the case of unallocated annuity contracts to the persons who are the contract holders, and who are residents of this State, or who are not residents of this State, but only under all of the following conditions: (i) the insurers that issued the policies are domiciled in this State; (ii) the insurers never held a license in the states in which the persons reside; (iii) the states have associations similar to the association created by this Article; and (iv) the persons are not eligible for coverage by the ~~associations.~~associations;

(3) To persons who are payees (or beneficiaries of payees if the payees are deceased) under structured settlement annuities if the payees are residents of this State, regardless of where the contract owners of the structured settlement annuities reside; and

(4) To persons who are payees (or beneficiaries of payees if the payees are deceased) under structured settlement annuities if the payees are not residents of this State, but only if all of the following conditions are met:

a. The contract owners of the structured settlement annuities are residents of this State or, if not residents of this state, (i) the insurers that issued the structured settlement annuities are domiciled in this State and (ii) the state in which the contract owners reside has an association similar to the Association created by this Article; and

b. Neither the payees (or beneficiaries of payees if the payees are deceased) nor the contract owners of the structured settlement annuities are eligible for coverage by an association of the state in which the payees or contract owners reside."

SECTION 3. This act is effective when it becomes law and applies to claims submitted to the Insurance Guaranty Association on or after that date.

HOUSE BILL 889:
Struc. Settlement Annuities/Ins. Guar. Assn

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Judiciary III	**Date:**	April 8, 2009
Introduced by:	Reps. Haire, Love, Blue, Faison	**Prepared by:**	Bill Patterson
Analysis of:	PCS to First Edition		Committee Counsel
	H889-CSTG-8		

SUMMARY: ***The Proposed Committee Substitute for House Bill 889 would expand the protection against defaulting insurers under the Life and Health Insurance Guaranty Association Act to include North Carolina residents who settle claims for personal injury or illness under an agreement funded at least in part by an annuity, regardless of whether the owner of the annuity contract is a State resident.***

The PCS would also extend protection to non-residents who settle their claims for personal injury or illness under agreements funded by annuities, if the following conditions are met:

> ***1) no coverage is offered by the insurance guaranty association of the state in which the payee or the contract owner reside, and***
>
> ***2) the contract owner is a resident of this State, or if not a resident of this State, the insurer issuing the annuity is domiciled in North Carolina and the contract owner's state of residence has an association similar to this State's association.***

[As introduced, this bill was identical to S780, as introduced by Sen. Berger of Franklin, which is currently in Senate Commerce.]

CURRENT LAW: The Life and Health Insurance Guaranty Association Act, codified as Article 62 of Chapter 58 of the General Statutes, provides protection to eligible persons against defaults by issuers of certain life and health insurance policies and annuity contracts, by creating an association of insurers responsible for fulfill the obligations of the defaulting insurer, subject to certain limitations.

Currently, the Act protects owners of annuity contracts issued to fund structured settlement agreements who reside in this State at the time when the issuing insurer is determined to be delinquent. If the contract owner is a non-resident, coverage is provided only if:

- the issuing insurer is domiciled in North Carolina and never held a license in the state where the contract owner resides, and
- the state where the contract owner resides has an association similar to North Carolina's Life and Health Insurance Guaranty Association but the contract owner is not eligible for coverage by that association.

G.S. 58-62-21(b)(2).

Currently, the Act limits its coverage to the lesser of the amount due under the annuity issued by the defaulting insurer or $300,000.00 with respect to any one individual.

BILL ANALYSIS: Under a structured settlement, the funding annuity is issued to someone other than the person whose claim is being settled. Under current law, if a North Carolina resident settles a personal injury or workers compensation claim by means of a structured settlement, and if the entity to whom the funding annuity is issued is not a resident of North Carolina, the Act does not provide coverage in the event that the annuity issuer becomes unable to meet its contractual obligations.

The PCS would provide coverage to payees under annuities issued to fund structured settlements regardless of whether the owner of the annuity contract is a resident of this State, where the payee is a resident of North Carolina at the time the issuer of the annuity is determined to be unable to meet its contractual obligations.

If the payee under a structured settlement annuity is not a resident of this State at the time the annuity issuer is determined to be unable to meet its contractual obligations, the PCS would provide coverage only if both of the following conditions are met:

- the contract owner is a resident of this State, or if not a resident of this State, the insurer issuing the annuity is domiciled in North Carolina and the contract owner's state of residence has an association similar to this State's association; and
- no coverage is offered by the insurance guaranty association of the state(s) in which the payee or the contract owner reside

By expanding the class of covered persons to include annuity payees who do not own the annuity contracts, the $300,000.00 limit under this section would apply to such individuals.

EFFECTIVE DATE: This act is effective when it becomes law and would apply to claims submitted to the Insurance Guaranty Association on or after that date.

H889-SMTG-14(CSTG-8) v1

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. PCS

H. B. No. 889 DATE 4/9/09

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

COMMITTEE SUBSTITUTE _____

Rep.) Holliman
Sen.)

moves to amend the bill on page 2, lines 12-13

( ) WHICH CHANGES THE TITLE

by inserting the following new bill sections between those lines to read:

"SECTION 3. G.S. 58-62-21(d)(2) reads as rewritten:

"(2) With respect to any one individual, regardless of the number of policies, ~~three hundred thousand dollars ($300,000)~~ one million dollars ($1,000,000) for all benefits, including cash value; or ;

SECTION 4. G.S. 58-62-21(e) reads ~~as~~ ~~amended~~ rewritten:

"(e) In no event is the Association liable to expend more than ~~three hundred thousand dollars ($300,000)~~ one million dollars ($1,000,000) in the aggregate with respect to any one individual under this section." ;

and by renumbering the remaining bill sections accordingly.

SIGNED [signature]

ADOPTED [signature] FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 989
PROPOSED COMMITTEE SUBSTITUTE H989-CSRD-24 [v.1]

4/9/2009 9:30:53 AM

Short Title: DOC Liability Insurance. (Public)

Sponsors:

Referred to:

April 2, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE DEPARTMENT OF CORRECTION TO PROVIDE MEDICAL LIABILITY INSURANCE FOR ITS EMPLOYEES AND CONTRACTUAL SERVICE PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 1 of Chapter 148 of the General Statutes is amended by adding a new section 148-10.4 to read:

"**§ 148-10.4. Medical liability insurance, Department of Correction employees and contractual service providers.**

Notwithstanding any contrary provision in the Current Operations Appropriations Act or any other provision of law, the Department of Correction may provide medical liability insurance coverage not to exceed one million dollars ($1,000,000) per incident on behalf of employees of the Department or contractual service providers licensed to practice medicine or dentistry for incidents that occur at correctional institutions or other Department facilities. This coverage may include commercial insurance or self-insurance and shall cover those persons for their acts or omissions only while they are engaged in providing medical and dental services pursuant to State employment or pursuant to contractual agreements with the State for the provision of those services.

SECTION 2. This act is effective when it becomes law.

HOUSE BILL 989:
DOC Liability Insurance

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Appropriations	**Date:**	April 9, 2009
Introduced by:	Reps. Bordsen, Love	**Prepared by:**	Ben Popkin Committee Counsel
Analysis of:	PCS to First Edition H989-CSRD-24		

SUMMARY: House Bill 989 would enact a new provision in Chapter 148 (State Prison System) to explicitly authorize the Department of Correction to provide medical liability insurance coverage of up to $1,000,000 for employees and contractual service providers licensed to practice medicine or dentistry at correctional institutions or other Department facilities.

CURRENT LAW: Section 10.2(c) of Session Law 2007-323 prohibits the Secretary of the Department of Correction from providing medical liability insurance coverage for contract employees of the Department of Correction, as follows (*see italicized section, below*):

LIABILITY INSURANCE

SECTION 10.2.(a) The Secretary of the Department of Health and Human Services, the Secretary of the Department of Environment and Natural Resources, and the Secretary of the Department of Correction may provide medical liability coverage not to exceed one million dollars ($1,000,000) per incident on behalf of employees of the Departments licensed to practice medicine or dentistry, on behalf of all licensed physicians who are faculty members of The University of North Carolina who work on contract for the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for incidents that occur in Division programs, and on behalf of physicians in all residency training programs from The University of North Carolina who are in training at institutions operated by the Department of Health and Human Services. This coverage may include commercial insurance or self-insurance and shall cover these individuals for their acts or omissions only while they are engaged in providing medical and dental services pursuant to their State employment or training.

SECTION 10.2.(b) The coverage provided under this section shall not cover any individual for any act or omission that the individual knows or reasonably should know constitutes a violation of the applicable criminal laws of any state or the United States or that arises out of any sexual, fraudulent, criminal, or malicious act or out of any act amounting to willful or wanton negligence.

SECTION 10.2.(c) *The coverage provided pursuant to this section* shall not require any additional appropriations and *shall not apply to any individual providing contractual service to* the Department of Health and Human Services, the Department of Environment and Natural Resources, or *the Department of Correction,* with the exception that coverage may include physicians in all residency training programs from The University of North Carolina who are in training at institutions operated by the Department of Health and Human Services and licensed physicians who are faculty members of The University of North Carolina who work for the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

BILL ANALYSIS: House Bill 989 would enact a new provision in Chapter 148 (State Prison System) to explicitly authorize the Department of Correction to provide medical liability insurance coverage of up to $1,000,000 for employees and contractual service providers licensed to practice medicine or dentistry at correctional institutions or other Department facilities.

EFFECTIVE DATE: This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 989
PROPOSED COMMITTEE SUBSTITUTE H989-CSRD-24 [v.1]

4/9/2009 9:30:53 AM

Short Title: DOC Liability Insurance. (Public)

Sponsors:

Referred to:

April 2, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE DEPARTMENT OF CORRECTION TO PROVIDE MEDICAL LIABILITY INSURANCE FOR ITS EMPLOYEES AND CONTRACTUAL SERVICE PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 1 of Chapter 148 of the General Statutes is amended by adding a new section 148-10.4 to read:

"**§ 148-10.4. Medical liability insurance, Department of Correction employees and contractual service providers.**

Notwithstanding any contrary provision in the Current Operations Appropriations Act or any other provision of law, the Department of Correction may provide medical liability insurance coverage not to exceed one million dollars ($1,000,000) per incident on behalf of employees of the Department or contractual service providers licensed to practice medicine or dentistry for incidents that occur at correctional institutions or other Department facilities. This coverage may include commercial insurance or self-insurance and shall cover those persons for their acts or omissions only while they are engaged in providing medical and dental services pursuant to State employment or pursuant to contractual agreements with the State for the provision of those services.

SECTION 2. This act is effective when it becomes law.

HOUSE BILL 989:
DOC Liability Insurance

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Appropriations	**Date:**	April 9, 2009
Introduced by:	Reps. Bordsen, Love	**Prepared by:**	Ben Popkin Committee Counsel
Analysis of:	PCS to First Edition H989-CSRD-24		

SUMMARY: House Bill 989 would enact a new provision in Chapter 148 (State Prison System) to explicitly authorize the Department of Correction to provide medical liability insurance coverage of up to $1,000,000 for employees and contractual service providers licensed to practice medicine or dentistry at correctional institutions or other Department facilities.

CURRENT LAW: Section 10.2(c) of Session Law 2007-323 prohibits the Secretary of the Department of Correction from providing medical liability insurance coverage for contract employees of the Department of Correction, as follows (*see italicized section, below*):

LIABILITY INSURANCE

SECTION 10.2.(a) The Secretary of the Department of Health and Human Services, the Secretary of the Department of Environment and Natural Resources, and the Secretary of the Department of Correction may provide medical liability coverage not to exceed one million dollars ($1,000,000) per incident on behalf of employees of the Departments licensed to practice medicine or dentistry, on behalf of all licensed physicians who are faculty members of The University of North Carolina who work on contract for the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for incidents that occur in Division programs, and on behalf of physicians in all residency training programs from The University of North Carolina who are in training at institutions operated by the Department of Health and Human Services. This coverage may include commercial insurance or self-insurance and shall cover these individuals for their acts or omissions only while they are engaged in providing medical and dental services pursuant to their State employment or training.

SECTION 10.2.(b) The coverage provided under this section shall not cover any individual for any act or omission that the individual knows or reasonably should know constitutes a violation of the applicable criminal laws of any state or the United States or that arises out of any sexual, fraudulent, criminal, or malicious act or out of any act amounting to willful or wanton negligence.

SECTION 10.2.(c) *The coverage provided pursuant to this section* shall not require any additional appropriations and *shall not apply to any individual providing contractual service to* the Department of Health and Human Services, the Department of Environment and Natural Resources, or *the Department of Correction,* with the exception that coverage may include physicians in all residency training programs from The University of North Carolina who are in training at institutions operated by the Department of Health and Human Services and licensed physicians who are faculty members of The University of North Carolina who work for the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

BILL ANALYSIS: House Bill 989 would enact a new provision in Chapter 148 (State Prison System) to explicitly authorize the Department of Correction to provide medical liability insurance coverage of up to $1,000,000 for employees and contractual service providers licensed to practice medicine or dentistry at correctional institutions or other Department facilities.

EFFECTIVE DATE: This act is effective when it becomes law.

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

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

DAY & DATE: **Thursday, April 9, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

HB 889 – STRUCT. SETTLEMENT ANNUNITIES/INS. GUAR. ASSN. – Reps. Haire, Love, Blue and Faison

HB 989 -DOC LIABILITY INSURANCE – Reps. Bordsen and Love

HB 1023 – PEO AMENDMENTS – Rep. Goforth

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at **11:30 am** on **April 7, 2009**.

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for
HB 989 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE DEPARTMENT OF CORRECTION TO PROVIDE MEDICAL LIABILITY INSURANCE FOR ITS EMPLOYEES AND CONTRACTUAL SERVICE PROVIDERS.

☒ 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/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.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for
HB 889 A BILL TO BE ENTITLED AN ACT TO EXPAND COVERAGE UNDER THE INSURANCE GUARANTY ASSOCIATION WITH RESPECT TO STRUCTURED SETTLEMENT ANNUITIES FOR MATTERS INVOLVING PERSONAL INJURY OR ILLNESS.

☒ 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 JUDICIARY III.

(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.

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

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

DAY & DATE: **Thursday, April 9, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

HB 889 – STRUCT. SETTLEMENT ANNUNITIES/INS. GUAR. ASSN. – Reps. Haire, Love, Blue and Faison

HB 989 -DOC LIABILITY INSURANCE – Reps. Bordsen and Love

HB 1023 – PEO AMENDMENTS – Rep. Goforth

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at **11:30 am** on **April 7, 2009**.

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

VISITOR REGISTRATION SHEET

House Committee on Insurance — 4-9-09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mike Okun	NC State AFL-CIO
Heather Barrett	Hunton & Williams
Kelly Graham	NCAJ
Paul Y. Smith	NCDOC
Mildred Spearman	NCDOC
Vicky Young	NCDOI
[illegible]	[illegible]
John Goodman	NC CHAMBER
[illegible]	JD, AL, PA
Elizabeth Jacox	NCLM
David Bray	NWC

VISITOR REGISTRATION SHEET

House Committee on Insurance — 4-9-09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
BILL SCOGGIN	KLG

VISITOR REGISTRATION SHEET

Insurance Committee — April 9, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
James Andrews	NC State AFL-CIO
Henry Patterson	Patterson Harkey LLP
Marc Allen	NCAHP
Heidi Chapman	Heidi Chapman PLLC
Michelle Frazier	MFS
Lowell Miller	NC Life + Health Ins Guaranty Assoc
Jim LORE	R. James Lore Atty Law, CARY, NC,
Dick Taylor	NCAJ
JOE LANIER	520 WICKER
Andy Ellen	NCPMA
	SA.

VISITOR REGISTRATION SHEET

Insurance Committee
Name of Committee

April 2, 2009
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	CNR

Comm 1228
LT 09

House Pages

Name Of Committee: INSURANCE Date: 4/9/09

1. Name: Allie Ethridge
   County: New Hanover
   Sponsor: Speaker Joe Hackney
2. Name: Auron Hunt
   County: Rutherford
   Sponsor: Dr. Bob England
3. Name: Kaitlyn Spencer
   County: Gaston
   Sponsor: Wil Neumann
4. Name: Kamryn Loftis
   County: Gaston
   Sponsor: Wil Neumann
5. Name: _____
   County: _____
   Sponsor: _____

Sgt-At-Arms

1. Name: Martha Madison
2. Name: Bob Russi
3. Name: Red Steiger
4. Name: FRANK TREVO

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

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

DAY & DATE: **Thursday, April 9, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

HB 889 – STRUCT. SETTLEMENT ANNUNITIES/INS. GUAR. ASSN. – Reps. Haire, Love, Blue and Faison

HB 989 -DOC LIABILITY INSURANCE – Reps. Bordsen and Love

HB 1023 – PEO AMENDMENTS – Rep. Goforth

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at **11:30 am** on **April 7, 2009**.

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 16, 2009

The House Committee on Insurance met at 11:00 AM on Thursday, April 16, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael H. Wray; Vice Chairs: M. Dickson and M. Setzer. Members attending were Reps. Barnhart, Braxton, Brubaker, Cole, Current, Faison, Howard, Hughes, Lewis, Pierce and Wainwright.

Chairman Goforth called the meeting to order and welcomed visitors. He recognized Sgt-At Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachment #1)

Chairman Goforth recognized Rep. Wray to explain HB 1159 – Insurance Licensing Changes. Rep. Lewis was recognized for a motion to have a PCS before the committee. Rep. Wray asked Rose Williams, Counsel with the Department of Insurance, to explain the bill. Ms. Williams explained that it was mostly technical corrections that clarifies when business entity licenses expires, provides for electronic filings with the DOI via the National Insurance Producer Registry and authorizes a fee for the electronic filing, and specifies that there must be a separate appointment by an insurer for each kind of insurance for which an agent is licensed in this state. Rep. Howard moved for a favorable report to the PCS, unfavorable to the original and re-referred to the Committee on Finance. Motion carried.

Chairman Goforth recognized Rep. Wray to explain HB 1161 – Revise Insurance Financial Conditions. Rep. Cole was recognized for a motion to have a PCS before the committee. Rep. Wray asked Rose Williams to explain the bill. House Bill 1161 would make changes to laws applicable to reinsurance intermediaries, to insurance company rehabilitation and liquidation, to workers compensation self-insurers, and to foreign insurers doing business in North Carolina. The PCS makes only technical conforming change to the original bill. Rep. Cole made a motion for a favorable report to the PCS, unfavorable to the original and re-referred to the Committee on Judiciary II. Motion carried.

Chairman Goforth turned the meeting over to Chairman Wray. Chairman Wray recognized Rep. Goforth to explain HB 1314. Rep. Goforth asked Rose William to explain the bill. The bill is based on a model act from the National Association of Insurance Commissioners. If NC does not adopt this new model law, it will lose its accreditation with NAIC. This accreditation allows NC companies to do business in other states. It adds a mandate of certain "best practices" and also requires insurers with $500 million or more in premiums to prepare "management assessments" of the internal controls they have in place. A motion was made by Rep. Braxton for a favorable report and bill to be re-referred to Judiciary II. Motion carried.

The meeting adjourned at 11:30 AM.

Representative Bruce Goforth, Chairman

Representative Michael H. Wray

Mary Capps – Committee Assistant

HOUSE INSURANCE COMMITTEE

April 16, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

HB 1314 – ANNUAL FINANCIAL REPORTING – Rep. Goforth

HB 1159 – INSURANCE LICENSING CHANGES – Rep. Wray

HB 1161 – REVISE INSURANCE FINANACIAL CONDITIONS – Rep. Wray

Adjourn

HOUSE BILL 1314
Senate Commerce Committee Substitute Adopted 6/15/09

Short Title: Annual Financial Reporting.-AB (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO IMPROVE THE INSURANCE COMMISSIONER'S ABILITY TO MONITOR THE FINANCIAL CONDITION OF INSURERS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 10 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 7. Annual Financial Reporting.

"**§ 58-10-185. Purpose and scope.**

(a) The purpose of this Part is to improve the Commissioner's ability to monitor the financial condition of insurers by requiring (i) an annual audit of financial statements reporting the financial position and the results of operations of insurers by independent certified public accountants, (ii) communication of internal control related matters noted in an audit, and (iii) management's report of internal control over financial reporting.

(b) Every insurer, as defined in G.S. 58-10-190, shall be subject to this Part. Insurers having direct premiums written in this State of less than one million dollars ($1,000,000) in any calendar year and fewer than 1,000 policyholders or certificate holders of direct written policies nationwide at the end of the calendar year shall be exempt from this Part for the year, unless the Commissioner makes a specific finding that compliance is necessary for the Commissioner to carry out statutory responsibilities, except that insurers having assumed premiums pursuant to contracts of reinsurance of one million dollars ($1,000,000) or more will not be exempt.

(c) Foreign or alien insurers filing the audited financial report in another state, pursuant to that state's requirement for filing of audited financial reports, which has been found by the Commissioner to be substantially similar to the requirements in this Part, are exempt from G.S. 58-10-195 through G.S. 58-10-240 if:

(1) A copy of the audited financial report, communication of internal control related matters noted in an audit, and the accountant's letter of qualifications that are filed with the other state are filed with the Commissioner in accordance with the filing dates specified in G.S. 58-10-195, 58-10-230, and 58-10-235, respectively. Canadian insurers may submit accountants' reports as filed with the Office of the Superintendent of Financial Institutions, Canada.

(2) A copy of any notification of adverse financial condition report filed with the other state is filed with the Commissioner within the time specified in G.S. 58-10-225.

(d) Foreign or alien insurers required to file management's report of internal control over financial reporting in another state are exempt from filing the report in this State provided

the other state has substantially similar reporting requirements and the report is filed with the Commissioner of the other state within the time specified.

(e) This Part shall not prohibit, preclude, or in any way limit the Commissioner from ordering, conducting, or performing examinations of insurers in accordance with G.S. 58-2-131 through G.S. 58-2-134, known as the Examination Law.

"**§ 58-10-190. Definitions.**

As used in this Part:

(1) "Accountant" or "independent certified public accountant" means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants (AICPA) and in all states in which he or she is licensed to practice; for Canadian and British companies, it means a Canadian-chartered or British-chartered accountant.

(2) An "affiliate" of, or person "affiliated" with, a specific person has the same meaning set forth in G.S. 58-19-5.

(3) "Audit committee" means a committee, or equivalent body, established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers and audits of financial statements of the insurer or group of insurers. The audit committee of any entity that controls a group of insurers may be deemed to be the audit committee for one or more of these controlled insurers at the election of the controlling person as provided in G.S. 58-10-245(f). If an audit committee is not designated by the insurer, the insurer's entire board of directors shall constitute the audit committee.

(4) "Audited financial report" means and includes those items specified in G.S. 58-10-200.

(5) "Controlling person" has the same meaning set forth in G.S. 58-19-5.

(6) "Group of insurers" means those licensed insurers included in the reporting requirements of Article 19 of this Chapter, or a set of insurers as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting.

(7) "Indemnification" means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting from other known misrepresentations made by the insurer or its representatives.

(8) "Insurer" means any insurance entity as identified in Articles 7, 8, 11, 15, 17, 23, 24, 25, 26, 65, and 67 of this Chapter and regulated by the Commissioner.

(9) "Internal control over financial reporting" means a process effected by an entity's board of directors, management, and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements, that is, those items specified in G.S. 58-10-200(b)(2) through G.S. 58-10-200(b)(6) and includes those policies and procedures that meet all of the following criteria:

a. Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets.

b. Provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements, that is, those items specified in G.S. 58-10-200(b)(2) through G.S. 58-10-200(b)(6) and that receipts and expenditures are being

made only in accordance with authorizations of management and directors.

c. Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of assets that could have a material effect on the financial statements, including those items specified in G.S. 58-10-200(b)(2) through G.S. 58-10-200(b)(6).

(10) "SEC" means the United States Securities and Exchange Commission, or any successor agency.

(11) "Section 404" means Section 404 of the Sarbanes-Oxley Act of 2002 and the SEC's rules and regulations promulgated under that act.

(12) "Section 404 report" means management's report on "internal control over financial reporting" as defined by the SEC and the related attestation report of the independent certified public accountant as described in Section 3A of the Sarbanes-Oxley Act of 2002.

(13) "SOX-compliant entity" means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002: (i) Section 202. Preapproval requirements of Title II, Auditor Independence; (ii) Section 301. Audit Committees independence requirements of Title III, Corporate Responsibility; and (iii) Section 404. Management assessment of internal controls requirements of Title IV, Enhanced Financial Disclosures.

"**§ 58-10-195. General requirements related to filing and extensions for filing of annual audited financial reports and audit committee appointment.**

(a) All insurers shall have an annual audit by an independent certified public accountant and shall file an audited financial report with the Commissioner on or before June 1 for the year ended December 31 immediately preceding. The Commissioner may require an insurer to file an audited financial report earlier than June 1 with 90 days' advance notice to the insurer.

(b) Extensions of the June 1 filing date may be granted by the Commissioner for 30-day periods upon a showing by the insurer and its independent certified public accountant of the reasons for requesting an extension and determination by the Commissioner of good cause for an extension. The request for extension must be received in writing not less than 10 days before the due date and in sufficient detail to permit the Commissioner to make an informed decision with respect to the requested extension.

(c) If an extension is granted in accordance with the provisions in subsection (b) of this section, a similar extension of 30 days is granted to the filing of management's report of internal control over financial reporting.

(d) Every insurer required to file an annual audited financial report pursuant to this Part shall designate a group of individuals as constituting its audit committee, as defined in G.S. 58-10-190. The audit committee of an entity that controls an insurer may be deemed to be the insurer's audit committee at the election of the controlling person.

"**§ 58-10-200. Contents of annual audited financial report.**

(a) The annual audited financial report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows, and changes in capital and surplus for the year then ended in conformity with G.S. 58-2-165(c). The financial statements included in the audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the Commissioner, and the financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. However, in the first year in which an insurer is required to file an audited financial report, the comparative data may be omitted.

(b) The annual audited financial report shall include the following:

(1) Report of independent certified public accountant.

(2) Balance sheet reporting admitted assets, liabilities, capital, and surplus.

(3) Statement of operations.

(4) Statement of cash flows.

(5) Statement of changes in capital and surplus.

(6) Notes to financial statements, which shall be those required by the appropriate NAIC Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual. The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to G.S. 58-2-165(c) with a written description of the nature of these differences.

"**§ 58-10-205. Designation of independent certified public accountant.**

(a) Each insurer required by this Part to file an annual audited financial report must, within 60 days after becoming subject to the requirement, register with the Commissioner in writing the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit. Insurers not retaining an independent certified public accountant on the effective date of this Part shall register the name and address of their retained independent certified public accountant not less than six months before the date when the first audited financial report is to be filed.

(b) The insurer shall obtain a letter from the accountant and file a copy with the Commissioner stating that the accountant is aware of the provisions of the insurance laws and the regulations of the State of North Carolina that relate to accounting and financial matters and affirming that the accountant will express his or her opinion on the financial statement in terms of its conformity to the statutory accounting practices prescribed or otherwise permitted by the Commissioner, specifying such exceptions as he or she may believe appropriate.

(c) If an accountant for the immediately preceding filed audited financial report is dismissed or resigns, the insurer shall within five business days notify the Commissioner of this event. The insurer shall also furnish the Commissioner with a separate letter within 10 business days after the notification stating whether in the 24 months preceding such event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure; which disagreements, if not resolved to the satisfaction of the former accountant, would have caused him or her to make reference to the subject matter of the disagreement in connection with his or her opinion. The disagreements required to be reported in response to this section include both those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction. Disagreements contemplated by this section could include, but are not limited to, disagreements between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer shall also in writing request the former accountant to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for which he or she does not agree; and the insurer shall furnish the responsive letter from the former accountant to the Commissioner together with its own.

"**§ 58-10-210. Qualifications of independent certified public accountant.**

(a) The Commissioner shall not recognize a person or firm as a qualified independent certified public accountant if the person or firm:

(1) Is not in good standing with the North Carolina State Board of Certified Public Accountant Examiners and in all other states in which the accountant is licensed to practice, or, for a Canadian or British company, that is not a chartered accountant; or

(2) Has either directly or indirectly entered into an agreement of indemnity or release from liability, collectively referred to as indemnification, with respect to the audit of the insurer.

(b) Except as otherwise provided in this Part, the Commissioner shall recognize an independent certified public accountant as qualified as long as he or she conforms to the standards of his or her profession, as contained in the Code of Professional Ethics of the AICPA 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.

(c) A qualified independent certified public accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under Article 30 of this Chapter, the mediation or arbitration provisions shall operate at the option of the statutory successor.

(d) Lead Audit Partner Rotation Required.

(1) The lead or coordinating audit partner, having primary responsibility for the audit, may not act in that capacity for more than five consecutive years. The person shall be disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for a period of five consecutive years. An insurer may apply to the Commissioner for relief from the rotation requirement on the basis of unusual circumstances. This application shall be made at least 30 days before the end of the calendar year. The Commissioner may consider any of the following factors in determining if the relief should be granted:

a. The number of partners, expertise of the partners, or the number of insurance clients in the currently registered firm.

b. The premium volume of the insurer.

c. The number of jurisdictions in which the insurer transacts business.

(2) The insurer shall file, with its annual statement filing, the approval for relief granted pursuant to subdivision (1) of this subsection with the states in which it is licensed or doing business and with the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format.

(e) The Commissioner shall neither recognize as a qualified independent certified public accountant, nor accept an annual audited financial report prepared, in whole or in part, by a natural person who meets any of the following criteria:

(1) The person has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. §§ 1961 to 1968k, or any dishonest conduct or practices under federal or state law.

(2) The person has been found to have violated the insurance laws of this State with respect to any previous reports submitted under this Part.

(3) The person has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this Part.

(f) The Commissioner may, as provided in G.S. 58-2-50, hold a hearing to determine whether an independent certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing his or her opinion on the financial statements in the annual audited financial report made pursuant to this Part and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this Part.

(g) Independence of Services.

(1) The Commissioner shall not recognize as a qualified independent certified public accountant nor accept an annual audited financial report prepared, in whole or in part, by an accountant who provides to an insurer, contemporaneously with the audit, any of the following nonaudit services:

a. Bookkeeping or other services related to the accounting records or financial statements of the insurer.

b. Financial information systems design and implementation.

c. Appraisal or valuation services, fairness opinions, or contribution-in-kind reports.

d. Actuarially oriented advisory services involving the determination of amounts recorded in the financial statements. The accountant may assist an insurer in understanding the methods, assumptions, and inputs used in the determination of amounts recorded in the financial statement only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification on an insurer's reserves if all of the following conditions have been met:

1. Neither the accountant nor the accountant's actuary has performed any management functions or made any management decisions.

2. The insurer has competent personnel, or engages a third-party actuary to estimate the reserves for which management takes responsibility.

3. The accountant's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the reserves.

e. Internal audit outsourcing services.

f. Management functions or human resources.

g. Broker or dealer, investment adviser, or investment banking services.

h. Legal services or expert services unrelated to the audit.

i. Any other services that the Commissioner determines, by administrative rule, are impermissible.

(2) In general, the principles of independence with respect to services provided by the qualified independent certified public accountant are largely predicated on three basic principles, violations of which would impair the accountant's independence. The principles are that the accountant cannot function in the role of management, cannot audit his or her own work, and cannot serve in an advocacy role for the insurer.

(h) Insurers having direct written and assumed premiums of less than one hundred million dollars ($100,000,000) in any calendar year may request an exemption from subdivision (1) of subsection (g) of this section. The insurer shall file with the Commissioner a written statement discussing the reasons why the insurer should be exempt from these provisions. If the Commissioner finds, upon review of this statement, that compliance with this Part would constitute a financial or organizational hardship upon the insurer, an exemption may be granted.

(i) A qualified independent certified public accountant who performs the audit may engage in other nonaudit services, including tax services, that are not described in subdivision (1) of subsection (g) of this section or that do not conflict with the principles set forth in subdivision (2) of subsection (g) of this section, only if the activity is approved in advance by the audit committee, in accordance with subsection (j) of this section.

(j) All auditing services and nonaudit services provided to an insurer by the qualified independent certified public accountant of the insurer shall be preapproved by the audit committee. The preapproval requirement is waived with respect to nonaudit services if the insurer is a SOX-compliant entity or is a direct or indirect wholly owned subsidiary of a SOX-compliant entity or all of the following apply:

(1) The aggregate amount of all such nonaudit services provided to the insurer constitutes not more than five percent (5%) of the total amount of fees paid by the insurer to its qualified independent certified public accountant during the fiscal year in which the nonaudit services are provided.

(2) The services were not recognized by the insurer at the time of the engagement to be nonaudit services.

(3) The services are promptly brought to the attention of the audit committee and approved before the completion of the audit by the audit committee or by one or more members of the audit committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the audit committee.

(k) The audit committee may delegate to one or more designated members of the audit committee the authority to grant the preapprovals required by subsection (j) of this section. The decisions of any member to whom this authority is delegated shall be presented to the full audit committee at each of its scheduled meetings.

(l) Cooling-Off Period.

(1) The Commissioner shall not recognize an independent certified public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for that insurer was employed by the independent certified public accountant and participated in the audit of that insurer during the one-year period preceding the date that the most current statutory opinion is due. This section shall only apply to partners and senior managers involved in the audit. An insurer may apply to the Commissioner for relief from this requirement on the basis of unusual circumstances.

(2) The insurer shall file, with its annual statement filing, the approval for relief granted pursuant to subdivision (1) of this subsection with the states in which it is licensed or doing business and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format.

"**§ 58-10-215. Consolidated or combined audits.**

An insurer may make written application to the Commissioner for approval to file audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies that utilizes a pooling or one hundred percent (100%) reinsurance agreement that affects the solvency of the insurer and affects the integrity of the insurer's reserves and the insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining worksheet that meets all of the following criteria shall be filed with the report:

(1) Amounts shown on the consolidated or combined audited financial report shall be shown on the worksheet.

(2) Amounts for each insurer subject to this section shall be stated separately.

(3) Noninsurance operations may be shown on the worksheet on a combined or individual basis.

(4) Explanations of consolidating and eliminating entries shall be included.

(5) A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual statements of the insurers.

"**§ 58-10-220. Scope of audit and report of independent certified public accountant.**

Financial statements furnished pursuant to G.S. 58-10-200 shall be examined by the independent certified public accountant. The audit of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. In accordance with AU Section 319 of the Professional Standards of the AICPA, Consideration of Internal Control in a Financial Statement Audit, the independent certified public accountant should obtain an understanding of internal control sufficient to plan the audit. To the extent required by AU Section 319, for those insurers required to file a management's report of internal control over financial reporting pursuant to G.S. 58-10-255, the independent certified public accountant should consider, as that term is defined in "Statement on Auditing Standards No. 102 of the AICPA Professional Standards, Defining Professional Requirements in Statements on Auditing Standards" or its replacement, the most recently available report in planning and performing the audit of the statutory financial statements. Consideration shall be given to the procedures illustrated in the Financial Condition Examiners Handbook promulgated by the NAIC as the independent certified public accountant deems necessary.

"**§ 58-10-225. Notification of adverse financial condition.**

(a) The insurer required to furnish the annual audited financial report shall require the independent certified public accountant to report, in writing, within five business days to the board of directors or its audit committee any determination by the independent certified public accountant that the insurer has materially misstated its financial condition as reported to the Commissioner as of the balance sheet date currently under audit or that the insurer does not meet the minimum capital and surplus requirement of G.S. 58-7-75 as of that date. An insurer that has received a report pursuant to this subsection shall forward a copy of the report to the Commissioner within five business days after receipt of the report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the Commissioner. If the independent certified public accountant fails to receive the evidence within the required five-business-day period, the independent certified public accountant shall furnish to the Commissioner a copy of its report within the next five business days.

(b) No independent certified public accountant shall be liable in any manner to any person for any statement made in connection with subsection (a) of this section if the statement is made in good faith in compliance with that subsection.

(c) If the accountant, subsequent to the date of the audited financial report filed pursuant to this Part, becomes aware of facts that might have affected his or her report, the Commissioner notes the obligation of the accountant to take such action as prescribed in Volume 1, Section AU 561 of the Professional Standards of the AICPA.

"**§ 58-10-230. Communication of internal control related matters noted in an audit.**

(a) In addition to the annual audited financial report, each insurer shall furnish the Commissioner with a written communication as to any unremediated material weaknesses in its internal control over financial reporting noted during the audit. Such communication shall be prepared by the accountant within 60 days after the filing of the annual audited financial report and shall contain a description of any unremediated material weakness, as the term "material weakness" is defined by "Statement on Auditing Standards No. 112 of the AICPA Professional Standards, Communication of Internal Control Related Matters Noted in an Audit," or its replacement, as of December 31 immediately preceding, so as to coincide with the audited financial report described in G.S. 58-10-195(a) in the insurer's internal control over financial reporting noted by the accountant during the course of their audit of the financial statements. If no unremediated material weaknesses are noted, the communication should so state.

(b) The insurer shall provide a description of remedial actions taken or proposed to correct unremediated material weaknesses, if the actions are not described in the accountant's communication.

"**§ 58-10-235. Accountant's letter of qualifications.**

The accountant shall furnish the insurer, in connection with, and for inclusion in, the filing of the annual audited financial report, a letter stating all of the following:

(1) That the accountant is independent with respect to the insurer and conforms to the standards of his or her profession as contained in the Code of Professional Ethics and pronouncements of the AICPA and the Rules of Professional Conduct of the North Carolina State Board of Certified Public Accountant Examiners Board of Public Accountancy, or similar code.

(2) The background and experience in general and the experience in audits of insurers of the staff assigned to the engagement and whether each is an independent certified public accountant. Nothing within this Part shall be construed as prohibiting the accountant from utilizing such staff as he or she deems appropriate where their use is consistent with the standards prescribed by generally accepted auditing standards.

(3) That the accountant understands the annual audited financial report and his opinion thereon will be filed in compliance with this Part and that the Commissioner will be relying on this information in the monitoring and regulation of the financial position of insurers.

(4) That the accountant consents to the requirements of G.S. 58-10-240 and that the accountant consents and agrees to make available for review by the Commissioner, or the Commissioner's designee or appointed agent, the work papers, as described in G.S. 58-10-240.

(5) A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the AICPA.

(6) A representation that the accountant is in compliance with the requirements of G.S. 58-10-210.

"**§ 58-10-240. Definition, availability, and maintenance of independent certified public accountants' work papers.**

(a) Work papers are the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the accountant's audit of the financial statements of an insurer. Work papers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents, and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of his or her audit of the financial statements of an insurer and which support the accountant's opinion.

(b) Every insurer required to file an audited financial report pursuant to this Part shall require the accountant to make available for review by the Commissioner all work papers prepared in the conduct of the accountant's audit and any communications related to the audit between the accountant and the insurer at the offices of the insurer, at the offices of the Commissioner, or at any other reasonable place designated by the Commissioner. The insurer shall require that the accountant retain the audit work papers and communications until the Commissioner has filed a report on examination covering the period of the audit but no longer than seven years after the date of the audit report.

(c) In the conduct of the periodic review by the Commissioner's examiners in subsection (b) of this section, copies of pertinent audit work papers may be made and retained by the Commissioner. Such reviews by the Commissioner's examiners shall be considered

investigations, and all working papers and communications obtained during the course of such investigations shall be confidential.

"**§ 58-10-245. Requirements for audit committees.**

(a) This section shall not apply to foreign or alien insurers licensed in this State or an insurer that is a SOX-compliant entity or a direct or indirect wholly owned subsidiary of a SOX-compliant entity.

(b) The audit committee shall be directly responsible for the appointment, compensation, and oversight of the work of any accountant, including resolution of disagreements between management and the accountant regarding financial reporting, for the purpose of preparing or issuing the audited financial report or related work. Each accountant shall report directly to the audit committee.

(c) Each member of the audit committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to subsection (f) of this section and G.S. 58-10-190(3).

(d) In order to be considered independent for purposes of this section, a member of the audit committee shall not, other than in his or her capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory, or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary of the entity. However, if North Carolina law requires board participation by otherwise nonindependent members, that law shall prevail and such members may participate in the audit committee and be designated as independent for audit committee purposes, unless they are an officer or employee of the insurer or one of its affiliates.

(e) If a member of the audit committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the Commissioner, may remain an audit committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one year from the occurrence of the event that caused the member to be no longer independent.

(f) To exercise the election of the controlling person to designate the audit committee, the ultimate controlling person shall provide written notice of the affected insurers to the Commissioner. Notification shall be made timely before the issuance of the statutory audit report and include a description of the basis for the election. The election can be changed through notice to the Commissioner by the insurer, which shall include a description of the basis for the change. The election shall remain in effect for perpetuity, until rescinded.

(g) Reports From Accountant.

(1) The audit committee shall require the accountant that performs for an insurer any audit required by this Part to timely report to the audit committee in accordance with the requirements of "Statement on Auditing Standards No. 61 of the AICPA Professional Standards, Communication with Audit Committees," or its replacement, including all of the following:

a. All significant accounting policies and material permitted practices.

b. All material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant.

c. Other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

(2) If an insurer is a member of an insurance holding company system, the reports required by subdivision (1) of subsection (g) of this section may be provided to the audit committee on an aggregate basis for insurers in the

holding company system, provided that any substantial differences among insurers in the system are identified to the audit committee.

(h) The proportion of independent audit committee members shall meet or exceed the following criteria:

Prior Calendar Year Direct Written and Assumed Premiums		
$0 – $300,000,000	Over $300,000,000 – $500,000,000	Over $500,000,000
No minimum requirements.	Majority (50% or more) of members shall be independent.	Supermajority of members (75% or more) shall be independent.

The Commissioner shall require the entity's board to enact improvements to the independence of the audit committee membership if the insurer is in a risk-based capital action level event, meets one or more of the standards of an insurer deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer. The Commissioner may order any insurer with less than five hundred million dollars ($500,000,000) in prior year direct written and assumed premiums to structure its audit committee with at least a supermajority of independent audit committee members. Prior calendar year direct written and assumed premiums shall be the combined total of direct premiums and assumed premiums from nonaffiliates for the reporting entities.

(i) An insurer with direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than five hundred million dollars ($500,000,000) may apply to the Commissioner for a waiver from the requirements in this section based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from this section with the states in which it is licensed or doing business and with the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format.

"**§ 58-10-250. Conduct of insurer in connection with the preparation of required reports and documents.**

(a) No director or officer of an insurer shall, directly or indirectly, do any of the following:

(1) Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review, or communication required under this Part.

(2) Omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review, or communication required under this Part.

(b) No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead, or fraudulently influence any accountant engaged in the performance of an audit pursuant to this Part if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading.

(c) For purposes of subsection (b) of this section, actions that, "if successful, could result in rendering the insurer's financial statements materially misleading" include, but are not limited to, actions taken at anytime with respect to the professional engagement period to coerce, manipulate, mislead, or fraudulently influence an accountant to do any of the following:

(1) Issue or reissue a report on an insurer's financial statements that is not warranted in the circumstances, due to material violations of statutory

accounting principles prescribed by the Commissioner, generally accepted auditing standards, or other professional or regulatory standards.

(2) Not perform audit, review, or other procedures required by generally accepted auditing standards or other professional standards.

(3) Not withdraw an issued report.

(4) Not communicate matters to an insurer's audit committee.

"**§ 58-10-255. Management's report of internal control over financial reporting.**

(a) Every insurer required to file an audited financial report pursuant to this Part that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of five hundred million dollars ($500,000,000) or more shall prepare a report of the insurer's or group of insurers' internal control over financial reporting, as these terms are defined in G.S. 58-10-190. The report shall be filed with the Commissioner along with the communication of internal control related matters noted in an audit described under G.S. 58-10-230. Management's report of internal control over financial reporting shall be as of December 31 immediately preceding.

(b) Notwithstanding the premium threshold in subsection (a) of this section, the Commissioner may require an insurer to file management's report of internal control over financial reporting if the insurer is in any risk-based capital level event, or meets any one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in G.S. 58-30-60(b).

(c) An insurer or a group of insurers that is:

(1) Directly subject to Section 404;

(2) Part of a holding company system whose parent is directly subject to Section 404;

(3) Not directly subject to Section 404 but is a SOX-compliant entity; or

(4) A member of a holding company system whose parent is not directly subject to Section 404 but is a SOX-compliant entity

may file its or its parent's Section 404 report and an addendum in satisfaction of this subsection's requirement provided that those internal controls of the insurer or group of insurers having a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements for items included in G.S. 58-10-200(b)(2) through G.S. 58-10-200(b)(6) were included in the scope of the Section 404 report. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurers' audited statutory financial statements for items included in G.S. 58-10-200(b)(2) through G.S. 58-10-200(b)(6) that were excluded from the Section 404 report. If there are internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements and those internal controls were not included in the scope of the Section 404 report, the insurer or group of insurers may either file (i) a G.S. 58-10-255 report, or (ii) the Section 404 report and a G.S. 58-10-255 report for those internal controls that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements not covered by the Section 404 report.

(d) Management's report of internal control over financial reporting shall include all of the following:

(1) A statement that management is responsible for establishing and maintaining adequate internal control over financial reporting.

(2) A statement that management has established internal control over financial reporting and an assertion, to the best of management's knowledge and belief, after diligent inquiry, as to whether its internal control over financial reporting is effective to provide reasonable assurance regarding the

reliability of financial statements in accordance with statutory accounting principles.

(3) A statement that briefly describes the approach or processes by which management evaluated the effectiveness of its internal control over financial reporting.

(4) A statement that briefly describes the scope of work that is included and whether any internal controls were excluded.

(5) Disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of December 31 immediately preceding. Management is not permitted to conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there are one or more unremediated material weaknesses in its internal control over financial reporting.

(6) A statement regarding the inherent limitations of internal control systems.

(7) Signatures of the chief executive officer and the chief financial officer, or equivalent position/title.

(e) Management shall document and make available upon a financial condition examination the basis upon which its assertions, required in subsection (d) of this section, are made. Management may base its assertions, in part, upon its review, monitoring, and testing of internal controls undertaken in the normal course of its activities. Management shall have discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost-effective manner and, as such, may include assembly of or reference to existing documentation. Management's report on internal control over financial reporting, required by subsection (a) of this section, and any documentation provided in support thereof during the course of a financial condition examination, shall be kept confidential by the Commissioner.

"**§ 58-10-260. Exemptions and effective dates.**

(a) Upon written application of any insurer, the Commissioner may grant an exemption from compliance with any and all provisions of this Part if the Commissioner finds, upon review of the application, that compliance with this Part would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at anytime and from time to time for a specified period or periods. Within 10 days after a denial of an insurer's written request for an exemption, the insurer may request in writing a hearing on its application for an exemption. The hearing shall be held in accordance with Article 3A of Chapter 150B of the General Statutes.

(b) Domestic insurers retaining a certified public accountant on the effective date of this Part who qualify as independent shall comply with this Part for the year ending December 31, 2010, and each year thereafter unless the Commissioner permits otherwise.

(c) Foreign insurers shall comply with this Part for the year ending December 31, 2010, and each year thereafter unless the Commissioner permits otherwise.

(d) The requirements of G.S. 58-10-210(d) shall become effective for audits of the year beginning January 1, 2010, and each year thereafter.

(e) The requirements of G.S. 58-10-245 shall become effective on January 1, 2010. An insurer or group of insurers that is not required to have independent audit committee members or only a majority of independent audit committee members, as opposed to a supermajority, because the total written and assumed premium is below the threshold and subsequently becomes subject to one of the independence requirements due to changes in premium shall have one year following the year the threshold is exceeded, but not earlier than January 1, 2010, to comply with the independence requirements. Likewise, an insurer that becomes subject to one of the independence requirements as a result of a business combination shall

have one calendar year following the date of acquisition or combination to comply with the independence requirements.

(f) The requirements of G.S. 58-10-255 become effective beginning with the reporting period ending December 31, 2010, and each year thereafter. An insurer or group of insurers that is not required to file a report because the total written premium is below the threshold and subsequently becomes subject to the reporting requirements shall have two years following the year the threshold is exceeded, but not earlier than December 31, 2010, to file a report. An insurer acquired in a business combination shall have two calendar years after the date of acquisition or combination to comply with the reporting requirements.

"**§ 58-10-265. Canadian and British companies.**

(a) In the case of Canadian and British insurers, the annual audited financial report shall be defined as the annual statement of total business on the form filed by such companies with their supervision authority duly audited by an independent chartered accountant.

(b) For such insurers, the letter required in G.S. 58-10-205(b) shall state that the accountant is aware of the requirements relating to the annual audited financial report filed with the Commissioner pursuant to G.S. 58-10-195 and shall affirm that the opinion expressed is in conformity with those requirements."

SECTION 2. G.S. 58-23-26(a) and (c) read as rewritten:

"(a) Each pool shall have an annual audit by an independent certified public ~~accountant,~~accountant, pursuant to Part 7 of Article 10 of this Chapter, at the expense of the pool, and shall make a copy of the audit available to the governing body or chief executive officer of each member of the pool. A copy of the audit shall be filed with the Commissioner within 130 days after the end of the pool's fiscal year, unless that time is extended by the Commissioner. The annual audit shall report the financial position of the pool in conformity with statutory accounting practices prescribed or permitted by the Commissioner.

...

(c) Each pool is subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, 58-3-71, 58-3-75, 58-3-81, 58-3-105, 58-6-5, 58-7-21, 58-7-26, 58-7-30, 58-7-31, 58-7-50, 58-7-55, 58-7-140, 58-7-160, 58-7-162, 58-7-163, 58-7-165, 58-7-167, 58-7-168, 58-7-170, 58-7-172, 58-7-173, 58-7-175, 58-7-179, 58-7-180, 58-7-183, 58-7-185, 58-7-187, 58-7-188, 58-7-192, 58-7-193, 58-7-197, 58-7-200, Part 7 of Article 10, and Articles 13, 19, and 34 of this Chapter. Annual financial statements required by G.S. 58-2-165 shall be filed by each pool within 60 days after the end of the pool's fiscal year, subject to extension by the Commissioner."

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:

...

Part 7 of Article 10. Annual Financial Reporting."

SECTION 4. 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:

...

Part 7 of Article 10. Annual Financial Reporting."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1161
PROPOSED COMMITTEE SUBSTITUTE H1161-CSRD-30 [v.1]

4/15/2009 6:51:04 PM

Short Title: Revise Insurance Financial Conditions.-AB (Public)

Sponsors:

Referred to:

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES IN THE LAWS RELATED TO THE FINANCIAL CONDITIONS OF INSURANCE COMPANIES, INCLUDING REINSURANCE INTERMEDIARIES, RECEIVERSHIP, THIRD-PARTY ADMINISTRATORS AND AUDITS OF WORKERS' COMPENSATION SELF-INSURERS, AND FOREIGN INSURERS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 9 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-9-22. Compliance with orders.**

An intermediary shall comply with any order of a court of competent jurisdiction or a duly constituted arbitration panel requiring the production of nonprivileged documents by the intermediary, or the testimony of an employee or other individual otherwise under the control of the intermediary with respect to any reinsurance transaction for which it acted as an intermediary."

SECTION 2. G.S. 58-30-85(e) reads as rewritten:

"(e) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger, runoff, or other transformation of the insurer is appropriate, he shall prepare a plan to effect such changes. Upon application of the rehabilitator for approval of the plan, and after such notice and hearings as the Court may prescribe, the Court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this section shall be, in the opinion of the Court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the policies of the insurer, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary."

SECTION 3. G.S. 58-30-165(d) reads as rewritten:

"(d) The liquidator shall give notice of the order to show cause by publication ~~and~~ or by first class mail to each member liable thereunder mailed to his last known address as it appears on the insurer's records, at least 20 days before the return day of the order to show cause."

SECTION 4. G.S. 58-47-205 reads as rewritten:

"**§ 58-47-205. Other requirements.**

(a) A TPA or service company, or any owner, officer, employee, or agent of a TPA or service company, or any other person affiliated with or related to the TPA or service company shall ~~not~~ not:

(1) ~~serve~~ Serve as a trustee of a self-insurer.

(2) Make a contribution to the surplus of a self-insurer.

...."

SECTION 5. G.S. 97-165 reads as rewritten:

"**§ 97-165. Definitions.**

As used in this Article:

....

(2) "Certified audit" means an audit on which a certified public accountant or a foreign registered public accounting firm expresses his or her professional opinion that the accompanying statements fairly present the financial position of the self-insurer or the guarantor, in conformity with accounting principles generally accepted in the United ~~States.~~States or prepared in accordance with International Financial Reporting Standards.

(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~~financial statements prepared in accordance with United States Generally Accepted Accounting Principles or International Financial Reporting Standards. The Commission may require the self-insurer or the guarantor to replace the CPA with another whose relationship with the self-insurer or the guarantor is independent within the meaning of this definition.

...

~~(6)~~(5a) ~~"GAAP financial~~"Financial statement" means a financial statement as defined by accounting principles generally accepted in the United ~~States.~~States or a financial statement prepared in accordance with International Financial Reporting Standards.

(6) "Foreign registered public accounting firm" means a public accounting firm that is organized and operates under the laws of a non-United States jurisdiction, government, or political subdivision and is registered and in good standing with the Public Company Accounting Oversight Board and authorized by the Board to prepare or issue any audit report with respect to any issuer.

...."

SECTION 6. G.S. 97-170(d) reads as rewritten:

"(d) The license application shall be comprised of the following information:

...

(2) Certified audited ~~GAAP~~ financial statements prepared by a CPA or submitted by a foreign registered public accounting firm for the two most

recent years. The financial statement presentation shall facilitate application of ratio and trend analysis.

...."

SECTION 7. G.S. 97-180(a) reads as rewritten:

"(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,~~CPA or submitted by a foreign registered public accounting firm, for that fiscal year. The financial statement 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."

SECTION 8. G.S. 58-16-5 reads as rewritten:

"**§ 58-16-5. Conditions of licensure.**

A foreign or alien insurance company may be licensed to do business when it:

....

(2) Satisfies the Commissioner that it is fully and legally organized under the laws of its state or government to do the business it proposes to transact as direct insurance or assumed ~~reinsurance, and that it has been successful in the conduct of the business;~~reinsurance; that it has, if a stock company, a free surplus and a fully paid-up and unimpaired capital, exclusive of stockholders' obligations of any description of an amount not less than that required for the organization of a domestic company writing the same kinds of business; and if a mutual company that its free surplus is not less than that required for the organization of a domestic company writing the same kind of business, and that the capital, surplus, and other funds are invested substantially in accordance with the requirements of this Chapter.

...."

SECTION 9. This act becomes effective October 1, 2009.

HOUSE BILL 1314:
Annual Financial Reporting.-AB

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Judiciary II	**Date:**	April 15, 2009
Introduced by:	Reps. Goforth, Wray	**Prepared by:**	Tim Hovis
Analysis of:	First Edition		Committee Counsel

SUMMARY: ***House Bill 1314 would add a new Part 7 entitled "Annual Financial Reporting" to Article 10 of Chapter 58 of the General Statutes. The new Part requires the following: (i) an annual audit of insurers' financial statements by independent certified public accountants; (ii) communication of internal control related matters noted in the audit; and (iii) management's report of internal control over financial reporting.***

BILL ANALYSIS: **Section 1** adds a new Part 7 to Chapter 58, *Insurance*, of the General Statutes entitled "Annual Financial Reporting." This Part includes the following new sections:

- **G.S. 58-10-185 Purpose and Scope**

  Provides that insurers having direct premiums written in the State of less than one million dollars in a calendar year and fewer than 1,000 policyholders or certificate holders nationwide at the end of the calendar year are exempt from the Article unless the Commissioner finds that compliance is necessary.

  Foreign or alien insurers filing the financial report in another state are exempt from the audited financial reporting requirements if a copy of the audited financial report, communication of internal control related matters and the accountant's letter of qualifications filed in another state are filed with the Commissioner.

  Foreign or alien insurers required to file a substantially similar management's report of internal control in another state are exempt from filing the report in this State.

- **G.S. 58-10-190 Definitions**

- **G.S. 58-10-195 General requirements related to filing and extensions for filing of annual audited financial reports and audit committee appointment**

  Reports must be prepared by an independent certified public accountant and filed on or before June 1 for the year ending December 31 immediately preceding. Extensions may be granted for thirty day periods upon a showing by the insurer and its certified public accountant of the reasons for the extension and upon a determination of good cause by the Commissioner. If an extension is granted, then a similar extension of 30 days is granted to the filing of the management's report of internal control.

  Every insurer is required to designate a group of individuals as constituting its audit committee.

- **G.S. 58-10-200 Contents of annual audited financial report**

  The financial report must show the financial position of the insurer as of the end of the most recent calendar year and the results of its operation, cash flows, and changes in capital and surplus for the year then ended and must include similar language and groupings as information submitted in the insurer's annual statement filed with the Commissioner. Data comparing the current year to the year immediately preceding must also be included.

The report must include the following: (1) report of an independent CPA; (2) balance sheet reporting admitted assets, liabilities, capital and surplus; (3) statement of operations; (4) statement of cash flows; (5) statement of changes in capital and surplus; and (6) notes to financial statements as required by the NAIC Annual Statement Instructions.

- **G.S. 58-10-210 Qualifications of independent certified public accountant**

  The CPA shall not recognize a CPA if the CPA: (1) is not in good standing with the NC State Board of CPA Examiners and in all other states in which he or she is licensed to practice; (2) has directly or indirectly entered into an agreement of indemnity or release from liability with respect to the audit of the insurer.

  Unless otherwise provided, the Commissioner shall recognize a CPA if he or she conforms to the specified ethical and professional standards of his or her profession. Mediation or arbitration agreements may be entered into with the insurer to settle disputes relating to the audit.

  The lead or coordinating audit partner having primary responsibility for the audit must be subject to rotation and may not act as lead partner for more than five consecutive years, unless otherwise approved by the Commissioner.

  The Commissioner may not accept audit reports prepared by a natural person who has been convicted of fraud, bribery, violation of insurance laws with respect to previous reports or has demonstrated a patter of failing to detect or disclose material information in previous reports.

  The Commissioner may hold a hearing to determine whether a person is qualified.

  A person is not an independent CPA if he or she provides the following non-audit services contemporaneously with the audit: (1) bookkeeping; (2) financial information systems design and implementation; (3) appraisal or valuation services; (4) actuarially-oriented services; (5) internal audit outsourcing; (6) management or human resources functions; (7) broker, dealer, investment adviser or investment banking services; legal or other expert services unrelated to the audit; (8) any other impermissible services as determined by the Commissioner. An insurer having direct premiums of less than $100,000,000 may request an exemption from these restrictions.

  This section includes a basic statement of principles providing that, to be independent, the CPA may not function in the role of management, cannot audit his or her own work, and cannot serve in an advocacy role for the insurer. The CPA may engage in any other services not specifically listed or not in violation of this statement of principles only if the activity is approved in advance by the audit committee.

  All audit and non-audit services provided by the CPA must be preapproved by the audit committee. Certain SOX-compliant entities are exempt from this requirement for non-audit services. An SOX-compliant entity is an insurer that is compliant with the auditor independence, audit committee, and internal control provisions of the federal Sarbanes-Oxley Act.

  The audit committee may delegate preapproval of audit and non-audit services to one or more designated members of the committee.

- **G.S. 58-10-215 Consolidated or combined audits**

  An insurer may seek approval from the Commissioner for approval to file a consolidated or combined financial statement if the insurer is part of a group of insurers that uses a pooling or 100% reinsurance agreement affecting solvency.

- **G.S. 58-10-220 Scope of audits**

The audit must be conducted in accordance with generally accepted auditing standards, including those specifically referenced in this section.

- **G.S. 58-210-225 Notice of adverse financial condition**

  The insurer required to furnish the annual audited financial report shall require the independent CPA to report, in writing, within 5 business days to the board of directors or the auditing committee any determination by the independent CPA that the insurer has materially misstated its financial condition as reported to the Commissioner or that the insurer does not meet the minimum capital and surplus requirements under Chapter 58. The insurer must forward the report to the Commissioner within 5 business days of receipt and shall provide evidence to the CPA of the report being forwarded to the Commissioner. If the CPA fails to receive the evidence, he or she shall furnish a copy of the report to the Commissioner.

- **G.S. 58-10-230 Communication of internal control related matters noted in an audit**

  This section contains the requirement for insurer to file, in addition to the annual audit financial report, written communication as to any unremediated material weakness in its internal control over financial reporting noted during the audit. This communication is to be prepared by the CPA within 60 days of the filing of the annual audited financial report.

- **G.S. 58-10-235 Accountant's letter of qualifications**

  The CPA must furnish the insurer, for inclusion in the annual audited financial report, a letter stating the CPA's independence, background and experience, that the audit will be filed in accordance with this Part, that the CPA is licensed and in compliance with the qualifications section of this Part, and that the CPA understands the work papers requirements of G.S. 58-10-240.

- **G.S. 58-10-240 Definition, availability, and maintenance of independent certified public accountants' work papers**

  This section defines work papers and requires the CPA to make available for review by the Commissioner all work papers prepared in the conduct of the audit. The insurer must require that the accountant retain the work papers until the Commissioner has filed a report covering the audit period, but no longer than 7 years. The Commissioner may make copies of the work papers, but the papers shall remain confidential.

- **G.S. 58-10-245 Requirements for audit committees**

  This section does not apply to SOX-compliant entities or foreign or alien insurers. An SOX-compliant entity is an insurer that is compliant with the auditor independence, audit committee, and internal control provisions of the federal Sarbanes-Oxley Act.

  The audit committee is responsible for the appointment, compensation, and oversight of the work of any CPA under this Part. Each member of the committee must be a member of the board of directors of the insurer or of the board of directors of the entity controlling a group of insurers.

  To be considered independent, members of the audit committee may not accept any fee or compensation other than in his or her capacity as a member of the audit committee or board of directors, unless board participation is otherwise required by NC law. If a member is no longer independent, then he or she may remain a member of the committee until the next annual meeting of the insurer or for one year, whichever is earlier.

  The audit committee shall require the CPA to perform the audit in a timely manner and in accordance with specified auditing, professional standards.

The following independent membership requirements apply:

Direct written or assumed premiums

$0-$300,000,000	No minimum requirements
$300,000,000-$500,000,000	Majority must be independent
Over $500,000,000	Supermajority (75%) must be independent

The Commissioner may require improvements to the independence levels of the committee if the insurer is in a risk-based capital level event, meets one or more of the standards to be deemed in hazardous financial condition, or exhibits qualities of a troubled insurer.

Certain insurers may seek a waiver from these requirements in the case of hardship.

- **G.S. 58-10-250 Conduct of insurer in connection with the preparation of required reports and documents**

No director or officer of an insurer shall directly or indirectly make or cause to be made materially false or misleading statements to the CPA or omit to state or cause another person to omit to state any material fact in order to make statements made not misleading to a CPA.

No director or officer of an insurer or other person acting under the direction of an officer or director shall directly influence or indirectly influence take any action to coerce, manipulate, mislead, or fraudulently influence any CPA if that person knew or should have known that the action could result in rendering the CPA's financial statements materially misleading.

- **G.S. 58-10-255 Management's report of internal control over financial reporting**

This section includes the requirement that insurers prepare a report on their internal control over financial reporting with the communication of internal control required under G.S. 58-10-230. Every insurer required to file an audited financial report is required to file the internal control report with certain exceptions. Notwithstanding the premium thresholds requiring the filing of an audited financial report, the Commissioner may require the report of internal control if the insurer is in a risk-based capital event or is in a hazardous financial condition.

Statements and information to be included in the internal control report are outlined in this section.

- **G.S. 58-10-260 Exemptions and effective dates**

The Commissioner may grant an exemption from any and all of the requirements of this Part if compliance would constitute a financial or organizational hardship upon the insurer.

Sections 2, 3 and 4 of the bill make technical and conforming changes.

EFFECTIVE DATE: House Bill 1314 is effective when it becomes law.

H1314-SMRG-11(e1) v2

HOUSE BILL 1159

Short Title:	Insurance Licensing Changes.-AB	(Public)
Sponsors:	Representatives Wray and Goforth (Primary Sponsors).	
Referred to:	Insurance, if favorable, Finance.	

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE LAWS ON INSURANCE BUSINESS ENTITY LICENSES; PROVIDE FOR A "STAGGERED" LICENSE SYSTEM FOR CERTAIN INSURANCE LICENSEES; TO CLARIFY THE LAW ON APPOINTMENTS OF INSURANCE ADJUSTERS; TO PROVIDE FOR ELECTRONIC FILINGS WITH THE DEPARTMENT OF INSURANCE; AND TO CLARIFY THE LAW ON APPOINTMENT OF AGENTS BY INSURANCE COMPANIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-33-26(j) reads as rewritten:

"(j) A business entity that sells, solicits, or negotiates insurance shall be licensed in accordance with G.S. 58-33-31(b). Every member of the partnership and every officer, director, stockholder, and employee of the business entity personally engaged in this State in selling, soliciting, or negotiating policies of insurance shall qualify as an individual licensee. A business entity license shall expire on ~~April 1~~ March 31 of each year unless the business entity pays the renewal fee."

SECTION 2. G.S. 58-33-125(h) reads as rewritten:

"(h) Fees paid by an insurer on behalf of a person who is licensed or appointed to represent the insurer ~~are payable to the Commissioner when billed. Billing of insurers for renewal fees must be on an annual basis. The frequency for billing insurers for other licensing and appointment fees is determined by the Commissioner and may be daily, monthly, or quarterly.~~ shall be remitted in a manner prescribed by the Commissioner at the point of the transaction or on a monthly or quarterly basis in the discretion of the Commissioner. An electronic payment made through the NAIC or an affiliate of NAIC is considered a payment to the Commissioner."

SECTION 3. G.S. 58-33-125 is amended by adding a new subsection to read:

"(i) The Commissioner may establish a staggered system in which the annual renewal fee prescribed by subsection (a) of this section for broker, adjuster, motor vehicle damage appraiser, and viatical settlement broker licenses are remitted on a biennial basis, based on the month and year of birth of each individual licensee. The Commissioner may establish for all other licenses "staggered" license renewal dates that will apportion renewals throughout each calendar year. The Commissioner is not required to print licenses for the purpose of renewing licenses. License renewal fees shall be paid by the licensee in a manner prescribed by the Commissioner in accordance with the license renewal schedule established by the Commissioner under this subsection."

SECTION 4. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-41. Appointment of adjusters.**

(a) No individual who holds a valid insurance adjuster's license issued by the Commissioner shall, investigate or report to the adjuster's principal concerning claims arising under insurance contracts other than life, health, or annuity, or otherwise act as an adjuster for an insurer by which the individual has not been appointed.

(b) Any insurer authorized to transact business in this State may appoint as its adjuster any individual who holds a valid adjuster's license issued by the Commissioner. Upon the appointment, the individual shall be authorized to act as an adjuster for the appointing insurer for all kinds of insurance for which the insurer is authorized in this State and for which the appointed adjuster is licensed in this State, unless specifically limited.

(c) Within 30 days the insurer shall file in a form prescribed by the Commissioner the names, addresses, and other information required by the Commissioner for its newly appointed adjusters.

(d) Every insurer shall remit in a manner prescribed by the Commissioner the appointment fee specified in G.S. 58-33-125 for each appointed adjuster.

(e) An appointment shall continue in effect as long as the appointed adjuster is properly licensed and the appointing insurer is authorized to transact business in this State, unless the appointment is cancelled.

(f) Before April 1 of each year, every insurer shall remit in a manner prescribed by the Commissioner the renewal appointment fee specified in G.S. 58-33-125."

SECTION 5. Article 2 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-2-250. Electronic filings.**

(a) As used in this section:

(1) "Commissioner's designee" includes the National Insurance Producer Registry of the NAIC.

(2) "License" includes any license, certificate, registration, or permit issued under this Chapter.

(3) "Licensee" means any person who holds a license.

(b) Notwithstanding any other provision of this Chapter, the Commissioner may adopt rules that require an applicant for a license or a licensee to file documents electronically with the Commissioner or the Commissioner's designee. The rules adopted under this section may contain procedures for the electronic payment of any fee required under this Chapter and the electronic filing of documents, including:

(1) Any document required as part of an application for a license under this Chapter.

(2) Any document required to be filed by an applicant for a license or a licensee to maintain the license in good standing.

(3) Any other document required or permitted to be filed.

(c) The Commissioner or the Commissioner's designee may charge an administrative fee for electronic filing. Fees charged for the processing of an electronic filing are in addition to any other fee imposed for the filing. Fees charged for an electronic filing are limited to the actual cost of the electronic transaction.

(d) This section does not supersede any other provision of law that requires the electronic filing of a document or requires an applicant for a license or a licensee to make any other filing electronically."

SECTION 6. G.S. 58-33-40(b) reads as rewritten:

"(b) Any insurer authorized to transact business in this State may appoint as its agent any individual who holds a valid agent's license issued by the Commissioner. Upon the appointment, the individual shall be authorized to act as an agent for the appointing insurer for ~~all~~ the kinds of insurance for which the insurer is authorized in this State and for which the

appointed agent is licensed in this State, unless specifically limited. For purposes of determining the number of appointments for an agent, there shall be one appointment for each kind of insurance for which the appointed agent is licensed in this State, unless specifically limited."

SECTION 7. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1159
PROPOSED COMMITTEE SUBSTITUTE H1159-CSRC-9 [v.2]

4/16/2009 8:36:08 AM

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

Sponsors:

Referred to:

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE LAWS ON INSURANCE BUSINESS ENTITY LICENSES; PROVIDE FOR A "STAGGERED" LICENSE SYSTEM FOR CERTAIN INSURANCE LICENSEES; TO CLARIFY THE LAW ON APPOINTMENTS OF INSURANCE ADJUSTERS; TO PROVIDE FOR ELECTRONIC FILINGS WITH THE DEPARTMENT OF INSURANCE; AND TO CLARIFY THE LAW ON APPOINTMENT OF AGENTS BY INSURANCE COMPANIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-33-26(j) reads as rewritten:

"(j) A business entity that sells, solicits, or negotiates insurance shall be licensed in accordance with G.S. 58-33-31(b). Every member of the partnership and every officer, director, stockholder, and employee of the business entity personally engaged in this State in selling, soliciting, or negotiating policies of insurance shall qualify as an individual licensee. A business entity license shall expire on ~~April 1~~ March 31 of each year unless the business entity pays the renewal fee."

SECTION 2. G.S. 58-33-125 is amended by adding a new subsection to read:

"(i) The Commissioner may establish a staggered system in which the annual renewal fee prescribed by subsection (a) of this section for broker, adjuster, motor vehicle damage appraiser, viatical settlement broker, and surplus line (individual) licenses are remitted on a biennial basis, based on the month and year of birth of each individual licensee. The Commissioner may establish for all other licenses "staggered" license renewal dates that will apportion renewals throughout each calendar year. The Commissioner is not required to print licenses for the purpose of renewing licenses. License renewal fees shall be paid by the licensee in a manner prescribed by the Commissioner in accordance with the license renewal schedule established by the Commissioner under this subsection."

SECTION 3. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-41. Appointment of adjusters.**

(a) No individual who holds a valid insurance adjuster's license issued by the Commissioner shall investigate or report to the adjuster's principal concerning claims arising under insurance contracts other than life, health, or annuity, or otherwise act as an adjuster for an insurer by which the individual has not been appointed.

(b) Any insurer authorized to transact business in this State may appoint as its adjuster any individual who holds a valid adjuster's license issued by the Commissioner. Upon the

appointment, the individual shall be authorized to act as an adjuster for the appointing insurer for all kinds of insurance for which the insurer is authorized in this State and for which the appointed adjuster is licensed in this State, unless specifically limited.

(c) Within 30 days the insurer shall file in a form prescribed by the Commissioner the names, addresses, and other information required by the Commissioner for its newly appointed adjusters.

(d) Every insurer shall remit in a manner prescribed by the Commissioner the appointment fee specified in G.S. 58-33-125 for each appointed adjuster.

(e) An appointment shall continue in effect as long as the appointed adjuster is properly licensed and the appointing insurer is authorized to transact business in this State, unless the appointment is cancelled.

(f) Before April 1 of each year, every insurer shall remit in a manner prescribed by the Commissioner the renewal appointment fee specified in G.S. 58-33-125."

SECTION 4. Article 2 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-2-250. Electronic filings.**

(a) As used in this section:

(1) "Commissioner's designee" includes the National Insurance Producer Registry of the NAIC.

(2) "License" includes any license, certificate, registration, or permit issued under this Chapter.

(3) "Licensee" means any person who holds a license.

(b) Notwithstanding any other provision of this Chapter, the Commissioner may adopt rules that require an applicant for a license or a licensee to file documents electronically with the Commissioner or the Commissioner's designee. The rules adopted under this section may contain procedures for the electronic payment of any fee required under this Chapter and the electronic filing of documents, including:

(1) Any document required as part of an application for a license under this Chapter.

(2) Any document required to be filed by an applicant for a license or a licensee to maintain the license in good standing.

(3) Any other document required or permitted to be filed.

(c) The Commissioner or the Commissioner's designee may charge an administrative fee for electronic filing. Fees charged for the processing of an electronic filing are in addition to any other fee imposed for the filing. Fees charged for an electronic filing are limited to the actual cost of the electronic transaction.

(d) This section does not supersede any other provision of law that requires the electronic filing of a document or requires an applicant for a license or a licensee to make any other filing electronically."

SECTION 6. G.S. 58-33-40(b) reads as rewritten:

"(b) Any insurer authorized to transact business in this State may appoint as its agent any individual who holds a valid agent's license issued by the Commissioner. Upon the appointment, the individual shall be authorized to act as an agent for the appointing insurer for ~~all~~ the kinds of insurance for which the insurer is authorized in this State and for which the appointed agent is licensed in this State, unless specifically limited. For purposes of determining the number of appointments for an agent, there shall be one appointment for each kind of insurance for which the appointed agent is licensed in this State, unless specifically limited."

SECTION 7. This act becomes effective October 1, 2009.

HOUSE BILL 1159:
Insurance Licensing Changes.-AB

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Finance	**Date:**	April 15, 2009
Introduced by:	Reps. Wray, Goforth	**Prepared by:**	Kory Goldsmith Committee Counsel
Analysis of:	PCS to First Edition H1159-CSRC-9		

SUMMARY: ***House Bill 1159 provides a "staggered" license system for the renewal of certain insurance licensees, clarifies the law on appointments of insurance adjusters, allows electronic filings with the Department of Insurance via the National Insurance Producer Registry, and specifies that there is must be a separate appointment by an insurer for each kind of insurance for which an agent is licensed in this state.***

The Proposed Committee Substitute removes Section 2 of the original bill. This change was requested by the Department of Insurance.

BILL ANALYSIS:

Section 1 clarifies that business entity licenses expire on March 1st (instead of April 1st) of each year unless renewed.

Section 2 provides a staggered system of license renewals based upon the licensee's month and year of birth. The change would apply to the following licenses: broker, adjuster, motor vehicle damage appraiser, viatical settlement brokers and surplus lines.

Section 3 creates a new section, G.S. 58-33-41, regarding the appointment of adjusters. It provides that no licensed insurance adjuster may investigate or report on claims arising under insurance contracts unless the individual has been appointed as an adjuster by that insurer. Also provides for the method of appointing an adjuster.

Section 4 creates a new section, G.S. 58-2-250 which allows electronic filing of licensing documents either with the Commissioner of Insurance or the Commissioner's designee. The designee may include the National Insurance Producer Registry of the National Association of Insurance Commissioners ("National Registry"). The bill allows the National Registry to charge an administrative fee for processing the electronic filing that is in addition to the actual filing fee.

Section 5 amends G.S. 58-33-40(b) to clarify that when an insurer appoints a licensed individual to be its agent, the individual is authorized to act as an agent for each type of insurance for which the individual holds a license and which the insurer is authorized to sell. There is one appointment for each type of insurance for which the appointed agent is licensed.

EFFECTIVE DATE: This act becomes effective October 1, 2009.

H1159-SMRC-11(CSRC-9) v3

HOUSE BILL 1159:
Insurance Licensing Changes.-AB

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Finance	**Date:**	April 15, 2009
Introduced by:	Reps. Wray, Goforth	**Prepared by:**	Kory Goldsmith Committee Counsel
Analysis of:	PCS to First Edition H1159-CSRC-9		

SUMMARY: ***House Bill 1159 provides a "staggered" license system for the renewal of certain insurance licensees, clarifies the law on appointments of insurance adjusters, allows electronic filings with the Department of Insurance via the National Insurance Producer Registry, and specifies that there is must be a separate appointment by an insurer for each kind of insurance for which an agent is licensed in this state.***

The Proposed Committee Substitute removes Section 2 of the original bill. This change was requested by the Department of Insurance.

BILL ANALYSIS:

Section 1 clarifies that business entity licenses expire on March 1st (instead of April 1st) of each year unless renewed.

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Section 3 creates a new section, G.S. 58-33-41, regarding the appointment of adjusters. It provides that no licensed insurance adjuster may investigate or report on claims arising under insurance contracts unless the individual has been appointed as an adjuster by that insurer. Also provides for the method of appointing an adjuster.

Section 4 creates a new section, G.S. 58-2-250 which allows electronic filing of licensing documents either with the Commissioner of Insurance or the Commissioner's designee. The designee may include the National Insurance Producer Registry of the National Association of Insurance Commissioners ("National Registry"). The bill allows the National Registry to charge an administrative fee for processing the electronic filing that is in addition to the actual filing fee.

Section 5 amends G.S. 58-33-40(b) to clarify that when an insurer appoints a licensed individual to be its agent, the individual is authorized to act as an agent for each type of insurance for which the individual holds a license and which the insurer is authorized to sell. There is one appointment for each type of insurance for which the appointed agent is licensed.

EFFECTIVE DATE: This act becomes effective October 1, 2009.

H1159-SMRC-11(CSRC-9) v3

HOUSE BILL 1161

Short Title:	Revise Insurance Financial Conditions.-AB	(Public)
Sponsors:	Representatives Wray, Goforth (Primary Sponsors); and Lucas.	
Referred to:	Insurance, if favorable, Judiciary II.	

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES IN THE LAWS RELATED TO THE FINANCIAL CONDITIONS OF INSURANCE COMPANIES, INCLUDING REINSURANCE INTERMEDIARIES, RECEIVERSHIP, THIRD-PARTY ADMINISTRATORS AND AUDITS OF WORKERS' COMPENSATION SELF-INSURERS, AND FOREIGN INSURERS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 9 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-9-22. Compliance with orders.**

An intermediary shall comply with any order of a court of competent jurisdiction or a duly constituted arbitration panel requiring the production of nonprivileged documents by the intermediary, or the testimony of an employee or other individual otherwise under the control of the intermediary with respect to any reinsurance transaction for which it acted as an intermediary."

SECTION 2. G.S. 58-30-85(e) reads as rewritten:

"(e) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger, runoff, or other transformation of the insurer is appropriate, he shall prepare a plan to effect such changes. Upon application of the rehabilitator for approval of the plan, and after such notice and hearings as the Court may prescribe, the Court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this section shall be, in the opinion of the Court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the policies of the insurer, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary."

SECTION 3. G.S. 58-30-165(d) reads as rewritten:

"(d) The liquidator shall give notice of the order to show cause by publication ~~and~~ or by first class mail to each member liable thereunder mailed to his last known address as it appears on the insurer's records, at least 20 days before the return day of the order to show cause."

SECTION 4. G.S. 58-47-205 reads as rewritten:

"**§ 58-47-205. Other requirements.**

(a) A TPA or service company, or any owner, officer, employee, or agent of a TPA or service company, or any other person affiliated with or related to the TPA or service company shall ~~not~~ not:

(1) ~~serve~~ Serve as a trustee of a self-insurer.

(2) Make a contribution to the surplus of a self-insurer.

...."

SECTION 5. G.S. 97-165 reads as rewritten:

"**§ 97-165. Definitions.**

As used in this Article:

....

(2) "Certified audit" means an audit on which a certified public accountant or a foreign registered public accounting firm expresses his or her professional opinion that the accompanying statements fairly present the financial position of the self-insurer or the guarantor, in conformity with accounting principles generally accepted in the United ~~States.~~States or prepared in accordance with International Financial Reporting Standards.

(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~~financial statements prepared in accordance with United States Generally Accepted Accounting Principles or International Financial Reporting Standards. The Commission may require the self-insurer or the guarantor to replace the CPA with another whose relationship with the self-insurer or the guarantor is independent within the meaning of this definition.

...

~~(6)~~(5a) ~~"GAAP financial~~"Financial statement" means a financial statement as defined by accounting principles generally accepted in the United ~~States.~~States or a financial statement prepared in accordance with International Financial Reporting Standards.

(6) "Foreign registered public accounting firm" means a public accounting firm that is organized and operates under the laws of a non-United States jurisdiction, government, or political subdivision and is registered and in good standing with the Public Company Accounting Oversight Board to prepare or issue any audit report with respect to any issuer.

...."

SECTION 6. G.S. 97-170(d) reads as rewritten:

"(d) The license application shall be comprised of the following information:

...

(2) Certified audited GAAP financial statements prepared by a CPA or submitted by a foreign registered accounting firm for the two most recent years. The financial statement presentation shall facilitate application of ratio and trend analysis.

...."

SECTION 7. G.S. 97-180(a) reads as rewritten:

"(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,~~CPA or submitted by a foreign

registered accounting firm, for that fiscal year. The financial statement 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."

SECTION 8. G.S. 58-16-5 reads as rewritten:

"**§ 58-16-5. Conditions of licensure.**

A foreign or alien insurance company may be licensed to do business when it:

....

(2) Satisfies the Commissioner that it is fully and legally organized under the laws of its state or government to do the business it proposes to transact as direct insurance or assumed ~~reinsurance, and that it has been successful in the conduct of the business;~~reinsurance; that it has, if a stock company, a free surplus and a fully paid-up and unimpaired capital, exclusive of stockholders' obligations of any description of an amount not less than that required for the organization of a domestic company writing the same kinds of business; and if a mutual company that its free surplus is not less than that required for the organization of a domestic company writing the same kind of business, and that the capital, surplus, and other funds are invested substantially in accordance with the requirements of this Chapter.

...."

SECTION 9. This act becomes effective October 1, 2009.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1161
PROPOSED COMMITTEE SUBSTITUTE H1161-CSRD-30 [v.1]

4/15/2009 6:51:04 PM

Short Title: Revise Insurance Financial Conditions.-AB (Public)

Sponsors:

Referred to:

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES IN THE LAWS RELATED TO THE FINANCIAL CONDITIONS OF INSURANCE COMPANIES, INCLUDING REINSURANCE INTERMEDIARIES, RECEIVERSHIP, THIRD-PARTY ADMINISTRATORS AND AUDITS OF WORKERS' COMPENSATION SELF-INSURERS, AND FOREIGN INSURERS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 9 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-9-22. Compliance with orders.**

An intermediary shall comply with any order of a court of competent jurisdiction or a duly constituted arbitration panel requiring the production of nonprivileged documents by the intermediary, or the testimony of an employee or other individual otherwise under the control of the intermediary with respect to any reinsurance transaction for which it acted as an intermediary."

SECTION 2. G.S. 58-30-85(e) reads as rewritten:

"(e) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger, runoff, or other transformation of the insurer is appropriate, he shall prepare a plan to effect such changes. Upon application of the rehabilitator for approval of the plan, and after such notice and hearings as the Court may prescribe, the Court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this section shall be, in the opinion of the Court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the policies of the insurer, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary."

SECTION 3. G.S. 58-30-165(d) reads as rewritten:

"(d) The liquidator shall give notice of the order to show cause by publication ~~and~~ or by first class mail to each member liable thereunder mailed to his last known address as it appears on the insurer's records, at least 20 days before the return day of the order to show cause."

SECTION 4. G.S. 58-47-205 reads as rewritten:

"**§ 58-47-205. Other requirements.**

(a) A TPA or service company, or any owner, officer, employee, or agent of a TPA or service company, or any other person affiliated with or related to the TPA or service company shall ~~not~~ not:

(1) ~~serve~~ Serve as a trustee of a self-insurer.

(2) Make a contribution to the surplus of a self-insurer.

...."

SECTION 5. G.S. 97-165 reads as rewritten:

"**§ 97-165. Definitions.**

As used in this Article:

....

(2) "Certified audit" means an audit on which a certified public accountant or a foreign registered public accounting firm expresses his or her professional opinion that the accompanying statements fairly present the financial position of the self-insurer or the guarantor, in conformity with accounting principles generally accepted in the United ~~States.~~States or prepared in accordance with International Financial Reporting Standards.

(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~~financial statements prepared in accordance with United States Generally Accepted Accounting Principles or International Financial Reporting Standards. The Commission may require the self-insurer or the guarantor to replace the CPA with another whose relationship with the self-insurer or the guarantor is independent within the meaning of this definition.

...

~~(6)~~(5a) ~~"GAAP financial~~"Financial statement" means a financial statement as defined by accounting principles generally accepted in the United ~~States.~~States or a financial statement prepared in accordance with International Financial Reporting Standards.

(6) "Foreign registered public accounting firm" means a public accounting firm that is organized and operates under the laws of a non-United States jurisdiction, government, or political subdivision and is registered and in good standing with the Public Company Accounting Oversight Board and authorized by the Board to prepare or issue any audit report with respect to any issuer.

...."

SECTION 6. G.S. 97-170(d) reads as rewritten:

"(d) The license application shall be comprised of the following information:

...

(2) Certified audited ~~GAAP~~ financial statements prepared by a CPA or submitted by a foreign registered public accounting firm for the two most

recent years. The financial statement presentation shall facilitate application of ratio and trend analysis.

...."

SECTION 7. G.S. 97-180(a) reads as rewritten:

"(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,~~CPA or submitted by a foreign registered public accounting firm, for that fiscal year. The financial statement 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."

SECTION 8. G.S. 58-16-5 reads as rewritten:

"**§ 58-16-5. Conditions of licensure.**

A foreign or alien insurance company may be licensed to do business when it:

....

(2) Satisfies the Commissioner that it is fully and legally organized under the laws of its state or government to do the business it proposes to transact as direct insurance or assumed ~~reinsurance, and that it has been successful in the conduct of the business;~~reinsurance; that it has, if a stock company, a free surplus and a fully paid-up and unimpaired capital, exclusive of stockholders' obligations of any description of an amount not less than that required for the organization of a domestic company writing the same kinds of business; and if a mutual company that its free surplus is not less than that required for the organization of a domestic company writing the same kind of business, and that the capital, surplus, and other funds are invested substantially in accordance with the requirements of this Chapter.

...."

SECTION 9. This act becomes effective October 1, 2009.

HOUSE BILL 1161:
Revise Insurance Financial Conditions.-AB

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Judiciary II	**Date:**	April 16, 2009
Introduced by:	Reps. Wray, Goforth	**Prepared by:**	Bill Patterson Ben Popkin Committee Counsel
Analysis of:	PCS to First Edition H1161-CSRD-30		

SUMMARY: House Bill 1161 would make changes to laws applicable to reinsurance intermediaries, to insurance company rehabilitation and liquidation, to workers compensation self-insurers, and to foreign insurers doing business in North Carolina. The Proposed Committee Substitute makes only technical conforming changes to the original bill.

BILL ANALYSIS:

Section 1

Pursuant to G.S. 58-9-26, the Commissioner of Insurance can impose sanctions upon reinsurance intermediaries (brokers) who violate the provisions of Article 9 of Chapter 58 of the General Statutes, including the suspension or revocation of their license. Currently, Article 9 does not specifically require intermediaries to comply with orders by courts or arbitration panels requiring production of documents or testimony of employees or other persons under their control concerning reinsurance transactions with which they were involved.

Section 1 of the bill would add a new section to Article 9, G.S. 58-9-22, that would mandate compliance with such orders issued by courts or arbitration panels. This change would subject offenders to sanctions by the Commissioner of Insurance in addition to whatever sanctions may be imposed by the issuing court or arbitration panel.

Section 2

Article 30 of Chapter 58 governs the rehabilitation of the business of an insurance company. G.S. 58-30-85(e) provides that "[i]f the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger, or other transformation of the insurer is appropriate, he shall prepare a plan to effect such changes" and submit it to a court for approval.

Section 2 of the bill would amend G.S. 58-30-85(e) to authorize the rehabilitator to include "runoff" as one of the components of a plan of rehabilitation.

Section 3

In a liquidation of an insurer carried out under Article 8 of Chapter 58, a court can levy an assessment against members who are liable for such assessments under the insurance company's bylaws, for the amount by which the company's liabilities exceed its assets. G.S. 58-30-165(d) requires the liquidator to issue a notice to show cause why the liquidator should not pursue a judgment for the amount of the levy. Currently, this section requires the notice to be served upon the members at their last known addresses by publication and by first class mail.

Section 3 of the bill would revise G.S. 58-30-165(d) to permit the liquidator to serve the show cause order either by publication or by first class mail.

Section 4

Employers who self-insure their workers compensation obligations, by pooling their liabilities to form a self-insured group, are subject to the requirements of Article 47 of Chapter 58 of the General Statutes. Under G.S. 58-47-150, a "third party administrator" or "TPA" is a person engaged by the self-insured group to provide it with day-to-day management, and a "service company" is an entity that has contracted with an employer or group for the purpose of providing any services related to claims adjustment, loss control, or both. Currently, G.S. 58-47-205 prohibits a TPA, service company, or any person related to or affiliated with either, from serving as a trustee of a self-insurer. Under G.S. 58-47-85, a self-insured group must maintain a minimum "surplus," meaning a minimum level of funds over and above liabilities and capital of the company.

Section 4 of the bill would revise G.S. 58-47-205 to prohibit a TPA, service company, or any person related to or affiliated with them from making any contribution to the surplus of the self-insurer.

Sections 5, 6, and 7

Under Article 5 of Chapter 97, employers who are self-insured must be licensed by the Commissioner of Insurance, and must submit financial statements to establish that they meet the statutory requirements. Current law requires that the financial statements be prepared by CPAs in accordance with accounting principles generally accepted in the United States ("GAAP").

Sections 5, 6, and 7 of the bill would amend applicable sections of Article 5 of Chapter 97 to recognize alternative methods of reporting under International Financial Reporting Standards in addition to GAAP, and would permit the required reports to be prepared by foreign public accounting firms registered with the Public Company Accounting Oversight Board established by the Sarbanes-Oxley Act of 2002.

Section 8

G.S. 58-16-5 currently requires a foreign insurance company wishing to do business in North Carolina to satisfy the Commissioner of Insurance not only that it is legally organized under the laws of its state or government to do the business it proposes to transact in North Carolina, but also "that it has been successful in the conduct of the business." Under applicable DOI regulations, this generally requires that the applicant "have net income for three consecutive years immediately preceding the date of application for admission." 11 NCAC 14.0504.

Section 8 of the bill would amend G.S. 58-16-5 by eliminating the requirement that the foreign insurance company show that it has been successful in the conduct of the business.

EFFECTIVE DATE: This act becomes effective October 1, 2009.

H1161-SMTG-23(CSRD-30) v2

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 1159 A BILL TO BE ENTITLED AN ACT TO CLARIFY THE LAWS ON INSURANCE BUSINESS ENTITY LICENSES; PROVIDE FOR A "STAGGERED" LICENSE SYSTEM FOR CERTAIN INSURANCE LICENSEES; TO CLARIFY THE LAW ON APPOINTMENTS OF INSURANCE ADJUSTERS; TO PROVIDE FOR ELECTRONIC FILINGS WITH THE DEPARTMENT OF INSURANCE; AND TO CLARIFY THE LAW ON APPOINTMENT OF AGENTS BY INSURANCE COMPANIES.

☒ 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 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.

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ The bill/resolution is re-referred to the Committee on _____.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 1161 A BILL TO BE ENTITLED AN ACT TO MAKE CHANGES IN THE LAWS RELATED TO THE FINANCIAL CONDITIONS OF INSURANCE COMPANIES, INCLUDING REINSURANCE INTERMEDIARIES, RECEIVERSHIP, THIRD-PARTY ADMINISTRATORS AND AUDITS OF WORKERS' COMPENSATION SELF-INSURERS, AND FOREIGN INSURERS.

☒ 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 JUDICIARY II.

(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.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 1314 A BILL TO BE ENTITLED AN ACT TO IMPROVE THE INSURANCE COMMISSIONER'S ABILITY TO MONITOR THE FINANCIAL CONDITION OF INSURERS.

☒ With a favorable report and recommendation that the bill be re-referred to the Committee on JUDICIARY II.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ The bill/resolution is re-referred to the Committee on _____.

Mary Capps (Rep. Wray)

om: Ann Jordan (Rep. Goforth)
ent: Tuesday, April 14, 2009 3:26 PM
Subject: Meeting Notice for April 16.doc

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

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

DAY & DATE: **Thursday, April 16, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

HB 1314 – ANNUAL FINANCIL REPORTING – Rep. Goforth

1159 – INSURANCE LICENSING CHANGES – Rep. Wray

HB 1161 – REVISE INSURANCE FINANCIAL CONDITIONS – Rep. Wray

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at **3:30 p.m. on April 14, 2009**

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

ATTACHMENT #1

VISITOR REGISTRATION SHEET

House Committee on Insurance — April 16, 09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chane Foster	NC VCE
Bob Bird	—
Barbara Carsler	BSCOA
DAVID RICE	MANNING FULTON
Leslie Arnold	SOG-Daily Bulletin
[illegible]	JD, NL, PA
Cam Crew	BOMHL
David Stoller	State Farm
[illegible]	NW
[illegible]	NMRS
[illegible]	MFDS

VISITOR REGISTRATION SHEET

House Committee on Insurance — April 16, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DAVID BARNES	Poyner Spruill
Jamal Jones	NCHA
ANN COLE	DUKE
Will Clapper	Moore + Van Allen
Louis Bolo	NCDOI
Kay Martinez	✓
JAN ANDREWS	NCDOI
Etta P Maynard	NCDOI
Angela Ford	NCDOI
MIKE WATERS	NCRPA
Clay Bayard	NCMS

VISITOR REGISTRATION SHEET

House Committee on Insurance

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS

VISITOR REGISTRATION SHEET

House Committee on Insurance

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Marlowe Foster	Pfizer
Bill Scoggin	KLG
David Brady	MWC

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

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HB 1159 – INSURANCE LICENSING CHANGES – Rep. Wray

HB 1161 – REVISE INSURANCE FINANCIAL CONDITIONS – Rep. Wray

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at **3:30 p.m. on April 14, 2009**

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 21, 2009

The House Committee on Insurance met at 11:00 AM on Tuesday, April 21, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael Wray; Vice Chairs: J. Dockham and M. Setzer. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Cole, Current, Faison, Gibson, Holliman, Howard, Hughes, Lewis, Pierce and Wainwright.

Chairman Wray called the meeting to order and welcomed visitors. He recognized Sgt-At Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachments)

Chairman Wray recognized Rep. Goforth to explain HB 1164 – Modernize HMO Oversight Requirements. Rep. Goforth asked for Rose Williams, Counsel for the Department of Insurance, to be recognized to explain the bill. Ms. Williams said that this bill deletes outdated language and removes the requirement that every HMO collect and report data for group contracts of 1,000 or more members according to Healthcare Effectiveness Data and Information Set (HEDIS) guidelines to the Commissioner annually and make the reports available to all employer groups. She said they have other methods of oversight in place and asks that that provision be stricken. Rep. Faison made a motion for a favorable report. The motion carried.

Chairman Wray recognized Rep. Tim Spears to explain HB 742 – Prohibit Beach Plan Surplus Distribution. Rep. Spears said that HB 742 amends the G.S. to provide that the accumulated surplus of the NCIUA (also known as the Beach Plan) must be retained and used to pay losses resulting from hurricanes and other events, reinsurance costs, and other operating expenses as necessary. The bill specifically provides that no member is entitled to the distribution of any portion of the Association's surplus. The bill also changes the heading and amends the statute to delete the word "profits." Without distribution of the surplus, member insurers will not participate in the profits of the Plan, only the expenses and losses.

Rep. Holliman was recognized to speak on the bill. He said this is part of a much bigger plan that is being negotiated at this point. Rep. Dockham agreed. Rep. Faison made a motion to pull the bill and wait a couple of days for further discussion. Rose Williams explained that DOI is also involved in the negotiations. Rep. Spear said he was willing to pull the bill until next Tuesday.

Chairman Wray recognized Rep. Goforth to explain HB 1183 – Health and Other Insurance Law Changes. Rep. Dockham moved for the PCS to be before the committee. Rep. Goforth asked Rose Williams with DOI to explain the bill. The bill made the following various changes, change health care laws to comport with recent congressional enactments, to make a technical correction in a credit insurance law, to conform motor vehicle inspection compliance requirement with discontinuation of stickers; and to repeal the expiration date of the Interstate Insurance Product Regulation Compact Act. Rep. Holliman made a motion for a favorable to the PCS and unfavorable to the original. Motion carried.

The meeting adjourned at 11:45 AM.

Representative Michael Wray, Chairman

Ann Jordan – Committee Assistant

HOUSE INSURANCE COMMITTEE

April 21, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

HB 426 – STAY ON HOMEOWNERS INSURANCE ACTIONS – Reps. Spear, Wainwright, Owens & McElraft

HB 26 – STAY BEACH PLAN RATES, DEDUCTIBLE, SURCHARGES – Reps. Spear, Grady, Justice, McElraft, Stiller and Underhill

HB 742 – PROHIBIT BEACH PLAN SURPLUS DISTRIBUTION – Reps. Spear, Goforth, Justice, McComas, McElraft, Stiller and Wainwright

HB 438 – STAY HEALTH PLAN/CALENDAR YEAR – Reps. Folwell, Holliman, Blackwell and Blue

HB 439 – STATE HEALTH PLAN/TAXPAYER RECOVERY ACT – Reps. Folwell, England, Hurley and Hall

HB 1164 – MODERNIZE HMO OVERSIGHT REQUIREMENTS – Reps. Goforth and Wray

HB 1183 – HEALTH AND OTHER INSURANCE LAW CHANGES – Reps. Goforth and Wray

Adjourn

HOUSE BILL 1164

Short Title:	Modernize HMO Oversight Requirements.	(Public)
Sponsors:	Representatives Goforth, Wray (Primary Sponsors); and Lucas.	
Referred to:	Health, if favorable, Insurance.	

April 8, 2009

A BILL TO BE ENTITLED

AN ACT REQUESTED BY THE COMMISSIONER OF INSURANCE TO ELIMINATE OBSOLETE DATA COLLECTION REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-67-50(e) reads as rewritten:

"**§ 58-67-50. Evidence of coverage and premiums for health care services.**

(e) ~~Effective January 1, 1989, every~~Every health maintenance organization shall provide at least minimum cost and utilization information for group contracts of 100 or more subscribers on an annual basis when requested by the group. Such information shall be compiled in accordance with the Data Collection Form developed by the Standardized HMO Date Form Task Force as endorsed by the Washington Business Group on Health and the Group Health Association of America on November 19, 1986, and any subsequent amendments. ~~In addition, beginning with data for the calendar year 1998, every HMO, for group contracts of 1,000 or more members, shall provide cost, use of service, prevention, outcomes, and other group specific data as collected in accordance with the latest edition of the Healthcare Effectiveness Data and Information Set guidelines, as published by the National Committee for Quality Assurance. Beginning with data for the calendar year 1998, every HMO shall file with the Commissioner and make available to all employer groups, not later than July 1 of the following calendar year, a report of health benefit plan wide experience on its costs, use of services, and other aspects of performance, in the Healthcare Effectiveness and Information Set format.~~"

SECTION 2. This act is effective when it becomes law.

HOUSE BILL 1164:
Modernize HMO Oversight Requirements

2009-2010 General Assembly

Committee:	House Insurance	**Date:**	April 20, 2009
Introduced by:	Reps. Goforth, Wray	**Prepared by:**	Ben Popkin
Analysis of:	First Edition		Committee Counsel

SUMMARY: ***House Bill 1164 is an agency bill that deletes outdated language and removes the requirement that every HMO collect and report data for group contracts of 1,000 or more members according to Healthcare Effectiveness Data and Information Set (HEDIS) guidelines to the Commissioner annually and make the reports available to all employer groups.***

CURRENT LAW: Subsection (e) of G.S. 58-67-50 "Evidence of coverage and premiums for health care services" directs Health Maintenance Organizations (HMOs) to provide cost and utilization information for group contracts of 100 or more on an annual basis when requested by the group.

This subsection also directs HMOs, for group contracts of 1,000 or more, to provide cost, use of service, prevention, outcomes and other data collected according to HEDIS guidelines, and to file annual reports of health benefit plan-wide cost, service and other performance experiences with the Commissioner of Insurance and make the reports available to all employer groups.

BILL ANALYSIS: House Bill 1164 would delete the latter portion of G.S. 58-67-50(e) to remove the reporting language applying to HMOs with group contracts of 1,000 or more members.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: Since the time of its enactment, additional methods for monitoring the performance of HMOs have been developed and the provisions of G.S. 58-67-50(e) regarding HMOs reporting HEDIS data set information for group contracts of 1,000 or more members have been supplanted by other monitoring tools.

H1164-SMRD-61(e1) v1

HOUSE BILL 742

Short Title:	Prohibit Beach Plan Surplus Distribution.	(Public)
Sponsors:	Representatives Spear; Goforth, Justice, McComas, McElraft, Stiller, and Wainwright.	
Referred to:	Insurance, if favorable, Judiciary II.	

March 24, 2009

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE RETENTION OF ACCUMULATED SURPLUS BY THE NORTH CAROLINA INSURANCE UNDERWRITING ASSOCIATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-45-25 reads as rewritten:

"**§ 58-45-25. Each member of Association to participate in its ~~expenses, profits, and losses.~~expenses and losses.**

(a) Each member of the Association shall participate in the ~~expenses, profits,~~ expenses and losses of the Association in the proportion that its net direct premium written in this State during the preceding calendar year for residential and commercial properties outside of the beach and coastal areas bears to the aggregate net direct premiums written in this State during the preceding calendar year for residential and commercial properties outside of the beach and coastal areas by all members of the Association, as certified to the Association by the Commissioner. The Commissioner shall certify each member's participation after review of annual statements and any other reports and data necessary to determine participation and may obtain any necessary information or data from any member of the Association for this purpose. Any insurer that is authorized to write and that is engaged in writing any insurance, the writing of which requires the insurer to be a member of the Association under G.S. 58-45-10, shall become a member of the Association on the first day of January after authorization. The determination of the insurer's participation in the Association shall be made as of the date of membership of the insurer in the same manner as for all other members of the Association.

(b) All member companies shall receive credit each year for essential property insurance, farmowners insurance, homeowners insurance, and the property portion of commercial multiple peril policies voluntarily written in the beach and coastal areas in accordance with guidelines and procedures to be submitted by the Directors to the Commissioner for approval. The participation of each member company in the ~~expenses, profits, and losses~~expenses and losses of the Association shall be reduced accordingly; provided, no credit shall be given where coverage for the peril of wind has been excluded. The guidelines and procedures for granting credit shall encourage and assist each member company to voluntarily write these coverages in the beach and coastal areas for commercial and residential properties.

(c) The North Carolina Insurance Underwriting Association shall use the "take out" program, as filed with and approved by the Commissioner, in the coastal area.

(d) The accumulated surplus of the Association shall be retained from year to year and used to pay losses, reinsurance costs, and other operating expenses as necessary. No member company shall be entitled to the distribution of any portion of the Association's surplus."

SECTION 2. This act is effective when it becomes law.

HOUSE BILL 742:
Prohibit Beach Plan Surplus Distribution

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Judiciary II	**Date:**	April 20, 2009
Introduced by:	Rep. Spear	**Prepared by:**	Tim Hovis
Analysis of:	First Edition		Committee Counsel

SUMMARY: ***House Bill 742 amends G.S. 58-45-25,*** *Each member of Association to participate in its expenses, profits, and losses,* ***to provide that the accumulated surplus of the North Carolina Insurance Underwriting Association (NCIUA), also known as the Beach Plan, must be retained and used to pay losses resulting from hurricanes and other events, reinsurance costs, and other operating expenses as necessary. The bill specifically provides that no member is entitled to the distribution of any portion of the Association's surplus.***

The bill also changes the heading and amends the statute to delete the word "profits." Without distribution of the surplus, member insurers will not participate in the profits of the Plan, only the expenses and losses.

CURRENT LAW: Under the current law, the Board of Directors of the NCIUA can choose to distribute the surplus to the member companies.

However, in 2005, the Board of Directors of the Beach Plan voted to begin retaining the Plan's surplus up to $750 million dollars. Four years ago, The Plan had just under $200 million dollars in surplus. In December of 2008, the Board increased the ceiling on the retention of surplus to $1.1 billion dollars. Currently, the Plan has over $700 million dollars in surplus.

EFFECTIVE DATE: House Bill 742 is effective when it becomes law.

H742-SMRG-12(e1) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1183
PROPOSED COMMITTEE SUBSTITUTE H1183-CSRD-32 [v.4]

4/20/2009 9:08:53 PM

Short Title: Health and Other Insurance Law Changes.-AB (Public)

Sponsors:

Referred to:

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS CHANGES IN THE LAWS GOVERNING HEALTH INSURANCE AND MANAGED CARE; TO CHANGE CERTAIN HEALTH INSURANCE LAWS TO COMPORT WITH RECENT CONGRESSIONAL ENACTMENTS; TO MAKE A TECHNICAL CORRECTION IN A CREDIT INSURANCE LAW; TO CONFORM MOTOR VEHICLE INSPECTION COMPLIANCE REQUIREMENT WITH DISCONTINUATION OF STICKERS; AND TO REPEAL THE EXPIRATION DATE OF THE INTERSTATE INSURANCE PRODUCT REGULATION COMPACT ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-51-17(a)(1)a. and b. read as rewritten:

"**§ 58-51-17. Portability for accident and health insurance.**

(a) Rules Relating to Crediting Previous Coverage.

(1) Creditable coverage defined. – For the purposes of this section, "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.~~group health plan as defined in G.S. 58-68-25(a)(4b.)

b. ~~Group or individual health insurance coverage.~~Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market, or otherwise."

SECTION 2. G.S. 58-68-25(a) is amended by adding the following new subdivisions to read:

"**§ 58-68-25. Definitions; excepted benefits; employer size rule.**

(a) Definitions. – In addition to other definitions throughout this Article, the following definitions and their cognates apply in this Article:

...

(4a) 'Group health insurance coverage'. – Health insurance coverage offered in connection with a group health plan.

(4b) 'Group health plan'. – The meaning given the term under 45 C.F.R.§ 146.145(a).

(4c) 'Group market'. – The market for health insurance coverage offered in connection with a group health plan.

...."

SECTION 3. G.S. 58-68-25(a)(5) reads as rewritten:

"(5) "Health insurance coverage" or "coverage" or "health insurance plan" or "plan". – Benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under any accident and health insurance policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, written by a health insurer. Health insurance coverage includes group health insurance coverage and individual health insurance coverage."

SECTION 4. G.S. 58-68-30(c)(1) 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.~~group health plan.

b. ~~Group or individual health insurance coverage.~~ Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market, or otherwise.

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. 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.~~ section."

SECTION 5. G.S. 58-68-60(b)(1) reads as rewritten:

"(b) Eligible Individual Defined. – In this Part, "eligible individual" means an individual:

(1) (i) For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is 18 or more months and (ii) whose most recent prior creditable coverage was under ~~an ERISA~~ a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);

...."

SECTION 6. G.S. 58-65-2 is amended by adding two new statutory references to read:

"**§ 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:

...

58-51-15(a)(2)b. Accident and health policy provisions.

58-51-17 Portability for accident and health insurance."

SECTION 7. G.S. 58-67-171 is amended by adding two new statutory references to read:

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

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

...

58-51-15(a)(2)b. Accident and health policy provisions.

58-51-17 Portability for accident and health insurance."

SECTION 8. G.S. 58-51-15 is amended by adding the following new subsection to read:

"(i) Applicability. – This section applies to all accident and health insurance policies delivered or issued for delivery in this State, including certificates issued under group policies that are delivered or issued for delivery in this State. This section also applies to certificates issued under a policy issued and delivered to a trust or association outside this State and covering persons residing in this State."

SECTION 9. G.S. 58-51-17 is amended by adding the following new subsection to read:

"(d) Applicability. – This section applies to all health benefit plans of individual health insurance coverage delivered or issued for delivery in this State, including certificates issued under group policies that are delivered or issued for delivery in this State. This section also applies to certificates issued under a policy issued and delivered to a trust or association outside this State and covering persons residing in this State."

SECTION 10. G.S. 58-51-17(b) reads as rewritten:

"**§ 58-51-17. Portability for accident and health insurance.**

...

(b) Exceptions.

(1) Exclusion not applicable to certain newborns. – Subject to subdivision (3) of this subsection, an individual health insurer shall not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the individual's date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children. – Subject to subdivision (3) of this subsection, ~~a group~~ an individual health insurer shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence does not apply to coverage before the date of the adoption or placement for adoption.

(3) Loss if break in coverage. – Subdivisions (1) and (2) of this subsection shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage."

SECTION 11. 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~~ Plan A available to persons eligible for Medicare by reason of disability before age ~~65.~~ 65 and also standardized Plan C or F if marketing either Plan to persons eligible for Medicare due to age. 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 12. G.S. 58-56-26(c) reads as rewritten:

"(c) In cases where a TPA administers benefits for more than 100 certificate holders on behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the TPA. At least one semiannual review shall be an on-site audit of the operations of the TPA. On July 1, 2010, and annually thereafter, every insurer shall file with the Commissioner a certification of completion of the audits as required by this subsection and performed during the previous calendar year, in the format, content, and manner as specified by the Commissioner. The insurer shall maintain in its corporate records documentation of the audits conducted to support its certification of audits for a period of five years or, if a domestic insurer, until the completion of the next quinquennial examination."

SECTION 13. G.S. 58-56-26 is amended by adding the following new subsection to read:

"**§ 58-56-26. Responsibilities of the insurer.**

...

(d) The Commissioner may adopt rules necessary to implement, administer, and enforce the provisions of this section."

SECTION 14. G.S. 58-58-146 reads as rewritten:

"**§ 58-58-146. Application for annuities required.**

(a) Each individual (non-group) annuity contract shall be issued only upon application of the ~~applicant.~~ annuitant or proposed owner. Any application ~~or enrollment form~~ form, whether paper or electronic, is subject to G.S. 58-3-150, and if taken by an agent, broker, or other producer, shall include the certificate of the ~~agent~~ agent, broker, or other producer that the ~~agent~~ agent, broker, or other producer has truly and accurately recorded on the application ~~or enrollment~~ form the information provided by the ~~applicant.~~ annuitant or proposed owner. Every annuity contract subject to this section shall contain as part of the contract the original or reproduction of the application required by this section.

(b) The agent, broker, or other producer shall provide to the annuitant or proposed owner a copy of any application executed in applying for any individual annuity contract. The delivery may be electronic unless the annuitant, the proposed owner, or the insurer instructs the agent, broker, or other producer to deliver the copy in paper form. The agent, broker, or other producer shall obtain from the proposed owner an acknowledgement of receipt of the copy of the executed application."

SECTION 15. G.S. 58-58-147 reads as rewritten:

"**§ 58-58-147. Surrender fees on death benefits.**

(a) ~~No authorized insurer shall deliver or issue for delivery in this State any~~ Any deferred annuity contract that contains a provision that reduces the death benefit of the contract by a surrender fee when death occurs during the surrender ~~period.~~ period shall include a statement to that effect in prominent print on the cover page of the first specifications page.

(b) Any deferred annuity for which the death benefit in any year is less than the account value shall include a statement to that effect in prominent print on the coverage page or the first specifications page."

SECTION 16. Article 63 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-63-75. Senior-specific certifications and professional designations; rules.**

The Commissioner may adopt rules to set forth standards to protect consumers from misleading and fraudulent marketing practices with respect to the use of senior-specific certifications and professional designations in the solicitation, sale, or purchase of, or advice made in connection with, a life insurance or annuity product. These rules shall be substantially similar to the NAIC Model Regulation on the Use of Senior-Specific Certifications and Professional Designations in the Sale of Life Insurance and Annuities, as amended. The Commissioner may adopt, amend, or repeal provisions of these rules under G.S. 150B-21.1 in order to keep these rules current with the NAIC model rule."

SECTION 17. G.S. 58-3-225(h) reads as rewritten:

"(h) Subject to the time lines required under this section, the insurer may recover overpayments made to the health care provider or health care facility by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of this section. Not less than 30 calendar days before an insurer seeks overpayment recovery or offsets future payments, the insurer shall give written notice to the health care provider or health care facility, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments ~~may be made not more than~~ shall be made within the two years after the date of the original claim payment unless the insurer has reasonable belief of fraud or other intentional misconduct by the health care provider or health care facility or its agents, or the claim involves a health care provider or health care facility receiving payment for the same service from a government payor. The health care provider or health care facility may recover underpayments or nonpayments by the insurer by making demands for refunds. Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by the insurer may include applicable interest under this section. ~~The period for which such recoveries may be made may not exceed~~ The recovery of underpayments or nonpayments shall be made within the two years after the date of the original claim adjudication, unless the claim involves a health provider or health care facility receiving payment for the same service from a government payor."

SECTION 18. G.S. 58-51-25 reads as rewritten:

"**§ 58-51-25. Policy coverage to continue as to mentally retarded or physically handicapped ~~children.~~children; coverage of dependent students on medically necessary leave of absence.**

(a) An individual or group accident and health insurance policy, hospital service plan policy, or medical service plan ~~policy, delivered or issued for delivery in this State after July 1, 1969, which~~ policy that provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract, shall also provide in substance that attainment of such limiting age shall not operate or terminate the coverage of such child while the child is and continues to be (i) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and (ii) chiefly dependent upon the policyholder or subscriber for support and maintenance: Provided, proof of such incapacity and dependency is furnished to the insurer, hospital service plan corporation, or medical service plan corporation by the policyholder or subscriber within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or corporation, but not more frequently than annually after the child's attainment of the limiting age.

(b) All health benefit plans, as defined in G.S. 58-3-167, that provide that coverage of a dependent child shall terminate upon a change in enrollment of the child in a postsecondary educational institution shall provide for the continued eligibility of the dependent child during a medically necessary leave of absence from the postsecondary educational institution in

accordance with all applicable requirements of Public Law 110-381, known as 'Michelle's Law.'"

SECTION 19. G.S. 58-3-215 is amended by adding the following new subsection to read:

"(d) Notwithstanding any other provision of this section, a health benefit plan, as defined in G.S. 58-3-167, and insurers, as defined in G.S. 58-3-167, shall comply with all applicable standards of Public Law 110-233 known as the 'Genetic Information Nondiscrimination Act of 2008' as amended by Public Law 110-343, and as further amended."

SECTION 20. G.S. 58-3-220 is amended by adding the following new subsections to read:

"(i) Notwithstanding any other provisions of this section, a group health benefit plan that covers both medical and surgical benefits and mental health benefits shall, with respect to the mental health benefits, comply with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

(j) Subsection (i) of this section applies only to a group health benefit plan covering a large employer as defined in G.S. 58-68-25(a)(10)."

SECTION 21. G.S. 58-51-50 is amended by adding the following new subsections to read:

"(f) Notwithstanding any other provisions of this section, a group health benefit plan that covers both medical and surgical benefits and chemical dependency treatment benefits shall, with respect to the chemical dependency treatment benefits, comply with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

(g) Subsection (f) of this section applies only to a group health benefit plan covering a large employer as defined in G.S. 58-68-25(a)(10)."

SECTION 22. G.S. 58-65-75 is amended by adding the following new subsections to read:

"(f) Notwithstanding any other provisions of this section, a group health benefit plan that covers both medical and surgical benefits and chemical dependency treatment benefits shall, with respect to the chemical dependency treatment benefits, comply with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

(g) Subsection (f) of this section applies only to a group health benefit plan covering a large employer as defined in G.S. 58-68-25(a)(10)."

SECTION 23. G.S. 58-67-70 is amended by adding the following new subsections to read:

"(g) Notwithstanding any other provisions of this section, a group health benefit plan that covers both medical and surgical benefits and chemical dependency treatment benefits shall, with respect to the chemical dependency treatment benefits, comply with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

(h) Subsection (g) of this section applies only to a group health benefit plan covering a large employer as defined in G.S. 58-68-25(a)(10)."

SECTION 24. G.S. 58-68-30(f) is amended by adding a new subdivision to read:

"(4) Special rules for application in case of Medicaid or State Children's Health Insurance Program (Title XXI of the Social Security Act). – 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 either of the following conditions is met:

a. Termination of Medicaid or State Children's Health Insurance Program. – The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State children's health plan under Title XXI of the Social Security Act and coverage of the employee or dependent under such a plan is terminated as a result of the loss of eligibility for such coverage and the employee requests coverage under the group health insurance coverage not later than 60 days after the termination of such coverage.

b. Eligibility for employment assistance under Medicaid or State Children's Health Insurance Program. – The employee or dependent becomes eligible for assistance, with respect to coverage under the group health insurance coverage, under such Medicaid plan or State child health plan (including any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance."

SECTION 25. G.S. 58-50-75(b) reads as rewritten:

"(b) This Part applies to all insurers that offer a health benefit plan and that provide or perform utilization review pursuant to G.S. 58-50-61, the State Health Plan for Teachers and State Employees, any optional plans or programs operating under Part 2 of ~~Article 3~~ Article 3A of Chapter 135 of the General Statutes, the North Carolina Health Insurance Risk Pool, and the Health Insurance Program for Children. With respect to second-level grievance review decisions, this Part applies only to second-level grievance review decisions involving no certification decisions."

SECTION 26. G.S. 58-50-79(b) reads as rewritten:

"(b) A covered person shall be considered to have exhausted the insurer's internal grievance process for purposes of this section, if the covered person:

(1) Has filed a second-level grievance involving a no certification appeal decision under G.S. 58-50-61 and G.S. 58-50-62, and

(2) Except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the insurer within 60 days since the date the covered person ~~filed the grievance with the insurer.~~can demonstrate that a grievance was filed with the insurer."

SECTION 27. G.S. 58-50-80(a) reads as rewritten:

"(a) Within ~~60~~ 120 days after the date of receipt of a notice under G.S. 58-50-77, a covered person may file a request for an external review with the Commissioner."

SECTION 28. G.S. 58-50-80(c) reads as rewritten:

"(c) If the finding of the preliminary review under subdivision (b)(2) of this section is that the request is not complete, the Commissioner shall request from the covered person the information or materials needed to make the request complete. The covered person shall furnish the Commissioner with the requested information or materials within ~~90~~ 150 days after the date of the insurer's decision for which external review is requested."

SECTION 29. The introductory paragraph of G.S. 58-50-82(a) reads as rewritten:

"(a) Except as provided in subsection (g) of this section, a covered person may ~~make a written or oral~~ file a request for an expedited external review with the Commissioner at the time the covered person receives:"

SECTION 30. G.S. 58-50-82(b)(1) reads as rewritten:

"(b) Within three business days of receiving a request for an expedited external review, the Commissioner shall complete all of the following:

(1) Notify the insurer that made the no certification, no certification appeal decision, or second-level grievance review decision which is the subject of the request that the request has been received and provide a copy of the ~~request or verbally convey all of the information included in the~~ request. The Commissioner shall also request any information from the insurer necessary to make the preliminary review set forth in G.S. 58-50-80(b)(2) and require the insurer to deliver the information not later than one business day after the request was made.

...."

SECTION 31. G.S. 58-50-82(f) reads as rewritten:

"(f) If the notice provided under subsection (e) of this section was not in writing, within two days after the date of providing that notice, the assigned organization shall provide written confirmation of the decision to the covered person, the covered person's provider who performed or requested the service, the insurer, and the Commissioner and include the information set forth in ~~G.S. 58-50-80(m).~~ G.S. 58-50-80(k).

Upon receipt of the notice of a decision under subsection (e) of this section that reverses the no certification, no certification appeal decision, or second-level grievance review decision, the insurer shall within one day reverse the no certification, noncertification appeal decision, or second-level grievance review decision that was the subject of the review and shall provide coverage or payment for the requested health care service or supply that was the subject of the noncertification, noncertification appeal decision, or second-level grievance review decision."

SECTION 32. G.S. 58-50-85(c) reads as rewritten:

"(c) ~~The Commissioner may determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet the minimum qualifications established under G.S. 58-50-87 will cause an independent review organization to be deemed to have met, in whole or in part, the requirements of this section and G.S. 58-50-87. A decision by the Commissioner to recognize an accreditation program for the purpose of granting deemed status may be made only after reviewing the accreditation standards and program information submitted by the accrediting body. An independent review organization seeking deemed status due to its accreditation shall submit original documentation issued by the accrediting body to demonstrate its accreditation.~~In order to be eligible for approval by the Commissioner, an independent review organization shall be accredited by a nationally recognized private accrediting entity that the Commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications established under G.S. 58-50-87. The Commissioner may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation."

SECTION 33. G.S. 58-50-90(b) reads as rewritten:

"(b) Each organization required to maintain written records on all requests for external review under subsection (a) of this section for which it was assigned to conduct an external review shall submit to the Commissioner, ~~at least annually,~~ upon the Commissioner's request, a report in the format specified by the Commissioner."

SECTION 34. G.S. 58-50-94(b) reads as rewritten:

"(b) After the public opening, the Commissioner shall review the proposals, examining the ~~costs and~~ quality of the services offered by the independent review organizations, the reputation and capabilities of the independent review organizations submitting the proposals, and the provisions in G.S. 58-50-85 and G.S. 58-50-87. The Commissioner shall determine which proposal or proposals would satisfy the provisions of this Part. The Commissioner shall

make his determination in consultation with an evaluation committee whose membership includes representatives of insurers subject to Part 4 of Article 50 of Chapter 58 of the General Statutes, health care providers, and insureds. In selecting the review organizations, in addition to considering cost, quality, and adherence to the requirements of the request for proposals, the Commissioner shall consider the desirability and feasibility of contracting with multiple review organizations and shall ensure that, for any given type of case involving highly specialized services and treatments, at least one review organization is available and capable of reviewing the case."

SECTION 35. G.S. 58-57-100(a) reads as rewritten:

"(a) Single interest or dual interest physical damage insurance may be written on nonfleet private passenger motor vehicles, as defined in G.S. 58-40-10, that are used as collateral for loans made under Article 15 of Chapter 53 of the General Statutes. Automobile physical damage insurance as described in this section is a form of credit property insurance, as referred to in G.S. 53-189. It is subject to the following conditions:

(1) Such insurance may be written only on a motor vehicle ~~on which there is a valid inspection sticker.~~that is in compliance with the inspection requirements of Part 2 of Article 3A of Chapter 20 of the General Statutes.

(2) If a motor vehicle is already insured and the lender is named loss payee and that insurance continues in force, then no other physical damage insurance may be written.

(3) Notification must be given orally and in writing to the borrower that he has the option to provide his own insurance coverage at any point during the term of the loan.

(4) The creditor must have either a first or second lien on the motor vehicle to be insured.

(5) The amount of insurance coverage may not exceed the lesser of (i) the principal amount of the loan plus allowable charges, excluding interest, plus two scheduled installment payments or (ii) the actual fair market value of the collateral at the time the insurance is written.

(6) When a creditor accepts other collateral in addition to a motor vehicle as herein defined, the combined insurance on all collateral may not exceed the initial indebtedness of the loan."

SECTION 36. Section 3 of S.L. 2005-183 reads as rewritten:

"**SECTION 3.** This act becomes effective October 1, ~~2005, and expires October 1, 2009.~~ 2005."

SECTION 37. Sections 34, 35 and 37 are effective when this act becomes law. The remainder of this act becomes effective October 1, 2009.

HOUSE BILL 1183:
Health and Other Insurance Law Changes.-AB

2009-2010 General Assembly

Committee:	House Insurance	**Date:**	April 20, 2009
Introduced by:	Reps. Goforth, Wray	**Prepared by:**	Ben Popkin
Analysis of:	PCS to First Edition H1183-CSRD-32		Committee Counsel

SUMMARY: House Bill 1183 would amend the following Articles of Chapter 58 - Insurance:

- Article 3 – General Regulations for Insurance.
- Article 50 – General Accident and Health Insurance Regulations.
- Article 51 - Nature of Policies.
- Article 54 – Medicare Supplement Insurance Minimum Standards.
- Article 56 – Third Party Administrators.
- Article 57 – Regulation of Credit Insurance.
- Article 58 – Life Insurance and Viatical Settlements.
- Article 63 – Unfair Trade Practices.
- Article 65 – Hospital, Medical, and Dental Service Corporations.
- Article 67 – Health Maintenance Organization Act.
- Article 68 – Health Insurance Portability and Accountability.

BILL ANALYSIS:

Section 1 – would amend the definition of 'creditable coverage' in G.S. 58-57-17 "Portability for accident and health insurance", to ensure that State law provides for portability of coverage between group and individual market.

Sections 2 & 3 – would amend Article 68 " Health Insurance Portability and Accountability" of Chapter 58 to insert definitions relating to group coverage and clarify that both individual and group health insurance coverage are considered to be health insurance coverage.

Section 4 – would amend the definition section of Article 68 to ensure that health insurance coverage includes both group and individual coverage and would remove reference to G.S. 58-51-15(a)(2)b (required policy provision relating to calculation of preexisting condition waiting period).

Section 5 – would delete incorrect reference to ERISA.

Sections 6 & 7 – would amend Articles 65 (Hospital, Medical, and Dental Service Corporations) and 67 (Health Maintenance Organization Act) to clarify applicability of preexisting condition calculation provision (G.S. 58-51-15(a)(2)b.) and portability provision (G.S. 58-51-17) to entities operating under the provisions of those articles.

Sections 8 & 9 – would amend accident and health policy provision (G.S. 58-51-15) and portability provision (G.S. 58-51-17) to apply these provisions to all accident and health insurance policies issued or delivered in the State and to certificates issued under policies issued and delivered to trusts or associations outside of the State that cover persons residing in the State.

Section 10 – would correct erroneous statutory provision in portability provision to identify individual not group health insurer.

Section 11 – would update reference to currently available standardized Medicare supplemental (Medigap) plans available.

Section 12 & 13 – would require that insurers who engage third party administrators (TPAs) of benefit plans with more than 100 certificate holders file audits with the Commissioner, in the manner specified by the Commissioner, on an annual basis, and that insurers maintain records of the audits for five years or, if a domestic insurer, until completion of its next quinquennial examination. Section 13 authorizes the Commissioner to adopt rules to implement this section.

Section 14 – would allow applications for annuities to be delivered electronically, unless paper copies are requested, and would receipts be provided for executed applications.

Section 15 – would remove existing prohibition against delivery or issuance in this State of "...any deferred annuity contract that contains a provision that reduces the death benefit of the contract...", to allow these provisions, with the requirement that deferred annuity contracts that contain provisions reducing death benefits include prominent statements to that effect.

Section 16 – would add a new section to Article 63 (Unfair Trade Practices) to authorize the Commissioner to adopt rules "...to protect consumers from misleading and fraudulent practices with respect to the use of senior-specific certifications and professional designations in the solicitation, sale, or purchase of...a life insurance or annuity product." Would direct that these rules be substantially similar to the NAIC Model Regulation on this issue.

Section 17 – would amend existing provision to clarify that time period within which over and underpayments of claims must be resolved is two years from date of original claim payment or adjudication.

Section 18 – would allow for continuation of health benefit plan coverage of dependent students on medically necessary leaves of absence from postsecondary educational institutions (Michelle's Law).

Section 19 – would require that health benefit plans and insurers comply with the Genetic Information Nondiscrimination Act of 2008 (Public Law 110-343).

Sections 20, 21, 22 & 23 – would require that group health benefit plans covering medical and surgical benefits and mental health benefits must comply with the Mental Health Parity and Addiction Equity Act of 2008 (Subtitle B of Title V of P. L. 110-343).

Section 24 – would allow for enrollment of eligible employees and their dependents into Medicaid or the State Children's Health Insurance Program (SCHIP) if they request enrollment within 60 days of termination of coverage or determination of eligibility.

Section 25 – would make external review of health benefit plan provisions applicable to the North Carolina Health Insurance Risk Pool.

Sections 26, 27, 28, 29, 30, 31, 32, 33 & 34 – would amend provisions of Part 4 (Health Benefit Plan External Review) of Article 50 of Chapter 58 to incorporate provisions of the NAIC Model Act (#76), modifying filing provisions and extending filing timelines relating to the grievance process.

Section 35 – would amend G.S. 58-57-100(a)(1) to reflect discontinuation of use of inspection stickers.

Section 36 – would repeal sunset of Article 91 (Interstate Insurance Product Regulation Compact Act).

EFFECTIVE DATE: Sections 34, 35 and 37 of the act would become effective when it becomes law, the remainder would be effective on October 1, 2009.

ATTACHMENT #1

VISITOR REGISTRATION SHEET

House Insurance — April 15, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Pamela Schore	NCASA
Patrick Buffkin	NMRS
Rose Williams	DOI
John Short	Fortegra Financial
Joe McCaw	Fortegra Financial
John Bowdrich	AstraZeneca
PATRICK HANNAH	LIBERTY MUTUAL
TYLER NEWMAN	BASF
Jessi Hays	NC HBA
David McGowan	NC Realtors
Glenn Jernigan	~~Insurance~~ Auto Insurance Agents of N.C

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Carroll	NC Farm Bureau Ins.
Henry Mesham	NCIUA
Lee E. Dunn, Jr.	NCIUA / NCJUA
Alvin Ashworth	NCIUA / NCJUA
Robert Passaro	Young Moore
Will Culpepper	Moore + Van Allen
Marlowe Foster	Pfizer
Carol Durrell	State Health Plan
Jack W. Walker	State Health Plan
Bill Tibbons	Farmers Group Inc.
[illegible]	Bryan Simpson

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Annaliese Dolph	DR NC
Lucy Lawrence	Warren Wilson College Asheville NC
Kate Donaldson	" "
Sara Fagan	Warren Wilson
Amelia Cleveland-Stevens	Warren Wilson College, Asheville, NC
Sara Slaughter	Warren Wilson College, Asheville, NC
Allison Canon	Warren Wilson College, Asheville, NC
Scott Mooney	The Insider
Sheyna Alterovitz	AARP
Ed Regan	NCRGEA
Bill Trott	Young Moore & Henderson PA

VISITOR REGISTRATION SHEET

House Committee on Insurance

Name of Committee **Date**

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Russ Dubisky	State Farm
Daniel Baum	K+L Gates
Bill Rustin	AARP
Julian Philpott	NCFB
Nate Fergus, M.D	CHS
Nathan Batts	NCBA
Alex Mansfield	FCB
Renee Wimbish	Rep Folwell's LA
Jamal Jones	NCHA
Michelle Brooks	University Health Systems Eastern Carolina
Karen McLeod	CFSA-NC

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Duke Geraghty	OBHBA - NC 20 817 Hwy 64 Manted
JACK REGISTER	National Assoc of Social Workers-NC

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John McMillan	MF+S
Michelle Frazier	MF+S
Jennifer Cohen	AFNC
Kathleen Riely	NRAR
Cam Cover	BPMLL
Susan Valaun	Nationwide
Chuck Adams	SEAK
Kathy Hartkopf	Freedom Works
Kelley Eistine	IIANC
[illegible]	NMRS
DWIGHT EISENHOWER	MILITARY INDUSTRIAL COMPLEX

VISITOR REGISTRATION SHEET

House Committee on Insurance

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ken Melton	K.M.A.
Kelli Kuhn	Duke
Elizabeth Dalton	NCHCMA
Amy McConkey	Smith Anderson
Chris Valauri	Valauri Group LLC

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	BCS

VISITOR REGISTRATION SHEET

House Insurance — April 15, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Stollen	State Farm
Hay Kaplan	MWC
Bob Mack	NCDOI
Ken Cabe	NCDOT
Rose V. Williams	NC DOI
Fred Fuller	NCDOI
Louis Belo	NCDOI
Alice Garland	NCEL
Richard Krumdieck	NCOA
Jennie Crews	NCOA
TED Hamby	NC DOI

House Pages

Insurance

Name of Committee : _____ **Date:** 4-21-09

1. Name: Shawna Wood
   County: Sanford
   Sponsor: Tarheel Challenge
2. Name: Capstal D. Bradford
   County: Cumberland
   Sponsor: Tarheel Challenge Academy
3. Name: _____
   County: _____
   Sponsor: _____
4. Name: _____
   County: _____
   Sponsor: _____
5. Name: _____
   County: _____
   Sponsor: _____

Sgt-At-Arms

1. Name: Charles Williams
2. Name: Martha Goodison
3. Name: Rod Finger
4. Name: Bob Rossi

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 1164 A BILL TO BE ENTITLED AN ACT REQUESTED BY THE COMMISSIONER OF INSURANCE TO ELIMINATE OBSOLETE DATA COLLECTION REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS.

☒ 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 _____.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 1183 A BILL TO BE ENTITLED AN ACT TO MAKE VARIOUS CHANGES IN THE LAWS GOVERNING HEALTH INSURANCE AND MANAGED CARE; TO CHANGE CERTAIN HEALTH INSURANCE LAWS TO COMPORT WITH RECENT CONGRESSIONAL ENACTMENTS; TO MAKE A TECHNICAL CORRECTION IN A CREDIT INSURANCE LAW; AND TO REPEAL THE EXPIRATION DATE OF THE INTERSTATE INSURANCE PRODUCT REGULATION COMPACT ACT.

☒ 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.

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

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

DAY & DATE: **Tuesday, April 21, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

HB 426 – STAY ON HOMEOWNERS INSURANCE ACTIONS – Reps. Spear, Wainwright, Owens & McElraft

HB 26 – STAY BEACH PLAN RATES, DEDUCTIBLE, SURCHARGES – Reps. Spear, Grady, Justice, McElraft, Stiller and Underhill

HB 742 – PROHIBIT BEACH PLAN SURPLUS DISTRIBUTION – Reps. Spear, Goforth, Justice, McComas, McElraft, Stiller and Wainwright

HB 438 – STAY HEALTH PLAN/CALENDAR YEAR – Reps. Folwell, Holliman, Blackwell and Blue

HB 439 – STATE HEALTH PLAN/TAXPAYER RECOVERY ACT – Reps. Folwell, England, Hurley and Hall

HB 1164 – MODERNIZE HMO OVERSIGHT REQUIREMENTS – Reps. Goforth and Wray

HB 1183 – HEALTH AND OTHER INSURANCE LAW CHANGES – Reps. Goforth and Wray

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at **2:00 pm** on **April 17, 2009.**

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 28, 2009

The House Committee on Insurance met at 11:00 AM on Tuesday, April 28, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael H. Wray; Vice Chairs: M. Dickson, J. Dockham and M. Setzer. Members attending were Reps. Blust, Braxton, Brubaker, Cole, Current, Faison, Gibson, Holliman, Howard, Hughes, Lewis, Pierce and Wainwright.

Chairman Goforth called the meeting to order and welcomed visitors. He recognized Sgt-At-Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachment #1)

Chairman Goforth recognized Rep. Spear to explain HB 742 – Prohibit Beach Plan Surplus Distribution. Rep. Spear stated the bill simply amends the current statute that provides that the surplus funds in the Beach Plan cannot be distributed out as part of the funds distributed to member companies now simply by a vote of the Board of Directors. This bill says those monies will be held in reserve and cannot be distributed out as profits to the companies. There is no opposition to the bill and Commissioner Goodwin is here in support of the bill. Rep. Current moved for a favorable report for HB 742 and re-referred to the Committee on Judiciary II. Motion carried.

Rep. Folwell was called upon to explain HB 439 – State Health Plan/Taxpayer Recovery Act. HB - 439 would require the State Health Plan to pay coverage benefits for county or city ambulance services directly to the provider or make the payments co-payable to the provider. The bill attempts to cut down on fraud for the State Health Plan and the local County Commissioners where people ride the ambulance, get paid from the State Health Plan but do not remit the money. There is no opposition to the bill. After questions, Rep. Lewis moved for a favorable report for HB 439 and re-referred to Appropriations. Motion carried.

Rep. Harrell was called upon to explain HB 896 – Cancer Drug Coverage Changes. Rep. Harrell stated HB 896 would amend the statutory reference to specific drug compendia relating to the coverage of cancer treatment drugs by various health insurance policies to update the reference to reflect the most current compendia available. Rep. Gibson moved for a favorable report for HB 896, and it carried.

Rep. Dockham was called upon to explain HB 964 – Insurance Guaranty Association Amendments. Rep. Dickson was recognized for a motion to have a PCS before the committee. Rep. Dockham stated that the Guaranty Association is a nonprofit unincorporated entity created by the state to protect North Carolina insurance policy holders and claimants from financial losses and delays in claim payments due to the insolence of a member property and casualty carrier. HB 964 would allow the North Carolina Insurance Guaranty Association to contract or be designated to handle the adjustment of claims for another entity, subject to the approval of the Association's Board and the Commissioner of Insurance. Rep. Braxton moved for a favorable report to the PCS for HB 964, unfavorable as to the original bill and recommendation

that the committee substitute bill be re-referred to the Committee on Judiciary II. Motion carried.

The meeting adjourned at 11:40 AM.

Representative Bruce Goforth, Chairman

Mary Capps – Committee Assistant

HOUSE INSURANCE COMMITTEE

April 28, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

HB 439 – STATE HEALTH PLAN/TAXPAYER RECOVERY ACT – Reps. Folwell, England, Hurley and Hall

HB 896 – CANCER DRUG COVERAGE CHANGES – Reps. Harrell, England and Faison

HB 964 – INSURANCE GUARANTY ASSOCIATION AMENDMENTS - Reps. Dockham and Braxton

HB 1162 – DOI DISASTER POWERS APPLY TO SHP – Reps. Wray and Goforth

Adjourn

HOUSE BILL 742

Short Title:	Prohibit Beach Plan Surplus Distribution.	(Public)
Sponsors:	Representatives Spear; Goforth, Justice, McComas, McElraft, Stiller, and Wainwright.	
Referred to:	Insurance, if favorable, Judiciary II.	

March 24, 2009

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE RETENTION OF ACCUMULATED SURPLUS BY THE NORTH CAROLINA INSURANCE UNDERWRITING ASSOCIATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-45-25 reads as rewritten:

"**§ 58-45-25. Each member of Association to participate in its ~~expenses, profits, and losses.~~expenses and losses.**

(a) Each member of the Association shall participate in the ~~expenses, profits,~~ expenses and losses of the Association in the proportion that its net direct premium written in this State during the preceding calendar year for residential and commercial properties outside of the beach and coastal areas bears to the aggregate net direct premiums written in this State during the preceding calendar year for residential and commercial properties outside of the beach and coastal areas by all members of the Association, as certified to the Association by the Commissioner. The Commissioner shall certify each member's participation after review of annual statements and any other reports and data necessary to determine participation and may obtain any necessary information or data from any member of the Association for this purpose. Any insurer that is authorized to write and that is engaged in writing any insurance, the writing of which requires the insurer to be a member of the Association under G.S. 58-45-10, shall become a member of the Association on the first day of January after authorization. The determination of the insurer's participation in the Association shall be made as of the date of membership of the insurer in the same manner as for all other members of the Association.

(b) All member companies shall receive credit each year for essential property insurance, farmowners insurance, homeowners insurance, and the property portion of commercial multiple peril policies voluntarily written in the beach and coastal areas in accordance with guidelines and procedures to be submitted by the Directors to the Commissioner for approval. The participation of each member company in the ~~expenses, profits, and losses~~expenses and losses of the Association shall be reduced accordingly; provided, no credit shall be given where coverage for the peril of wind has been excluded. The guidelines and procedures for granting credit shall encourage and assist each member company to voluntarily write these coverages in the beach and coastal areas for commercial and residential properties.

(c) The North Carolina Insurance Underwriting Association shall use the "take out" program, as filed with and approved by the Commissioner, in the coastal area.

(d) The accumulated surplus of the Association shall be retained from year to year and used to pay losses, reinsurance costs, and other operating expenses as necessary. No member company shall be entitled to the distribution of any portion of the Association's surplus."

SECTION 2. This act is effective when it becomes law.

HOUSE BILL 742:
Prohibit Beach Plan Surplus Distribution

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Judiciary II	**Date:**	April 20, 2009
Introduced by:	Rep. Spear	**Prepared by:**	Tim Hovis
Analysis of:	First Edition		Committee Counsel

SUMMARY: ***House Bill 742 amends G.S. 58-45-25,*** *Each member of Association to participate in its expenses, profits, and losses,* ***to provide that the accumulated surplus of the North Carolina Insurance Underwriting Association (NCIUA), also known as the Beach Plan, must be retained and used to pay losses resulting from hurricanes and other events, reinsurance costs, and other operating expenses as necessary. The bill specifically provides that no member is entitled to the distribution of any portion of the Association's surplus.***

The bill also changes the heading and amends the statute to delete the word "profits." Without distribution of the surplus, member insurers will not participate in the profits of the Plan, only the expenses and losses.

CURRENT LAW: Under the current law, the Board of Directors of the NCIUA can choose to distribute the surplus to the member companies.

However, in 2005, the Board of Directors of the Beach Plan voted to begin retaining the Plan's surplus up to $750 million dollars. Four years ago, the Plan had just under $200 million dollars in surplus. In December of 2008, the Board increased the ceiling on the retention of surplus to $1.1 billion dollars. These changes requiring retention of the surplus to specified amounts were approved by the Commissioner and, once approved, would require the Commissioner's approval to be rescinded. Currently, the Plan has over $700 million dollars in surplus.

EFFECTIVE DATE: House Bill 742 is effective when it becomes law.

H742-SMRG-12(e1) v4

HOUSE BILL 439:
State Health Plan/Taxpayer Recovery Act

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Appropriations	**Date:**	April 20, 2009
Introduced by:	Reps. Folwell, England, Hurley, Hall	**Prepared by:**	Bill Patterson
Analysis of:	First Edition		Committee Counsel

SUMMARY: House Bill 439 would require the State Health Plan to pay coverage benefits for county or city ambulance services directly to the provider or make the payments copayable to the provider.

CURRENT LAW: Currently, the State Health Plan pays coverage benefits for in-network city or county ambulance services directly to the provider, but coverage benefits for out-of-network county or city ambulance services are paid to the subscriber only.

BILL ANALYSIS: House Bill 439 would require the State Health Plan to pay benefits directly to the provider, or make the payment co-payable to the provider, for services provided by an ambulance service owned or franchised by a county or supplemented with county funds, or owned and operated by a municipality or supplemented by municipal funds.

EFFECTIVE DATE: This act becomes effective July 1, 2009, and would apply to county or city ambulance services provided on and after that date.

H439-SMTG-25(e1) v3

HOUSE BILL 439

Short Title:	State Health Plan/Taxpayer Recovery Act.	(Public)
Sponsors:	Representatives Folwell, England, Hurley, Hall (Primary Sponsors); Blackwood, Bryant, Cleveland, Current, Dockham, Glazier, Gulley, Harrison, Langdon, Luebke, Samuelson, Starnes, and Weiss.	
Referred to:	Insurance, if favorable, Appropriations.	

March 9, 2009

A BILL TO BE ENTITLED

AN ACT TO REDUCE THE FINANCIAL LOSS TO COUNTIES AND CITIES FOR UNREIMBURSED COUNTY OR CITY AMBULANCE SERVICES PROVIDED TO STATE HEALTH PLAN MEMBERS BY REQUIRING THE STATE HEALTH PLAN TO MAKE PAYMENTS FOR COUNTY OR CITY AMBULANCE SERVICES DIRECTLY OR CO-PAYABLE TO THE COUNTY OR CITY AMBULANCE SERVICE PROVIDER.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-43 is amended by adding the following new subsection to read:

"(c) Allowable payments for services provided by a county or city ambulance service shall be paid directly or shall be co-payable to the county or city ambulance service provider. As used in this subsection, 'county or city ambulance service' means ambulance services provided by a county or county-franchised ambulance service supplemented by county funds, or a municipally owned and operated ambulance service or by an ambulance service supplemented by municipal funds."

SECTION 2. This act becomes effective July 1, 2009, and applies to county or city ambulance services provided on and after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: House Bill 439 (First Edition)

SHORT TITLE: State Health Plan/Taxpayer Recovery Act.

SPONSOR(S): Representatives England, Folwell, Hurley, and Hall

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY: The bill requires reimbursement payments for city or county ambulance services to be paid by the Plan directly to the city or county ambulance service provider, or made co-payable to the provider and plan member.

EFFECTIVE DATE: July 1, 2009, and applies to county or city ambulance services provided on and after that date.

ESTIMATED IMPACT ON STATE:

Aon Consulting, the consulting actuary for the State Health Plan for Teachers and State Employees, estimates that the bill will have no financial impact on medical claims, but will have administrative costs of approximately $43,000 to $76,000 to implement the bill's requirements assuming ambulance services are paid by direct method.

Hartman & Associates, the consulting actuary for the General Assembly's Fiscal Research Division, estimates that the bill will have no financial impact on the Plan's medical claims payments. Based on the Plan's staff comments, administrative costs to implement the bill's provisions of approximately $43,000 to $76,000 assuming ambulance services are paid by direct method.

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

The estimate of no impact to the Plan's medical costs is based on the assumption that the Plan will maintain its current percentage number of in-network ambulance service providers relative to the number of out-of-network ambulance providers. This assumption is based on the application of the bill being limited to ambulance services reimbursed by the Plan only, and not those reimbursed by the total commercial provider network the Plan participates in through its Claims Processing Contractor (CPC).

Data to estimate potential savings from alleged over utilization of services by Plan members who use out-of-network ambulance providers excessively was not available. In discussions with several county emergency medical service providers, whom currently do not contract with the CPC, there were several anecdotal examples of individuals utilizing ambulance services excessively and in turn not reimbursing the county ambulance service provider once the CPC made payment to the individual. None of the anecdotal examples given could be attributed to services paid for by the Plan on behalf of a plan member, but were related to the CPC's provider network through which the Plan participates.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2008, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.6 billion for FY 2008-09. The Plan's PPO benefit design includes three alternative benefit levels offered to plan members. The three alternative benefit levels include the following:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums;

2) The "Standard" 80/20 plan; and

3) The "Plus" 90/10 plan with enhanced benefits via lower out-of pocket requirements as compared to the other PPO plan alternatives offered.

Employees and retired employees electing coverage under the Plus alternative must make a partially contributory premium contribution for their own coverage. The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under all plans is offered on a fully contributory basis.

Financial Condition

Financial Projection (Revised) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year are projected to be $2.3 billion from premium collections, $53.9 million from Medicare Part D subsidies, and $2.7 million from investment earnings, for a total of slightly over $2.3 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.4 billion in claim-payment expenses and $168.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating loss is projected to be approximately $264.4 million for the fiscal year, assuming a 9% annual claims growth trend.

Projected operating losses are expected to deplete the Plan's cash balance of $139.8 million and leave it without sufficient operating resources to continue operations for the fiscal year. It is currently estimated by the Plan's Executive Administrator that the Plan will not be able to pay claims on a timely basis by March 31, 2009.

Consequently, the reforecast of Plan finances now indicates that the Plan will require up to $300 million in additional resources to operate for the balance of the 2008-09 fiscal year. This amount represents the estimated funds necessary to pay claims and administrative expenses through June 30, 2009, plus funding a minimum stabilization reserve equal to 7.5% of projected claims, and assuming a future premium rate increase effective October 1, 2009.

Other Information

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment Data as of December 31, 2008

I. No. of Participants	Basic	Standard	Plus	Total	Percent of Total
Actives					
Employees	11,623	271,243	47,687	330,553	49.6%
Dependents	20,454	115,875	28,156	164,485	24.7%
Sub-total	32,077	387,118	75,843	495,038	74.2%
Retired					
Employees	1,726	127,081	17,967	146,774	22.0%
Dependents	1,117	14,935	3,476	19,528	2.9%
Sub-total	2,843	142,016	21,443	166,302	24.9%
Former Employees with Continuation Coverage					
Employees	60	1,349	344	1,753	0.3%
Dependents	61	501	182	744	0.1%
Sub-total	121	1,850	526	2,497	0.4%
Firefighters, Rescue Squad & National Guard					
Employees	-	3	2	5	0.0%
Dependents	-	3	-	3	0.0%
Sub-total	-	6	2	8	0.0%
Local Governments					
Employees	72	1,577	319	1,968	0.3%
Dependents	141	637	218	996	0.1%
Sub-total	213	2,214	537	2,964	0.4%
Total					
Employees	13,481	401,253	66,319	481,053	72.1%
Dependents	21,773	131,951	32,032	185,756	27.9%
Grand Total	**35,254**	**533,204**	**98,351**	**666,809**	**100%**
Percent of Total	**5.3%**	**80.0%**	**14.7%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	2,684	328,635	49,246	380,565
Employee Child(ren)	4,958	36,903	8,589	50,450
Employee Spouse	2,274	18,145	4,469	24,888
Employee Family	3,565	17,570	4,015	25,150
Total	**13,481**	**401,253**	**66,319**	**481,053**

Percent Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	19.9%	81.9%	74.3%	79.1%
Employee Child(ren)	36.8%	9.2%	13.0%	10.5%
Employee Spouse	16.9%	4.5%	6.7%	5.2%
Employee Family	26.4%	4.4%	6.1%	5.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Enrollment Data Continued

III. Enrollment by Sex	Basic	Standard	Plus	Total
Female	18,837	334,917	61,752	415,506
Male	16,417	198,287	36,599	251,303
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Sex	Basic	Standard	Plus	Total
Female	53.4%	62.8%	62.8%	62.3%
Male	46.6%	37.2%	37.2%	37.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	17,390	136,277	27,211	180,878
30 to 44	8,125	107,375	17,315	132,815
45 to 54	5,164	94,548	18,277	117,989
55 to 64	3,195	102,901	23,452	129,548
65 & Over	1,380	92,103	12,096	105,579
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	49.3%	25.6%	27.7%	27.1%
30 to 44	23.0%	20.1%	17.6%	19.9%
45 to 54	14.6%	17.7%	18.6%	17.7%
55 to 64	9.1%	19.3%	23.8%	19.4%
65 & Over	3.9%	17.3%	12.3%	15.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	49,534	12,080	61,614
Medicare Eligible	97,240	7,448	104,688
Total	**146,774**	**19,528**	**166,302**

Percent by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.7%	61.9%	37.0%
Medicare Eligible	66.3%	38.1%	63.0%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, "House Bill 439: An Act to Require the State Health Plan to Make Payments for County of City Ambulance Services Directly or Co-Payable to the Provider", April 16, 2009, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "House Bill 439 State Health Plan/Taxpayer Recovery Act", April 16, 2009, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Marilyn Chism, Director
Fiscal Research Division

DATE: April 21, 2009

Signed Copy Located in the NCGA Principal Clerk's Offices

NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

HOUSE BILL 439

STATE HEALTH PLAN / TAXPAYER RECOVERY ACT

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30305

April 2009

ACTUARIAL STATEMENT

The North Carolina State Health Plan for Teachers and State Employees has requested that Aon Consulting prepare an Actuarial Note in response to House Bill 439 entitled "An Act To Reduce The Financial Loss To Counties And Cities For Unreimbursed County Or City Ambulance Services Provided To State Health Plan Members By Requiring The State Health Plan To Make Payments For County Or City Ambulance Services Directly Or Co-Payable To The County Or City Ambulance Service Provider."

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

April 16, 2009

Kenneth C. Vieira, F.S.A., M.A.A.A.
Senior Vice President

Date

April 16, 2009

Kirsten R. Schatten, A.S.A., M.A.A.A.
Assistant Vice President

Date

STATE HEALTH PLAN / TAXPAYER RECOVERY ACT

PLAN CHANGES

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-43 is amended by adding the following new subsection to read:

"(c) Allowable payments for services provided by a county or city ambulance service shall be paid directly or shall be co-payable to the county or city ambulance service provider. As used in this subsection, 'county or city ambulance service' means ambulance services provided by a county or county-franchised ambulance service supplemented by county funds, or a municipally owned and operated ambulance service or by an ambulance service supplemented by municipal funds."

SECTION 2. This act becomes effective July 1, 2009, and applies to county or city ambulance services provided on and after that date.

PROJECTED COSTS

	Based on "Midpoint" Increase (in millions)		
Plan Design Change	2009-2010 Fiscal Year Cost	2010-2011 Fiscal Year Cost	Total Biennium Cost
Pay non-participating county/city ambulance services directly	$.04-$.08		$.04-$.08

* Based on total projected expenses of $2,687,502,073 and $2,919,507,795 for the 2010 and 2011 fiscal years respectively.

PRICING APPROACH AND COMMENTS

The following information was compiled and utilized in determining the projected costs or savings of each benefit component addressed in this actuarial note:

- We expect no financial impact to medical costs based on county/city ambulance services receiving payment directly or through co-payable checks. However, if fraud exists based on the current payment structure, medical costs may be slightly reduced through this plan design change.

- The implementation cost for this bill is projected to be between $43,000 and $76,000 based on paying ambulance services directly. The implementation cost for the copayable option is expected to be more costly.

HARTMAN & ASSOCIATES, LLC

ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

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Phone: (336) 731-4038
Fax: (336) 731-2583

668 Link Road
Lexington, NC 27295

April 16, 2009

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: House Bill 439: An Act to Require the State Health Plan to Make Payments for County or City Ambulance Services Directly or Co-Payable to the Provider

Dear Mr. Trogdon:

This bill adds a new section to G.S. 135-43 to provide that the North Carolina State Health Plan for Teachers and State Employees (the "Plan") shall make payments for services provided by a county or city ambulance service directly or co-payable to the county or city ambulance service provider. This act is effective July 1, 2009 and applies to services provided on or after that date.

This bill is intended to reduce the financial loss to counties and cities for unreimbursed ambulance services. This provision would change the payee for such services. This bill is not expected to have a material financial impact on the Plan's medical costs.

The Plan has estimated administrative costs to implement the procedures of this bill at $43,000 to $76,000.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, FCA, EA
Consulting Actuary

MVH/mt

HOUSE BILL 896

Short Title:	Cancer Drug Coverage Changes.	(Public)
Sponsors:	Representatives Harrell, England, Faison (Primary Sponsors); K. Alexander, Bell, Glazier, Hall, Harrison, Insko, Jones, Lucas, Pierce, Stevens, Stewart, Wainwright, and Whilden.	
Referred to:	Health, if favorable, Insurance.	

March 31, 2009

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE CANCER COMPENDIA STATUTE TO REFLECT NEW COMPENDIA THAT ARE AVAILABLE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-51-59 reads as rewritten:

"**§ 58-51-59. Coverage of certain prescribed drugs for cancer treatment.**

(a) No policy or contract of accident or health insurance, and no preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, and that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

(1) ~~The American Medical Association Drug Evaluations;~~ The National Comprehensive Cancer Network Drugs & Biologics Compendium;

(2) ~~The American Hospital Formulary Service Drug Information; or~~ The ThomsonMicromedex DrugDex;

(3) ~~The United States Pharmacopeia Drug Information.~~ The Elsevier Gold Standard's Clinical Pharmacology; or

(4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

(b) Notwithstanding subsection (a) of this section, coverage shall not be required for any experimental or investigational drugs or any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

(c) This section shall apply only to cancer drugs and nothing in this section shall be construed, expressly or by implication, to create, impair, alter, limit, notify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition."

SECTION 2. G.S. 58-65-94 reads as rewritten:

"**§ 58-65-94. Coverage of certain prescribed drugs for cancer treatment.**

(a) No insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and no preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after

January 1, 1994, and that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

(1) ~~The American Medical Association Drug Evaluations;~~ The National Comprehensive Cancer Network Drugs & Biologics Compendium;

(2) ~~The American Hospital Formulary Service Drug Information; or~~ The ThomsonMicromedex DrugDex;

(3) ~~The United States Pharmacopeia Drug Information.~~ The Elsevier Gold Standard's Clinical Pharmacology; or

(4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

(b) Notwithstanding subsection (a) of this section, coverage shall not be required for any experimental or investigational drugs or any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

(c) This section shall apply only to cancer drugs and nothing in this section shall be construed, expressly or by implication, to create, impair, alter, limit, notify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition."

SECTION 3. G.S. 58-67-78 reads as rewritten:

"**§ 58-67-78. Coverage of certain prescribed drugs for cancer treatment.**

(a) No health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1994, and that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

(1) ~~The American Medical Association Drug Evaluations;~~ The National Comprehensive Cancer Network Drugs & Biologics Compendium;

(2) ~~The American Hospital Formulary Service Drug Information; or~~ The ThomsonMicromedex DrugDex;

(3) ~~The United States Pharmacopeia Drug Information.~~ The Elsevier Gold Standard's Clinical Pharmacology; or

(4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

(b) Notwithstanding subsection (a) of this section, coverage shall not be required for any experimental or investigational drugs or any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

(c) This section shall apply only to cancer drugs and nothing in this section shall be construed, expressly or by implication, to create, impair, alter, limit, notify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition."

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

HOUSE BILL 896:
Cancer Drug Coverage Changes

2009-2010 General Assembly

Committee:	House Insurance	**Date:**	April 27, 2009
Introduced by:	Reps. Harrell, England, Faison	**Prepared by:**	Ben Popkin Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***House Bill 896 would amend the statutory reference to specific drug compendia relating to the coverage of cancer treatment drugs by various health insurance policies to update the reference to reflect the most current compendia available.***

CURRENT LAW: Article 51 of Chapter 58 provides for the Nature of Insurance Policies and Section 59 of this Article provides for the required coverage of certain prescribed drugs for cancer treatment.

Article 65 governs any corporation organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital or medical or dental service plan whereby hospital care or medical or dental service may be provided in whole or in part by the corporation or by hospitals, physicians, or dentists participating in the plan and Section 94 provides for the coverage of certain prescribed drugs for cancer treatment.

Article 67 governs Health Maintenance Organizations in North Carolina and Section 78 of this Article provides for the coverage of certain prescribed drugs for cancer treatment.

BILL ANALYSIS: House Bill 896 would amend G.S. 58-51-59, G.S. 58-65-94, and G.S. 58-67-78 by replacing the existing compendia references with the following references:

- The National Comprehensive Cancer Network Drugs and Biological Compendium
- The Thomson Micromedex DrugDex
- The Elsevier Gold Standard's Clinical Pharmacology
- Any other authoritative compendia recognized periodically by the United States Secretary of Health and Human Services.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: In 1993, the U.S. Congress directed the Medicare program to refer to 3 existing published compendia, *American Medical Association Drug Evaluations*, *United States Pharmacopoeia Drug Information for the Health Professional*, and *American Hospital Formulary Service Drug Information*, to identify unlabeled but medically accepted uses of drugs and biologicals in anticancer chemotherapy regimens.[1]

The American Medical Association Drug Evaluations is no longer published; the *United States Pharmacopeia Drug Information for the Health Professional* was discontinued in 2007 and its contents were incorporated into a successor compendium, DrugPoints. In 2008, (CMS) added *Clinical Pharmacology*, DRUGDEX, and *National Comprehensive Cancer Network Drugs and Biologics Compendium* to its list of approved compendia.

Shawn Parker, Staff to House Health, substantially contributed to this summary.

H896-SMRD-67(e1) v1

[1] http://www.annals.org/cgi/content/full/0000605-200903030-00109v1

HOUSE BILL 964:
Insurance Guaranty Association Amendments

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Judiciary II	**Date:**	April 27, 2009
Introduced by:	Reps. Dockham, Braxton	**Prepared by:**	Kory Goldsmith Committee Counsel
Analysis of:	PCS to First Edition H964-CSRC-15		

SUMMARY: ***House Bill 964 would allow the North Carolina Insurance Guaranty Association to contract or be designated to handle the adjustment of claims for another entity, subject to the approval of the Association's Board and the Commissioner of Insurance.***

The PCS removes an unnecessary Section of the bill.

CURRENT LAW: The North Carolina Insurance Guaranty Association (Association) is a nonprofit, unincorporated legal entity created by statute (See Article 48 of Chapter 58 of the General Statutes.) It is made up of all insurers in the State that offer property and casualty insurance including that for automobiles and workers' compensation.

The Association is required cover claims of insureds in the event the insurer becomes insolvent. The obligation is the amount of each covered claim over $50, but not to exceed $300,000, unless the covered claim is under a policy of workers' compensation, in which case the Association must pay the full amount of the covered claim. The Association also assists in the detection and prevention of insurer insolvencies, and assesses the cost of such protection among insurers.

EFFECTIVE DATE: This act is effective when it becomes law.

H964-SMRC-21(CSRC-15) v2

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 964
PROPOSED COMMITTEE SUBSTITUTE H964-CSRC-15 [v.1]

4/27/2009 8:08:16 PM

Short Title: Insurance Guaranty Association Amendments. (Public)

Sponsors:

Referred to:

April 2, 2009

A BILL TO BE ENTITLED

AN ACT TO EXPAND THE DISCRETIONARY POWERS OF THE INSURANCE GUARANTY ASSOCIATION TO ALLOW IT TO CONTRACT AS A SERVICING FACILITY FOR OTHER ENTITIES AND CONFORM THE ASSOCIATION'S STATUTORY IMMUNITY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-48-35 reads as rewritten:

"**§ 58-48-35. Powers and duties of the Association.**

...

(b) The Association may:

(1) Employ or retain such persons as are necessary to handle claims and perform other duties of the Association.

(2) Borrow funds necessary to effect the purposes of this Article in accord with the plan of operation.

(3) Sue or be sued.

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this Article.

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this Article.

(6) Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities if, at the end of any calendar year, the board of directors finds that the assets of the Association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year.

(7) Be designated or may contract as a servicing facility for any entity which may be recommended by the Association's board of directors and approved by the Commissioner of Insurance."

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 964
PROPOSED COMMITTEE SUBSTITUTE H964-CSRC-15 [v.1]

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(7) Be designated or may contract as a servicing facility for any entity which may be recommended by the Association's board of directors and approved by the Commissioner of Insurance."

SECTION 2. This act is effective when it becomes law.

HOUSE BILL 964:
Insurance Guaranty Association Amendments

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Judiciary II	**Date:**	April 27, 2009
Introduced by:	Reps. Dockham, Braxton	**Prepared by:**	Kory Goldsmith Committee Counsel
Analysis of:	PCS to First Edition H964-CSRC-15		

SUMMARY: ***House Bill 964 would allow the North Carolina Insurance Guaranty Association to contract or be designated to handle the adjustment of claims for another entity, subject to the approval of the Association's Board and the Commissioner of Insurance.***

The PCS removes an unnecessary Section of the bill.

CURRENT LAW: The North Carolina Insurance Guaranty Association (Association) is a nonprofit, unincorporated legal entity created by statute (See Article 48 of Chapter 58 of the General Statutes.) It is made up of all insurers in the State that offer property and casualty insurance including that for automobiles and workers' compensation.

The Association is required cover claims of insureds in the event the insurer becomes insolvent. The obligation is the amount of each covered claim over $50, but not to exceed $300,000, unless the covered claim is under a policy of workers' compensation, in which case the Association must pay the full amount of the covered claim. The Association also assists in the detection and prevention of insurer insolvencies, and assesses the cost of such protection among insurers.

EFFECTIVE DATE: This act is effective when it becomes law.

H964-SMRC-21(CSRC-15) v2

HOUSE BILL 964

Short Title:	Insurance Guaranty Association Amendments.	(Public)
Sponsors:	Representatives Dockham and Braxton (Primary Sponsors).	
Referred to:	Insurance, if favorable, Judiciary II.	

April 2, 2009

A BILL TO BE ENTITLED

AN ACT TO EXPAND THE DISCRETIONARY POWERS OF THE INSURANCE GUARANTY ASSOCIATION TO ALLOW IT TO CONTRACT AS A SERVICING FACILITY FOR OTHER ENTITIES AND CONFORM THE ASSOCIATION'S STATUTORY IMMUNITY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-48-35 reads as rewritten:

"**§ 58-48-35. Powers and duties of the Association.**

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(b) The Association may:

(1) Employ or retain such persons as are necessary to handle claims and perform other duties of the Association.

(2) Borrow funds necessary to effect the purposes of this Article in accord with the plan of operation.

(3) Sue or be sued.

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this Article.

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this Article.

(6) Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities if, at the end of any calendar year, the board of directors finds that the assets of the Association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year.

(7) Be designated or may contract as a servicing facility for any entity which may be recommended by the Association's board of directors and approved by the Commissioner of Insurance."

SECTION 2. G.S. 58-48-80 reads as rewritten:

"**§ 58-48-80. Immunity.**

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, the Association or its agents or employees, the board of directors, or the Commissioner or his representatives for any action taken by them in the performance of their powers and duties under this ~~Article.~~Article, including, but not limited to, those powers and duties enumerated in G.S. 58-48-35."

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

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for
HB 742 A BILL TO BE ENTITLED AN ACT TO REQUIRE THE RETENTION OF ACCUMULATED SURPLUS BY THE NORTH CAROLINA INSURANCE UNDERWRITING ASSOCIATION.

☒ With a favorable report and recommendation that the bill be re-referred to the Committee on JUDICIARY II.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ The bill/resolution is re-referred to the Committee on _____.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 439 A BILL TO BE ENTITLED AN ACT TO REDUCE THE FINANCIAL LOSS TO COUNTIES AND CITIES FOR UNREIMBURSED COUNTY OR CITY AMBULANCE SERVICES PROVIDED TO STATE HEALTH PLAN MEMBERS BY REQUIRING THE STATE HEALTH PLAN TO MAKE PAYMENTS FOR COUNTY OR CITY AMBULANCE SERVICES DIRECTLY OR CO-PAYABLE TO THE COUNTY OR CITY AMBULANCE SERVICE PROVIDER.

☒ With a favorable report and recommendation that the 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 _____.

_____ The bill/resolution is re-referred to the Committee on _____.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 896 A BILL TO BE ENTITLED AN ACT TO UPDATE THE CANCER COMPENDIA STATUTE TO REFLECT NEW COMPENDIA THAT ARE AVAILABLE.

☒ 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 _____.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 964 A BILL TO BE ENTITLED AN ACT TO EXPAND THE DISCRETIONARY POWERS OF THE INSURANCE GUARANTY ASSOCIATION TO ALLOW IT TO CONTRACT AS A SERVICING FACILITY FOR OTHER ENTITIES AND CONFORM THE ASSOCIATION'S STATUTORY IMMUNITY.

☒ 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 JUDICIARY II.

(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 Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carol Durrell	State Health Plan
	JD, AL, PA
Reid McMillan	Moore & Van Allen
Tommy Suter	NOVARTIS
Fred Fulla	NCDOI
DAVID BARNES	Poyner Spruill
Ken Wright	BCBS
Donna Girard DOT	BASF
BM Brogden Jr.	Sec. Div., NC SOS
David Vanderweide	NC DST
Daniel Baum	K&L GATES

VISITOR REGISTRATION SHEET

House Committee on Insurance

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amy McConkey	Smith Anderson
Chip Baggett	NCMS
Heather Barrett	Hunton & Williams
Dana Simpson	Smith Anders
Penny Griffin	School of Gov.
[illegible]	NMRS
Michelle Harris	MFRS
Renee Wimbish	Rep Folwell's LA
John McMullan	MFRS
Ashley Bell	American Cancer Society
Kathryn Lavrinc	Sanofi-aventis, US

VISITOR REGISTRATION SHEET

House Committee on Insurance

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cady Thomas	NC Assn of Realtors
Jessi Hayes	NCHBA
David Boary	MWC

Mary Capps (Rep. Wray)

m: Ann Jordan (Rep. Goforth)
ıt: Wednesday, April 22, 2009 11:20 AM
Subject: Meeting Notice for April 28.doc

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

CORRECTED – ADD HB 439

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

DAY & DATE: **Tuesday, April 28, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

HB 439 – STATE HEALTH PLAN/TAXPAYER RECOVERY ACT – Reps. Folwell, England, Hurley and

HB 896 – CANCER DRUG COVERAGE CHANGES – Reps. Harrell, England and Faison

HB PCS 964 – INSURANCE GUARANTY ASSOCIATION AMENDMENTS - Reps. Dockham and Braxton

HB 1040 – AMEND VIATICAL SETTLEMENT CONTRACT DEFINITION – Rep. Dockham

HB 1160 – FIREFIGHTERS' RELIEF FUND ADDITIONS – Reps. Wray and Goforth

HB 1162 – DOI DISASTER POWERS APPLY TO SHP – Reps. Wray and Goforth

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at:**1:00 p.m.**on **April 22, 2009**.

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

04/23/2009

MINUTES
HOUSE COMMITTEE ON INSURANCE
April 30, 2009

The House Committee on Insurance met at 11:00 AM on Thursday, April 30, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael Wray; Vice Chairs: J. Dockham and M. Setzer. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Cole, Current, Faison, Gibson, Howard, Hughes, Lewis, and Pierce.

Chairman Wray called the meeting to order and welcomed visitors. He recognized Sgt-At Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachments)

Chairman Wray announced that House Bills, 1166, 1485 and 1494 have been pulled from the agenda. He recognized Rep. Goforth to explain HB 1165 – Update Standard Fire Insurance Policy. Rep. Goforth asked for Rose Williams, Counsel for the Department of Insurance, to be recognized to explain the bill. Ms. Williams said that this bill codifies the provisions set forth in the photographic version of the Standard Fire Insurance Policy' and makes conforming amendment; and repeals the statute that contains the photographic version of the Standard Fire Insurance Policy. Rep. Goforth presented an amendment to amend the dates from October 1, 2009 to January 1, 2010. Rep. Faison moved for a favorable as amendment, unfavorable to the original and be forwarded to the Judiciary III committee.

Chairman Wray recognized Rep. Goforth to explain HB 1313 – Regulate Public Adjusters. Rep. Goforth asked Rose Williams to explain. Mrs. Williams said that HB 1313 is an agency bill that would enact a new Article 33A "Public Adjusters" of Chapter 58 to provide for the licensure, examination continuing education, contracting policies, record retention, and standards of conduct of public adjusters operating in the State. The Bill contains provisions from the NAIC Model Act on Public Adjusters. Rep. Faison moved for a favorable report and to be referred to the Finance committee. Motion carried.

The meeting adjourned at 11:15.

Representative Michael Wray, Chairman

Ann Jordan – Committee Assistant

HOUSE INSURANCE COMMITTEE

April 30, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

HB 1165 – UPDATE STANDARD FIRE INSURANCE POLICY – AB – Rep. Goforth & Wray

HB 1166 – INSURANCE LAW CHANGES – AB - Reps. Goforth & Wray

HB 1313 – REGULATE PUBLIC ADJUSTORS – AB – Reps. Goforth & Wray

HB 1485 – INSURANCE/HEALTH CARE PROVIDER RELATIONSHIP – Reps. Steen, Barnhart, Neumann and England

HB 1494 – REVISE UM/UIM COVERAGE REQUIREMENTS – Reps. Goforth, Insko, Lucas & Tarleton

Adjourn

HOUSE BILL 1165

Short Title:	Update Standard Fire Insurance Policy.-AB	(Public)
Sponsors:	Representatives Goforth, Wray (Primary Sponsors); and Lucas.	
Referred to:	Insurance, if favorable, Judiciary III.	

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO CODIFY THE PROVISIONS SET FORTH IN THE PHOTOGRAPHIC VERSION OF THE STANDARD FIRE INSURANCE POLICY; MAKE CONFORMING AMENDMENTS; AND REPEAL THE STATUTE THAT CONTAINS THE PHOTOGRAPHIC VERSION OF THE STANDARD FIRE INSURANCE POLICY.

The General Assembly of North Carolina enacts:

SECTION 1. Article 44 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-44-16. Fire insurance policies; standard fire insurance policy provisions.**

(a) The provisions of a fire insurance policy, as set forth in subsection (f) of this section, shall be known and designated as the "standard fire insurance policy."

(b) With the exception of policies covering (i) automobile fire, theft, comprehensive, and collision, or (ii) marine and inland marine insurance, no fire insurance policy shall be made, issued, or delivered by any insurer or by any agent or representative of the insurer, on any property in this State, unless it conforms in substance with all of the provisions, stipulations, agreements, and conditions in subsection (f) of this section.

(c) There shall be printed at the head of the policy the name of the insurer or insurers issuing the policy; the location of the home office of the insurer or insurers; a statement whether the insurer or insurers are stock or mutual corporations or are reciprocal insurers. This section does not limit an insurer to the use of any particular size or manner of folding the paper upon which the policy is printed; provided, however, that any insurer organized under special charter provisions may so indicate upon its policy and add a statement of the plan under which it operates in this State.

(d) The standard fire insurance policy need not be used for effecting reinsurance between insurers.

(e) The provisions of the standard fire policy are stated in this section and shall be incorporated in fire insurance policies subject to this section. If any conditions of this section are construed to be more liberal than any other policy conditions relating to the perils of fire, lightning, or removal, the provisions of this section shall apply.

(f) The following subdivisions comprise all of the provisions, stipulations, agreements, and conditions of the standard fire insurance policy:

(1) General provisions. – In consideration of the provisions, stipulations, agreements, and conditions in this policy or added to this policy, and of the premium specified in the declarations or in endorsements made a part of this policy, this insurer, for the term of years specified in the declarations from inception date shown in the declarations at 12:01 a.m. to expiration date shown in the declarations at 12:01 A.M. at the location of the property

covered, to an amount not exceeding the limit of liability specified in the declarations, does insure the insured named in the declarations and legal representatives, to the extent of the actual cash value of the property at the time of loss, but not exceeding the amount that it would cost to repair or replace the property with material of like kind and quality within a reasonable time after the loss, without allowance for any increased cost of repair or reconstruction by reason of any ordinance or law regulating construction or repair, and without compensation for loss resulting from interruption of business or manufacture, nor in any event for more than the interest of the insured against all direct loss by fire, lightning, and other perils insured against in this policy including removal from premises endangered by the perils insured against in this policy, except as hereinafter provided, to the property described in the declarations while located or contained as described in this policy, or pro rata for five days at each proper place to which any of the property shall necessarily be removed for preservation from the perils insured against in this policy, but not elsewhere. Assignment of this policy shall not be valid except with the written consent of this insurer. This policy is made and accepted subject to the provisions, stipulations, agreements, and conditions in this section, which are hereby made a part of this policy, together with such other provisions, stipulations, agreements, and conditions that may be added to this policy as provided in this policy.

(2) Concealment or fraud. – This entire policy shall be void if, whether before or after a loss, the insured has willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject of this insurance, or the interest of the insured in the subject of this insurance, or in the case of any fraud or false swearing by the insured relating the subject of this insurance.

(3) Uninsurable and excepted property. – This policy shall not cover accounts, bills, currency, deeds, evidences of debt, money, or securities; nor, unless specifically named in this policy in writing, bullion ,or manuscripts.

(4) Perils not included. – This insurer shall not be liable for loss by fire or other perils insured against in this policy caused, directly or indirectly, by enemy attack by armed forces, including action taken by military, naval, or air forces in resisting an actual or an immediately impending enemy attack; invasion; insurrection; rebellion; revolution; civil war; usurped power; order of any civil authority except acts of destruction at the time of and for the purpose of preventing the spread of fire, provided that the fire did not originate from any of the perils excluded by this policy; neglect of the insured to use all reasonable means to save and preserve the property at and after a loss, or when the property is endangered by fire in neighboring premises; or for loss by theft.

(5) Other insurance. – Other insurance may be prohibited or the amount of insurance may be limited by endorsement attached to this policy.

(6) Conditions suspending or restricting insurance. – Unless otherwise provided in writing added to this policy, this insurer shall not be liable for loss occurring:

a. While the hazard is increased by any means within the control or knowledge of the insured;

b. While a described building, whether intended for occupancy by owner or tenant, is vacant or unoccupied beyond a period of 60 consecutive days; or

c. As a result of explosion or riot, unless fire ensues, and in that event for loss by fire only.

(7) Other perils or subjects. – Any other peril to be insured against or subject of insurance to be covered in this policy shall be by endorsement in writing on this policy or added to this policy.

(8) Added provisions. – The extent of the application of insurance under this policy and of the contribution to be made by this insurer in case of loss, and any other provision or agreement not inconsistent with the provisions of this policy, may be provided for in writing added to this policy; provided, however, no provision may be waived except such as by the terms of this policy is subject to change.

(9) Waiver provisions. – No permission affecting this insurance shall exist, or waiver of any provision be valid, unless granted in this policy or expressed in writing added to this policy. No provision, stipulation, or forfeiture shall be held to be waived by any requirement or proceeding on the part of this insurer relating to appraisal or to any examination provided for in this policy.

(10) Cancellation of policy. – This policy shall be cancelled at any time at the request of the insured, in which case this insurer shall, upon demand and surrender of this policy, refund the excess of paid premium above any short rates for the expired time. This policy may be cancelled at any time by this insurer by giving to the insured a five days' written notice of cancellation with or without tender of the excess of paid premium above the pro rata premium for the expired time, which excess, if not tendered, shall be refunded on demand. Notice of cancellation shall state that said excess premium (if not tendered) will be refunded on demand.

(11) Mortgagee interests and obligations. – If loss is made payable, in whole or in part, to a designated mortgagee not named in this policy as the insured, such interest in this policy may be cancelled by giving to such a mortgagee a ten days' written notice of cancellation. If the insured fails to render proof of loss, the mortgagee, upon notice, shall render proof of loss as specified in this policy within 60 days thereafter and shall be subject to the provisions of this policy relating to appraisal and time of payment and of bringing suit. If this insurer claims that no liability existed as to the mortgagor or owner, it shall, to the extent of payment of loss to the mortgagee, be subrogated to all the mortgagee's rights of recovery, but without impairing the mortgagee's right to sue; or this insurer may pay off the mortgage debt and require an assignment of that debt and of the mortgage. Other provisions relating to the interests and obligations of the mortgagee may be added to this policy by agreement in writing.

(12) Pro rata liability. – This insurer shall not be liable for a greater proportion of any loss than the amount insured by this policy bears to all insurance covering the property against the peril involved, whether collectible or not.

(13) Requirements in case loss occurs. – The insured shall give immediate written notice to this insurer of any loss, protect the property from further damage, forthwith separate the damaged and undamaged personal property, put it in the best possible order, furnish a complete inventory of the destroyed, damaged, and undamaged property, showing in detail quantities, costs,

actual cash value, and amount of loss claimed. Within 60 days after the loss, unless that time is extended in writing by this insurer, the insured shall render to this insurer a proof of loss, signed and sworn to by the insured, stating the knowledge and belief of the insured as to the following: the time and origin of the loss, the interest of the insured and of all others in the property, the actual cash value of each item of the property and the amount of loss to the property, all encumbrances on the property, all other contracts of insurance, whether valid or not, covering any of the property, any changes in the title, use, occupation, location, possession, or exposures of the property since the issuing of this policy, by whom and for what purpose any building described in this policy and the several parts of the building were occupied at the time of loss and whether or not it then stood on leased ground, and shall furnish a copy of all the descriptions and schedules in all policies and, if required, verified plans and specifications of any building, fixtures, or machinery destroyed or damaged. The insured, as often as may be reasonably required, shall exhibit to any person designated by this insurer all that remains of any property described in this policy, and submit to examinations under oath by any person named by this insurer, and subscribe the same; and, as often as may be reasonably required, shall produce for examination all books of account, bills, invoices, and other vouchers, or certified copies of them if originals are lost, at such reasonable time and place as may be designated by this insurer or its representative, and shall permit extracts and copies of them to be made.

(14) Appraisal. – If the insured and this insurer fail to agree as to the actual cash value or the amount of loss, then, on the written demand of either, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within 20 days after the demand. The appraisers shall first select a competent and disinterested umpire; and failing for 15 days to agree upon a competent and disinterested umpire, on the request of the insured or this insurer, a competent and disinterested umpire shall be selected by a judge of a court of record in the state in which the property covered is located. The appraisers shall then appraise the loss, stating separately actual cash value and loss to each item; and, failing to agree, shall submit only their differences to the umpire. An award in writing, so itemized, of any two when filed with this insurer shall determine the amount of actual cash value and loss. Each appraiser shall be paid by the party selecting him and the expenses of appraisal and umpire shall be paid by the parties equally.

(15) Company's options. – It shall be optional with this insurer to take all, or any part, of the property at the agreed or appraised value, and also to repair, rebuild, or replace the property destroyed or damaged with other of like kind and quality within a reasonable time, on giving notice of its intention so to do within 30 days after the receipt of the proof of loss required in this policy.

(16) Abandonment. – There can be no abandonment to this insurer of any property.

(17) When loss payable. – The amount of loss for which this insurer may be liable shall be payable 60 days after proof of loss, as provided in this policy, is received by this insurer and ascertainment of the loss is made either by written agreement between the insured and this insurer or by the filing with this insurer of an award as provided in this policy.

(18) Suit. – No suit or action on this policy for the recovery of any claim shall be sustainable in any court of law unless all the requirements of this policy have

been complied with, and unless commenced within three years after inception of the loss.

(19) Subrogation. – This insurer may require from the insured an assignment of all rights of recovery against a party for loss to the extent that payment therefor is made by this insurer."

SECTION 2. G.S. 58-44-30 reads as rewritten:

"**§ 58-44-30. Notice by insured or agent as to increase of hazard, unoccupancy and other insurance.**

If notice in writing signed by the insured, or his agent, is given before loss or damage by any peril insured against under the standard fire insurance policy to the agent of the company of any fact or condition stated in ~~paragraphs (a), (b) or with respect to "other insurance" of the standard form of policy set out in G.S. 58-44-15~~G.S. 58-44-16 it is equivalent to an agreement in writing added ~~thereto,~~to the policy, and has the force of the agreement in writing referred to in the ~~foregoing form of~~standard fire insurance policy with respect to the liability of the company and the waiver; but this notice does not affect the right of the company to cancel the policy as ~~therein stipulated.~~stipulated in the policy."

SECTION 3. G.S. 58-44-25 reads as rewritten:

"**§ 58-44-25. Optional provisions as to loss or damage from nuclear reaction, nuclear radiation or radioactive contamination.**

Insurers issuing the standard fire insurance policy pursuant to ~~G.S. 58-44-15,~~G.S. 58-44-16, or any permissible variation ~~thereof,~~of that policy, and policies issued pursuant to G.S. 58-44-20 and Article 36 of this Chapter, are ~~hereby~~ authorized to affix ~~thereto~~ to the policy or include ~~therein~~ in the policy a written statement that the policy does not cover loss or damage caused by ~~nuclear reaction or nuclear radiation or radioactive contamination,~~nuclear reaction, nuclear radiation, or radioactive contamination, all whether directly or indirectly resulting from an insured peril under ~~said~~the policy; provided, however, that nothing ~~herein contained~~in this section shall be construed to prohibit the attachment to any such policy of an endorsement or endorsements specifically assuming coverage for loss or damage caused by ~~nuclear reaction or nuclear radiation or radioactive contamination.~~nuclear reaction, nuclear radiation, or radioactive contamination."

SECTION 4. The preamble of G.S. 58-44-20 reads as rewritten:

"**§ 58-44-20. Standard policy; permissible variations.**

With the exception of policies covering (i) automobile fire, theft, comprehensive, and collision, or (ii) marine and inland marine insurance, no~~No~~ fire insurance company shall issue fire insurance policies~~, except policies of automobile fire, theft, comprehensive and collision, marine and inland marine insurance,~~ on property in this State other than those ~~of the substance of the standard form as~~containing the provisions set forth in ~~G.S. 58-44-15~~G.S. 58-44-16 except as follows:

...."

SECTION 5. G.S. 1-52(12) reads as rewritten:

"**§ 1-52. Three years.**

Within three years an action –

...

(12) Upon a claim for loss covered by an insurance policy ~~which~~ that is subject to the three-year limitation contained in ~~lines 158 through 161 of the Standard Fire Insurance Policy for North Carolina, G.S. 58-44-15(c).~~G.S. 58-44-16."

SECTION 6. G.S. 58-44-15 is repealed.

SECTION 7. This act becomes effective October 1, 2009, and applies to fire insurance policies issued or renewed on and after that date.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1165

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

H1165-ARG-13 [v.1]

Comm. Sub. [NO]
Amends Title [NO]
First Edition

Date _____,2009

Representative Bruce Goforth

moves to amend the bill on page 5, line 48, by deleting "October 1, 2009," and substituting "January 1, 2010,".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 1313

Short Title:	Regulate Public Adjusters.-AB	(Public)
Sponsors:	Representatives Goforth, Wray (Primary Sponsors); and Lucas.	
Referred to:	Insurance, if favorable, Finance.	

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR MEANINGFUL REGULATION OF INSURANCE PUBLIC ADJUSTERS.

The General Assembly of North Carolina enacts:

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

"Article 33A.

"Public Adjusters.

"**§ 58-33A-1. Purpose and scope.**

This Article governs the qualifications and procedures for the licensing of public adjusters. It specifies the duties of and restrictions on public adjusters, which include limiting their licensure to assisting insureds in first-party claims.

"**§ 58-33A-5. Definitions.**

(1) Business entity. – A corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

(2) Catastrophic incident. – As defined in the National Response Framework, any natural or man-made incident, including terrorism, that results in extraordinary levels of mass casualties, damage, or disruption severely affecting the population, infrastructure, environment, economy, national morale, and/or government functions. A catastrophic incident shall be declared by the President of the United States or the Governor of the state or district in which the disaster occurred. If state and local resources are insufficient, the Governor may ask the President of the United States to make such a declaration.

(3) Fingerprints. – An impression of the lines on the finger taken for purpose of identification. The impression may be electronic or in ink converted to electronic format.

(4) Home state. – The District of Columbia and any state or territory of the United States in which the public adjuster's principal place of residence or principal place of business is located. If neither the state in which the public adjuster maintains the principal place of residence nor the state in which the public adjuster maintains the principal place of business has a substantially similar law governing public adjusters, the public adjuster may declare another state in which it becomes licensed and acts as a public adjuster to be the home state.

(5) Individual. – A natural person.

(6) Person. – An individual or a business entity.

(7) Public adjuster. – Any person who, for compensation or any other thing of value on behalf of the insured, does any of the following:

a. Acts or aids, solely in relation to first-party claims arising under insurance contracts that insure the real or personal property of the insured, on behalf of an insured in negotiating for, or effecting the settlement of, a claim for loss or damage covered by an insurance contract.

b. Advertises for employment as an public adjuster of insurance claims or solicits business or represents himself or herself to the public as a public adjuster of first-party insurance claims for losses or damages arising out of policies of insurance that insure real or personal property.

c. Directly or indirectly solicits business, investigates or adjusts losses, or advises an insured about first-party claims for losses or damages arising out of policies of insurance that insure real or personal property for another person engaged in the business of adjusting losses or damages covered by an insurance policy for the insured.

(8) Uniform individual application. – The current version of the NAIC Uniform Individual Application for resident and nonresident individuals.

(9) Uniform business entity application. – The current version of the NAIC Uniform Business Entity Application for resident and nonresident business entities.

"**§ 58-33A-10. License required.**

(a) A person shall not act or hold himself or herself out as a public adjuster in this State unless the person is licensed as a public adjuster in accordance with this Article.

(b) A person licensed as a public adjuster shall not misrepresent to a claimant that he or she is an adjuster representing an insurer in any capacity, including acting as an employee of the insurer or acting as an independent adjuster unless so appointed by an insurer in writing to act on the insurer's behalf for that specific claim or purpose. A licensed public adjuster is prohibited from charging that specific claimant a fee when appointed by the insurer and the appointment is accepted by the public adjuster.

(c) A business entity acting as a public adjuster is required to obtain a public adjuster license. Application shall be made using the uniform business entity application. Before approving the application, the Commissioner shall find all of the following:

(1) The business entity has paid the fees set forth in G.S. 58-33-125.

(2) The business entity has designated a licensed public adjuster responsible for the business entity's compliance with the insurance laws and regulations of this State.

(d) Notwithstanding subsections (a) through (c) of this section, a license as a public adjuster shall not be required of any of the following:

(1) An attorney-at-law admitted to practice in this State, when acting in his or her professional capacity as an attorney.

(2) A person who negotiates or settles claims arising under a life or health insurance policy or an annuity contract.

(3) A person employed only for the purpose of obtaining facts surrounding a loss or furnishing technical assistance to a licensed public adjuster, including photographers, estimators, private investigators, engineers, and handwriting experts.

(4) A licensed health care provider, or employee of a licensed health care provider, who prepares or files a health claim form on behalf of a patient.

(5) A person who settles subrogation claims between insurers.

"§ 58-33A-15. Application for license.

(a) A person applying for a public adjuster license shall apply to the Commissioner on the appropriate uniform application or other application prescribed by the Commissioner.

(b) The applicant shall declare under penalty of perjury and under penalty of refusal, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the applicant's knowledge and belief.

(c) In order to make a determination of license eligibility, the Commissioner may require fingerprints of applicants and submit the fingerprints and the fee required to perform the criminal history record checks to the State Bureau of Investigation and the Federal Bureau of Investigation (FBI) for state and national criminal history record checks; the Commissioner shall require a criminal history record check on each applicant in accordance with this Article. The Commissioner shall require each applicant to submit a full set of fingerprints in order for the Commissioner to obtain and receive National Criminal History Records from the FBI Criminal Justice Information Services Division.

(1) The Commissioner may contract for the collection, transmission, and resubmission of fingerprints required under this section. If the Commissioner does so, the fee for collecting, transmitting, and retaining fingerprints shall be payable directly to the contractor by the person. The Commissioner may agree to a reasonable fingerprinting fee to be charged by the contractor.

(2) The Commissioner may waive submission of fingerprints by any person that has previously furnished fingerprints and those fingerprints are on file with the Central Repository of the NAIC or the NAIC's affiliates or subsidiaries.

(3) The Commissioner may submit electronic fingerprint records and necessary identifying information to the NAIC, its affiliates, or subsidiaries for permanent retention in a centralized repository. The purpose of such a centralized repository is to provide state insurance regulators with access to fingerprint records in order to perform criminal history record checks.

"§ 58-33A-20. Resident license.

(a) Before issuing a public adjuster license to an applicant under this section, the Commissioner shall find that the applicant meets all of the following criteria:

(1) Is eligible to designate this State as his or her home state or is a nonresident who is not eligible for a license under G.S. 58-33A-35.

(2) Has not committed any act that is a ground for denial, suspension, or revocation of a license as set forth in G.S. 58-33A-45.

(3) Is trustworthy, reliable, and of good reputation, evidence of which may be determined by the Commissioner.

(4) Is financially responsible to exercise the license and has provided proof of financial responsibility as required in G.S. 58-33A-50.

(5) Has paid the fees set forth in G.S. 58-33-125.

(6) Maintains an office in the home state of residence with public access by reasonable appointment and/or regular business hours. This includes a designated office within a home state of residence.

(b) In addition to satisfying the requirements of subsection (a) of this section, an individual shall:

(1) Be at least 18 years of age; and

(2) Have successfully passed the public adjuster examination.

(c) The Commissioner may require any documents reasonably necessary to verify the information contained in the application.

"§ 58-33A-25. Examination.

(a) An individual applying for a public adjuster license under this act shall pass a written examination unless exempt pursuant to G.S. 58-33A-30. The examination shall test the

knowledge of the individual concerning the duties and responsibilities of a public adjuster and the insurance laws and regulations of this State. Examinations required by this section shall be developed and conducted under rules and regulations prescribed by the Commissioner.

(b) The Commissioner may make arrangements, including contracting with an outside testing service, for administering examinations and collecting the nonrefundable fee set forth in G.S. 58-33-125.

(c) Each individual applying for an examination shall remit a nonrefundable fee as prescribed by the Commissioner as set forth in G.S. 58-33-125.

(d) An individual who fails to appear for the examination as scheduled or fails to pass the examination shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination.

"**§ 58-33A-30. Exemptions from examination.**

(a) An individual who applies for a public adjuster license in this State who was previously licensed as a public adjuster in another state based on a public adjuster examination shall not be required to complete any prelicensing examination. This exemption is only available if the person is currently licensed in that state or if the application is received within 12 months of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the state's producer database records or records maintained by the NAIC, its affiliates, or subsidiaries indicate that the public adjuster is or was licensed in good standing.

(b) A person licensed as a public adjuster in another state based on a public adjuster examination who moves to this State shall apply within 90 days after establishing legal residence to become a resident licensee pursuant to G.S. 58-33A-20. No prelicensing examination shall be required of that person to obtain a public adjuster license.

(c) An individual who applies for a public adjuster license in this State who was previously licensed as a public adjuster in this State shall not be required to complete any prelicensing examination. This exemption is only available if the application is received within 12 months after the cancellation of the applicant's previous license in this State and if, at the time of cancellation, the applicant was in good standing in this State.

"**§ 58-33A-35. Nonresident license reciprocity.**

(a) Unless denied licensure pursuant to G.S. 58-33A-45, a nonresident person shall receive a nonresident public adjuster license if the person meets all of the following criteria:

(1) The person is currently licensed as a resident public adjuster and in good standing in his or her home state.

(2) The person has submitted the proper request for licensure, has paid the fees required by G.S. 58-33-125, and has provided proof of financial responsibility as required in G.S. 58-33A-50.

(3) The person has submitted or transmitted to the Commissioner the appropriate completed application for licensure.

(4) The person's home state awards nonresident public adjuster licenses to residents of this State on the same basis.

(b) The Commissioner may verify the public adjuster's licensing status through the producer database maintained by the NAIC, its affiliates, or subsidiaries.

(c) As a condition to continuation of a public adjuster license issued under this section, the licensee shall maintain a resident public adjuster license in his or her home state. The nonresident public adjuster license issued under this section shall terminate and be surrendered immediately to the Commissioner if the home state public adjuster license terminates for any reason, unless the public adjuster has been issued a license as a resident public adjuster in his or her new home state. Notification to the state or states where nonresident license is issued must be made as soon as possible, yet no later that 30 days after change in new state resident license. Licensee shall include new and old address. A new state resident license is required for

nonresident licenses to remain valid. The new state resident license must have reciprocity with the licensing nonresident state(s) for the nonresident license not to terminate.

"**§ 58-33A-40. License.**

(a) Unless denied licensure under this Article, persons who have met the requirements of this Article shall be issued a public adjuster license.

(b) A public adjuster license shall remain in effect unless revoked, terminated, or suspended as long as the request for renewal and fee set forth in G.S. 58-33-125 is paid and any other requirements for license renewal are met by the due date.

(c) The licensee shall inform the Commissioner by any means acceptable to the Commissioner of a change of address, change of legal name, or change of information submitted on the application within 30 days after the change.

(d) A licensed public adjuster shall be subject to Article 63 of this Chapter.

(e) A public adjuster who allows his or her license to lapse may, within 12 months from the due date of the renewal, be issued a new public adjuster license upon the Commissioner's receipt of the request for renewal. However, an administrative fee in the amount of double the unpaid renewal fee shall be required for the issuance of the new public adjuster license. The new public adjuster license shall be effective the date the Commissioner receives the request for renewal and the late payment penalty.

(f) Any public adjuster licensee that fails to apply for renewal of a license before expiration of the current license shall pay a lapsed license fee of twice the license fee and be subject to other penalties as provided by law before the license will be renewed. If the Department receives the request for reinstatement and the required lapsed license fee within 60 days after the date the license lapsed, the Department shall reinstate the license retroactively to the date the license lapsed. If the Department receives the request for reinstatement and the required lapsed license fee after 60 days but within one year of the date the license lapsed, the Department shall reinstate the license prospectively with the date the license is reinstated. If the person applies for reinstatement more than one year from the date of lapse, the person shall reapply for the license under this Article.

(g) A licensed public adjuster who is unable to comply with license renewal procedures because of military service, a long-term medical disability, or some other extenuating circumstance may request a waiver of those procedures. The public adjuster may also request a waiver of any examination requirement, fine, or other sanction imposed for failure to comply with renewal procedures.

(h) The license shall contain the licensee's name, city and state of business address, personal identification number, the date of issuance, the expiration date, and any other information the Commissioner deems necessary.

(i) In order to assist in the performance of the Commissioner's duties, the Commissioner may contract with nongovernmental entities, including the NAIC or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions related to licensing, including the collection of fees and data, that the Commissioner may deem appropriate.

"**§ 58-33A-45. License denial, nonrenewal, or revocation.**

(a) The Commissioner may place on probation, suspend, revoke, or refuse to issue or renew a public adjuster's license or may levy a civil penalty in accordance with G.S. 58-2-70 or any combination of actions for any one or more of the following causes:

(1) Providing incorrect, misleading, incomplete, or materially untrue information in the license application.

(2) Violating any insurance laws or violating any regulation, subpoena, or order of the Commissioner or of another state's insurance regulator.

(3) Obtaining or attempting to obtain a license through misrepresentation or fraud.

(4) Improperly withholding, misappropriating, or converting any monies or properties received in the course of doing insurance business.
(5) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance.
(6) Having been convicted of a felony or a misdemeanor involving dishonesty or breach of trust.
(7) Having admitted or been found to have committed any insurance unfair trade practice or insurance fraud.
(8) Using fraudulent, coercive, or dishonest practices or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this State or elsewhere.
(9) Having an insurance license, or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory.
(10) Forging another's name to an application for insurance or to any document related to an insurance transaction.
(11) Cheating, including improperly using notes or any other reference material, to complete an examination for an insurance license.
(12) Knowingly accepting insurance business from an individual who is not licensed but who is required to be licensed by the Commissioner.
(13) Failing to comply with an administrative or court order imposing a child support obligation.
(14) Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax.

(b) If the action by the Commissioner is to deny an application for or not renew a license, the Commissioner shall notify the applicant or licensee and advise, in writing, the applicant or licensee of the reason for the nonrenewal or denial of the applicant's or licensee's license. The applicant or licensee may make written demand upon the Commissioner in accordance with Article 3A of Chapter 150B of the General Statutes for a hearing before the Commissioner to determine the reasonableness of the Commissioner's action. The hearing shall be held pursuant to Article 3A of Chapter 150B of the General Statutes.

(c) The license of a business entity may be suspended, revoked, or refused if the Commissioner finds, after hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers, or managers acting on behalf of the business entity and the violation was neither reported to the Commissioner nor corrective action taken.

(d) In addition to or in lieu of any applicable denial, suspension, or revocation of a license, a person may, after hearing, be subject to a civil penalty according to G.S. 58-2-70.

(e) The Commissioner shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this Chapter against any person who is under investigation for or charged with a violation of this Chapter, even if the person's license or registration has been surrendered or has lapsed by operation of law.

"**§ 58-33A-50. Bond or letter of credit.**

(a) Before issuance of a license as a public adjuster and for the duration of the license, the applicant shall secure evidence of financial responsibility in a format prescribed by the Commissioner through any of the following instruments:

(1) A bond executed and issued by an insurer authorized to issue bonds in this State which meets all of the following requirements:
a. It shall be in the minimum amount of twenty thousand dollars ($20,000).
b. It shall be in favor of this State and shall specifically authorize recovery by the Commissioner on behalf of any person in this State

who sustained damages as the result of erroneous acts, failure to act, conviction of fraud, or conviction of unfair practices in his or her capacity as a public adjuster.

c. It shall not be terminated unless at least 30 days' prior written notice will have been filed with the Commissioner and given to the licensee.

(2) An irrevocable letter of credit issued by a qualified financial institution, which meets all of the following requirements:

a. It shall be in the minimum amount of twenty thousand dollars ($20,000).

b. It shall be to an account to the Commissioner and subject to lawful levy of execution on behalf of any person to whom the public adjuster has been found to be legally liable as the result of erroneous acts, failure to act, fraudulent acts, or unfair practices in his or her capacity as a public adjuster.

c. It shall not be terminated unless at least 30 days' prior written notice will have been filed with the Commissioner and given to the licensee.

(b) The issuer of the evidence of financial responsibility shall notify the Commissioner upon termination of the bond or letter of credit, unless otherwise directed by the Commissioner.

(c) The Commissioner may ask for the evidence of financial responsibility at any time he or she deems relevant.

(d) The authority to act as a public adjuster shall automatically terminate if the evidence of financial responsibility terminates or becomes impaired.

"**§ 58-33A-55. Continuing education.**

(a) An individual who holds a public adjuster license and who is not exempt under subsection (b) of this section shall satisfactorily complete a minimum of 24 hours of continuing education courses, including ethics, reported on a biennial basis in conjunction with the license renewal cycle.

(b) This section shall not apply to any of the following:

(1) Licensees not licensed for one full year before the end of the applicable continuing education biennium.

(2) Licensees holding nonresident public adjuster licenses who have met the continuing education requirements of their home state and whose home state gives credit to residents of this State on the same basis.

(c) Only continuing education courses approved by the Commissioner shall be used to satisfy the continuing education requirement of subsection (a) of this section.

"**§ 58-33A-60. Public adjuster fees.**

(a) A public adjuster shall not pay a commission, service fee, or other valuable consideration to a person for investigating or settling claims in this State if that person is required to be licensed under this Article and is not so licensed.

(b) A person shall not accept a commission, service fee, or other valuable consideration for investigating or settling claims in this State if that person is required to be licensed under this Article and is not so licensed.

(c) A public adjuster may pay or assign commission, service fees, or other valuable consideration to persons who do not investigate or settle claims in this State, unless the payment would violate G.S. 58-33-85 or G.S. 58-63-15(8).

(d) In the event of a catastrophic incident, there shall be limits on catastrophic fees, no public adjuster shall charge, agree to, or accept as compensation or reimbursement any payment, commission, fee, or other thing of value equal to more than ten percent (10%) of any insurance settlement or proceeds. No public adjuster shall require, demand, or accept any fee, retainer, compensation, deposit, or other thing of value before settlement of a claim.

"**§ 58-33A-65. Contract between public adjuster and insured.**

(a) Public adjusters shall ensure that all contracts for their services are in writing and contain all of the following terms:

(1) Legible full name of the adjuster signing the contract, as specified in Department records.

(2) Permanent home state business address and phone number.

(3) Department license number.

(4) Title of "Public Adjuster Contract."

(5) The insured's full name, street address, insurance company name and policy number, if known or upon notification.

(6) A description of the loss and its location, if applicable.

(7) Description of services to be provided to the insured.

(8) Signatures of the public adjuster and the insured.

(9) Date contract was signed by the public adjuster and date the contract was signed by the insured.

(10) Attestation language stating that the public adjuster is fully bonded pursuant to state law.

(11) Full salary, fee, commission, compensation, or other considerations the public adjuster is to receive for services.

(b) The contract may specify that the public adjuster shall be named as a co-payee on an insurer's payment of a claim.

(1) If the compensation is based on a share of the insurance settlement, the exact percentage shall be specified.

(2) Initial expenses to be reimbursed to the public adjuster from the proceeds of the claim payment shall be specified by type, with dollar estimates set forth in the contract and with any additional expenses first approved by the insured.

(3) Compensation provisions in a public adjusting contract shall not be redacted in any copy of the contract provided to the Commissioner. Such a redaction shall constitute an omission of material fact in violation of Article 63 of this Chapter.

(c) If the insurer, not later than 72 hours after the date on which the loss is reported to the insurer, either pays or commits in writing to pay to the insured the policy limit of the insurance policy, the public adjuster shall comply with all of the following:

(1) Not receive a commission consisting of a percentage of the total amount paid by an insurer to resolve a claim.

(2) Inform the insured that loss recovery amount might not be increased by insurer.

(3) Be entitled only to reasonable compensation from the insured for services provided by the public adjuster on behalf of the insured, based on the time spent on a claim and expenses incurred by the public adjuster, until the claim is paid or the insured receives a written commitment to pay from the insurer.

(d) A public adjuster shall provide the insured a written disclosure concerning any direct or indirect financial interest that the public adjuster has with any other party who is involved in any aspect of the claim, other than the salary, fee, commission, or other consideration established in the written contract with the insured, including but not limited to, any ownership of, other than as a minority stockholder, or any compensation expected to be received from any construction firm, salvage firm, building appraisal firm, motor vehicle repair shop, or any other firm that provides estimates for work, or that performs any work, in conjunction with damages caused by the insured loss on which the public adjuster is engaged. The word "firm" shall include any corporation, partnership, association, joint-stock company, or person.

(e) A public adjuster contract may not contain any contract term that includes any of the following terms:

(1) Allows the public adjuster's percentage fee to be collected when money is due from an insurance company, but not paid, or that allows a public adjuster to collect the entire fee from the first check issued by an insurance company, rather than as a percentage of each check issued by an insurance company.

(2) Requires the insured to authorize an insurance company to issue a check only in the name of the public adjuster.

(3) Imposes collection costs or late fees.

(4) Precludes a public adjuster from pursuing civil remedies.

(f) Before the signing of the contract the public adjuster shall provide the insured with a separate disclosure document regarding the claim process that states:

(1) Property insurance policies obligate the insured to present a claim to his or her insurance company for consideration. There are three types of adjusters that could be involved in that process. The definitions of the three types are as follows:

a. "Company adjuster" means the insurance adjusters who are employees of an insurance company. They represent the interest of the insurance company and are paid by the insurance company. They will not charge you a fee.

b. "Independent adjuster" means the insurance adjusters who are hired on a contract basis by an insurance company to represent the insurance company's interest in the settlement of the claim. They are paid by your insurance company. They will not charge you a fee.

c. "Public adjuster" means the insurance adjusters who do not work for any insurance company. They work for the insured to assist in the preparation, presentation, and settlement of the claim. The insured hires them by signing a contract agreeing to pay them a fee or commission based on a percentage of the settlement or other method of compensation.

(2) The insured is not required to hire a public adjuster to help the insured meet his or her obligations under the policy, but has the right to do so.

(3) The insured has the right to initiate direct communications with the insured's attorney, the insurer, the insurer's adjuster, and the insurer's attorney, or any other person regarding the settlement of the insured's claim. Once a public adjuster has been retained, the company adjuster or other insurance representative may not communicate directly with the insured without the permission or consent of the public adjuster or the insured's legal counsel.

(4) The public adjuster is not a representative or employee of the insurer.

(5) The salary, fee, commission, or other consideration is the obligation of the insured, not the insurer.

(g) The contracts shall be executed in duplicate to provide an original contract to the public adjuster, and an original contract to the insured. The public adjuster's original contract shall be available at all times for inspection without notice by the Commissioner.

(h) The public adjuster shall provide the insurer a notification letter, which has been signed by the insured, authorizing the public adjuster to represent the insured's interest.

(i) The insured has the right to rescind the contract within three business days after the date the contract was signed. The rescission shall be in writing and mailed or delivered to the public adjuster at the address in the contract within the three business day period.

(j) If the insured exercises the right to rescind the contract, anything of value given by the insured under the contract will be returned to the insured within 15 business days after the receipt by the public adjuster of the cancellation notice.

"**§ 58-33A-70. Escrow or trust accounts.**

A public adjuster who receives, accepts, or holds any funds on behalf of an insured, toward the settlement of a claim for loss or damage, shall deposit the funds in a noninterest-bearing escrow or trust account in a financial institution that is insured by an agency of the federal government in the public adjuster's home state or where the loss occurred.

"**§ 58-33A-75. Record retention.**

(a) A public adjuster shall maintain a complete record of each transaction as a public adjuster. The records required by this section shall include all of the following:

(1) Name of the insured.
(2) Date, location, and amount of the loss.
(3) Copy of the contract between the public adjuster and insured.
(4) Name of the insurer, amount, expiration date and number of each policy carried with respect to the loss.
(5) Itemized statement of the insured's recoveries.
(6) Itemized statement of all compensation received by the public adjuster, from any source whatsoever, in connection with the loss.
(7) A register of all monies received, deposited, disbursed, or withdrawn in connection with a transaction with an insured, including fees, transfers, and disbursements from a trust account and all transactions concerning all interest-bearing accounts.
(8) Name of public adjuster who executed the contract.
(9) Name of the attorney representing the insured, if applicable, and the name of the claims representatives of the insurance company.
(10) Evidence of financial responsibility in a format prescribed by the Commissioner.

(b) Records shall be maintained for at least five years after the termination of the transaction with an insured and shall be open to examination by the Commissioner at all times.

(c) Records submitted to the Commissioner in accordance with this section that contain information identified in writing as proprietary by the public adjuster shall be treated as confidential by the Commissioner and shall not be subject to Chapter 132 of the General Statutes or G.S. 58-2-100.

"**§ 58-33A-80. Standards of conduct of public adjusters.**

(a) A public adjuster shall, under his or her license, serve with objectivity and complete loyalty the interest of his or her client alone; and render to the insured such information, counsel, and service, as within the knowledge, understanding, and opinion in good faith of the licensee, as will best serve the insured's insurance claim needs and interest.

(b) A public adjuster shall not solicit, or attempt to solicit, an insured during the progress of a loss-producing occurrence, as defined in the insured's insurance contract.

(c) A public adjuster shall not permit an unlicensed employee or representative of the public adjuster to conduct business for which a license is required under this Article.

(d) A public adjuster shall not have a direct or indirect financial interest in any aspect of the claim, other than the salary, fee, commission, or other consideration established in the written contract with the insured, unless full written disclosure has been made to the insured as set forth in G.S. 58-33A-65.

(e) A public adjuster shall not acquire any interest in salvage of property subject to the contract with the insured unless the public adjuster obtains written permission from the insured after settlement of the claim with the insurer as set forth in G.S. 58-33A-65.

(f) The public adjuster shall abstain from referring or directing the insured to get needed repairs or services in connection with a loss from any person described by any of the following criteria, unless disclosed to the insured:

(1) The public adjuster has a financial interest in the person.

(2) The public adjuster may receive direct or indirect compensation for the referral from the person.

(g) The public adjuster shall disclose to an insured if the public adjuster has any interest or will be compensated by any construction firm, salvage firm, building appraisal firm, motor vehicle repair shop, or any other firm that performs any work in conjunction with damages caused by the insured loss. The word "firm" includes any corporation, partnership, association, joint-stock company, or person.

(h) Any compensation or anything of value in connection with an insured's specific loss that will be received by a public adjuster shall be disclosed by the public adjuster to the insured in writing including the source and amount of any such compensation.

(i) Public adjusters shall adhere to all of the following general ethical requirements:

(1) A public adjuster shall not undertake the adjustment of any claim if the public adjuster is not competent and knowledgeable as to the terms and conditions of the insurance coverage, or which otherwise exceeds the public adjuster's current expertise.

(2) A public adjuster shall not knowingly make any oral or written material misrepresentations or statements that are false or maliciously critical and intended to injure any person engaged in the business of insurance to any insured client or potential insured client.

(3) No public adjuster, while so licensed by the Department, may represent or act as a company adjuster or independent adjuster on the same claim.

(4) The contract shall not be construed to prevent an insured from pursuing any civil remedy after the three business day revocation or cancellation period.

(5) A public adjuster shall not enter into a contract or accept a power of attorney that vests in the public adjuster the effective authority to choose the persons who shall perform repair work.

(6) A public adjuster shall ensure that all contracts for the public adjuster's services are in writing and set forth all terms and conditions of the engagement.

(j) A public adjuster may not agree to any loss settlement without the insured's knowledge and consent.

(k) Public adjusters shall not solicit a client for employment between the hours of 9:00 P.M. and 9:00 A.M.

"**§ 58-33A-90. Reporting of actions.**

(a) A public adjuster shall report to the Commissioner any administrative action taken against the public adjuster in another jurisdiction or by another governmental agency in this State within 30 days after the final disposition of the matter. This report shall include a copy of the order, consent order, or other relevant legal documents.

(b) Within 30 days after the initial pretrial hearing date, the public adjuster shall report to the Commissioner any criminal prosecution of the public adjuster taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

"**§ 58-33A-95. Rules.**

The Commissioner may, in accordance with Chapter 150B of the General Statutes, adopt rules that are necessary or proper to carry out the purposes of this Article."

SECTION 2. This act becomes effective July 1, 2010.

HOUSE BILL 1313:
Regulate Public Adjusters.-AB

2009-2010 General Assembly

Committee:	Senate Finance	**Date:**	July 15, 2009
Introduced by:	Reps. Goforth, Wray	**Prepared by:**	Heather Fennell
Analysis of:	Third Edition		Committee Counsel

SUMMARY: ***House Bill 1313 is an agency bill that would enact a new Article 33A "Public Adjusters" of Chapter 58 to provide for the licensure, examination, continuing education, contracting policies, record retention, and standards of conduct of public adjusters operating in the State. The Bill contains provisions from the NAIC Model Act on Public Adjusters.***

House Bill 1313 has been referred to Senate Finance because it authorizes the payment of a fee to perform criminal history record checks as a part of determining license eligibility.

CURRENT LAW: The North Carolina Administrative Code (11 NCAC 06A Section .0900 Public Adjusters) sets forth provisions regulating certain actions of public adjusters in the State, including adjuster transactions with insureds, and relationships with third parties.

NCAC 06A .091(2) defines 'public adjuster' to mean, "...any individual who, for salary, fee, commission, or other compensation, engages in public adjusting and who is licensed under G.S. 58-33-30 or who is authorized to adjust under G.S. 58-33-70;"

G.S. 58-33-30 sets forth requirements for issuance of a license by the Commissioner of Insurance to agents, brokers, limited representatives, adjusters, and motor vehicle damage appraisers. This section addresses education and training, examinations, collection of examination and registration fees, denial of licensure, and reciprocity.

G.S. 58-33-70 authorizes the Commissioner to issue 90 day adjuster learner's permits and permit certain out of state adjusters to operate in state in certain limited circumstances.

BILL ANALYSIS: House Bill 1313 would enact a new Article 33A "Public Adjusters" of Chapter 58.

Definition of public adjuster: Any person who acts on behalf of the insured to settle claims for loss or damage of real or personal property covered by an insurance contract; or advertises for or solicits business as an adjuster; or advises insureds about property loss or damage claims under insurance policies.

Qualification of Licensure: Individuals or businesses seeking licensure must comply with all of the following:

- Payment of fees required under G.S. 58-33-125.
- Provide fingerprints and recent photo for criminal history check. For business entities, the key person for each entity must provide fingerprints and recent photo.
- Pass a written examination, unless exempted.
- Complete 24 hours of continuing education every 2 years.
- Resident licensees must maintain a publicly accessible office.
- Nonresident individuals may qualify for reciprocity if the person is licensed in good standing another state, pays all applicable fees, and the home state of the individual offers reciprocity to North Carolina licensees.
- The following are exempt from licensure as a public adjuster:

- Attorneys acting in a professional capacity.
- Persons negotiating claims under life or health insurance policies, or an annuity contract.
- Photographers, estimators, private investigators, engineers, handwriting experts, and other similar persons hired by an adjuster to provide technical assistance.
- A licensed health care employee who prepares files for a health claim.
- A person who settles subrogation claims between insurers.

Bond or letter of credit: Each public adjuster must secure either a bond or irrevocable letter of credit of at least $20,000 for the purpose of providing recover for an individual damaged by the adjuster acting in his or her capacity as an adjuster.

Fees and Contracts: In the event of a catastrophic incident, an adjuster may not charge more than 10% of the settlement or proceeds. Contracts for services for public adjusters must be in writing, may be rescinded within 3 days of signing, and must contain all of the following:

- Legible full name of the adjuster signing the contract, as specified in Department records, permanent home state business address and phone number, and license number of the adjuster.
- Title of "Public Adjuster Contract."
- The insured's full name, street address, insurance company name and policy number.
- A description of the loss and its location, if applicable.
- Description of services to be provided to the insured.
- Signatures of the public adjuster and the insured, date contract was signed by the public adjuster and date the contract was signed by the insured.
- Attestation language stating that the public adjuster is fully bonded pursuant to state law.
- Full salary, fee, commission, compensation, or other considerations the public adjuster is to receive for services.

Disclosure: In addition to the specific requirements for contracts, public adjusters must provide the following written disclosures:

- Any direct or indirect financial interest the adjuster has with any other party to the claim, other than the fee or salary established in the contract.
- A statement regarding the claim process that explains all of the following:
  - The difference between adjusters hired by the insurance company and a public adjuster.
  - A public adjuster is not required to fulfill the obligations under a policy.
  - The public adjuster is not a representative of the insurer.
  - The fee or charge of the public adjuster is an obligation of the insured.

Escrow and Record Retention: All funds held by an adjuster on behalf of an insured must deposit the funds in a noninterest-baring escrow or trust account. Public adjusters must maintain records of all transactions for at least 5 years, and the records must be open to inspection by the Commissioner.

EFFECTIVE DATE: This act becomes effective July 1, 2010.

Ben Popkin and Martha Walston, counsel to House Insurance and Finance Committees, substantially contributed to this summary.

H1313-SMTD-116(e3) v4

ATTACHMENT #1

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John McMillan	MFOs
Jennifer Cohen	IFNC
Susan Valaur	NW
Harry Taylor	MWC
DAVID BARNES	Poyner Spruill
MIKE MANN	NCBAA
Bob Mack	NCDOI
Etta P Maynard	NCDOI
Ginger (Intern)	NCDOI
Brian L. Nickerson	NCDOI
TED HAMBY	NCDOI

VISITOR REGISTRATION SHEET

House Committee on Insurance

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Canales	BCCA
ANN LOVE	OVIC
	K&L Gates
Preston Howard	MCIC
Leslie Arnold	SOG - Daily Bulletin
Robert Pasahal	Young Moore
	NMRS

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for
HB 1165 A BILL TO BE ENTITLED AN ACT TO CODIFY THE PROVISIONS SET FORTH IN THE PHOTOGRAPHIC VERSION OF THE STANDARD FIRE INSURANCE POLICY; MAKE CONFORMING AMENDMENTS; AND REPEAL THE STATUTE THAT CONTAINS THE PHOTOGRAPHIC VERSION OF THE STANDARD FIRE INSURANCE POLICY.

☒ 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 JUDICIARY III.

(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.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 1313 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR MEANINGFUL REGULATION OF INSURANCE PUBLIC ADJUSTERS.

☒ With a favorable report and recommendation that the 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 _____.

_____ The bill/resolution is re-referred to the Committee on _____.

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

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

DAY & DATE: **Thursday, April 30, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

HB 1165 – UPDATE STANDARD FIRE INSURANCE POLICY – AB – Rep. Goforth & Wray

HB 1166 – INSURANCE LAW CHANGES – AB - Reps. Goforth & Wray

HB 1313 – REGULATE PUBLIC ADJUSTORS – AB – Reps. Goforth & Wray

HB 1485 – INSURANCE/HEALTH CARE PROVIDER RELATIONSHIP – Reps. Steen, Barnhart, Neumann and England

HB 1494 – REVISE UM/UIM COVERAGE REQUIREMENTS – Reps. Goforth, Insko, Lucas & Tarleton

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at:**2:00 p.m.**on **April 29, 2009.**

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

MINUTES
HOUSE COMMITTEE ON INSURANCE
May 5, 2009

The House Committee on Insurance met at 11:00 AM on Tuesday, May 5, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael H. Wray; Vice Chairs: J. Dockham and M. Setzer. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Cole, Current, Faison, Gibson, Holliman, Howard, Hughes, Lewis, Pierce and Wainwright.

Chairman Goforth called the meeting to order and welcomed visitors. He recognized Sgt-At-Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachment #1)

Chairman Goforth recognized Rep. Dockham who moved for adoption of a PCS for HB 334-Revise NC Ski Safety Statutes. Chairman Goforth recognized Rep. Tarleton and he asked Mr. Bill Patterson to explain the bill. HB 334 would impose additional duties upon skiers and would impose additional inspection and reporting obligations upon ski area operators. The bill modifies current law to define skier to include any person who participates in "winter sports" – any use of skis, snowboards, snow shoes, or any other device for skiing, sliding, jumping or traveling on snow or ice. Rep. Faison moved that the PCS for HB 334 be given a favorable report, unfavorable as to the original bill, and be re-referred to the Judiciary I Committee, and the motion passed.

Chairman Goforth recognized Rep. Wainwright to explain HB 1090-UI/Severance Modifications. This bill would allow a person who is receiving severance pay to be considered unemployed for purpose of collecting unemployment insurance benefits provided that person met the other criteria for determining employment. Rep. Holliman moved to give HB 1090 a favorable report and be re-referred to the Appropriations Committee, and the motion passed.

The Chair recognized Rep. Hill to explain HB 1084-Revise LPG Dealer Requirements. Rep. Gibson moved that the PCS be heard before the committee. He stated HB 1084 was requested by the Department of Agriculture. The PCS will satisfy some of the concerns raised by some industry people and he knows of no opposition. The bill will increase the insurance requirements for liquefied petroleum gas dealers who transport LP gas, require inspection of LP gas containers and installations by the Agriculture Commissioner, and increases civil penalties for dealer violations. Rep. Gibson moved for a favorable report to the PCS, unfavorable as to original bill, and recommendation that the bill be referred to the Committee on Commerce, Small Business and Entrepreneurship, and the motion passed.

The Chair called upon Rep. Wray to explain HB 1162 – DOI Disaster Powers Apply to SHP-AB. Rep. Setzer moved that the PCS for HB 1162 be adopted. Rep. Wray stated it is an agency bill that would add the State Health Plan to the definition of 'insurance company' in G.S. 58-2-46(2) so that Plan enrollees would be allowed to defer premium or debt payments for 30 days whenever a state of disaster has been proclaimed or declared for the State or the area where the enrollee resides. In additional to payments, this provision applies 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."

Rep. Holliman moved to give a favorable report to the committee substitute bill, unfavorable to original bill and recommendation that the committee substitute bill be re-referred to the Appropriations Committee, and the motion passed.

The Chair recognized Rep. Insko to explain HB 1294 – NC Risk Pool Clarifications. Rep. Pierce moved that a PCS for HB 1294 be adopted. Rep. Insko stated the PCS would allow the Board of Directors of the High Risk Insurance Pool to provide premium subsidies to individuals with income levels up to 300% of the federal poverty guidelines, if funds are available. It would also require insurers to notify applicants for health insurance coverage about the existence of the High Risk Insurance Pool. The Chair called upon Mr. Ben Popkin to present an amendment offered by Rep. Brubaker (Attachment 2). Rep. Dockham moved that PCS for 1294 as amended be rolled into a new committee substitute and given a favorable report, unfavorable as to the original bill and recommendation that the bill be referred to the Judiciary II Committee, and the motion passed.

Chairman Goforth asked Rep. Insko to discuss HB 1392 – NC Risk Pool Changes/Out-of-State Services. Rep. Lewis moved that the PCS for HB 1392 be adopted. HB 1392 would authorize the North Carolina Health Insurance Risk Pool to negotiate and settle claims for Medicare-covered emergency services provided outside North Carolina to an insured. The negotiated reimbursement rate may exceed the rates allowed for those services under Medicare. The PCS makes a technical change by substituting a defined term for language in the 2nd Edition. Rep. Lewis moved to give a favorable report to the committee substitute bill, unfavorable as to the original bill, and the motion passed.

Chairman Goforth adjourned the meeting at 11:50 AM.

Bruce Goforth

Representative Bruce Goforth, Chairman

Mary Capps

Mary Capps – Committee Assistant

HOUSE INSURANCE COMMITTEE

May 5, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

HB 334 – REVISE NC SKI SAFETY STATUTES – Reps. Tarleton, Goforth, Frye and Rapp

HB 1084 – REVISE LPG DEALER REQUIREMENTS – Rep. Hill

HB 1090 – UI/SEVERANCE MODIFICATIONS – Reps. Wainwright, Faison, Lucas and Parmon

HB 1162 – DOI DISASTER POWERS APPLY TO SHP – AB – Reps. Wray, Goforth; Faison and Lucas

HB 1294 – NC RISK POOL CLARIFICATIONS - Reps. Dockham, England and Insko

HB 1392 – NC RISK POOL CHANGES/OUT-OF-STATE SERVICES – Reps. Insko, Harrison, Holliman and Lucas

Adjourn

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 334
PROPOSED COMMITTEE SUBSTITUTE H334-PCS70395-MH-1

Short Title: Revise NC Ski Safety Statutes. (Public)

Sponsors:

Referred to:

March 2, 2009

A BILL TO BE ENTITLED

AN ACT TO AMEND THE SKIER SAFETY STATUTES TO CLARIFY THE RESPECTIVE DUTIES OF SKI AREA OPERATORS AND SKIERS AND TO MAKE OTHER RELATED CHANGES.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 99C of the General Statutes reads as rewritten:

"Chapter 99C.

"Actions Relating to ~~Skier~~

~~Safety and Skiing Accidents.~~ Winter Sports Safety and Accidents.

"§ 99C-1. Definitions.

When used in this Chapter, unless the context otherwise requires:

(1) ~~"Competitor" means~~Competitor. – ~~a~~ A skier actually engaged in competition or in practice therefor with the permission of the ski area operator on any slope or trail or portion thereof designated by the ski area operator for the purpose of competition.

(2) ~~"Passenger" means~~Passenger. – ~~any~~ Any person who is being transported or is awaiting transportation, or being conveyed on a passenger tramway or is moving from the disembarkation point of a passenger tramway or is in the act of embarking upon or disembarking from a passenger tramway.

(3) ~~"Passenger Tramway" shall mean~~Passenger tramway. – ~~any~~ Any device used to transport passengers uphill on skis or other winter sports devices, or in cars on tracks, or suspended in the air, by the use of steel cables, chains, belts or ropes. Such definition shall include such devices as a chair lift, J Bar, or platter pull, rope tow, and wire tow.

(4) ~~"Ski Area" means~~Ski area. – ~~all the ski~~All winter sports slopes, ~~ski~~ alpine and Nordic ski trails, freestyle terrain and passenger tramways, that are administered or operated as a ski area enterprise within this State.

(5) ~~"Ski Area Operator" means~~Ski area operator. – ~~a~~ A person, corporation, or organization that is responsible for the safe operation and maintenance of the ski area.

(6) ~~"Skier" means~~Skier. – ~~any~~ Any person who is wearing skis or other winter sports devices or any person who for the purpose of skiing or other winter sports is on a designated and clearly marked ~~ski slope~~winter sports slope, ~~or~~

~~ski~~alpine or Nordic ski trail or freestyle terrain that is located at a ski area, or any person who is a passenger or spectator at a ski area.

(7) Winter sports. – Any use of skis, snowboards, snowshoes, or any other device for skiing, sliding, jumping, or traveling on snow or ice.

(8) Freestyle terrain. – Constructed and natural features in ski areas intended for winter sports including, but not limited to, terrain parks and terrain park features such as jumps, rails, fun boxes, half-pipes, quarter-pipes, and freestyle-bump terrain.

"§ 99C-2. Duties of ski area operators and skiers.

(a) A ski area operator shall be responsible for the maintenance and safe operation of any passenger tramway in his ski area and insure that such is in conformity with the rules and regulations prescribed and adopted by the North Carolina Department of Labor pursuant to G.S. 95-120(1) as such appear in the North Carolina Administrative Procedures Act. The North Carolina Department of Labor shall conduct certifications and inspections of passenger tramways.

A ski area operator's responsibility regarding passenger tramways shall include, but is not limited to, insuring operating personnel are adequately trained and are adequate in number; meeting all standards set forth for terminals, stations, line structures, and line equipment; meeting all rules and regulations regarding the safe operation and maintenance of all passenger lifts and tramways, including all necessary inspections and record keeping.

(b) ~~A skier and/or a passenger~~A skier shall have the following responsibilities:

(1) To know the range of ~~his own~~the skier's abilities to negotiate any ski slope or trail and to ski within the limits of such ability;

(2) To maintain control of ~~his~~ the skier's speed and course at all times when skiing and to maintain a proper lookout so as to be able to avoid other skiers and ~~visible objects~~;obvious hazards and inherent risks, including variations in terrain, snow, or ice conditions, bare spots and rocks, trees and other forms of forest growth or forest debris;

(3) To stay clear of snow grooming equipment, all vehicles, pole lines, lift towers, signs, snowmaking equipment, and any other equipment on the ski slopes and trails;

(4) To heed all posted information and other warnings and to refrain from acting in a manner which may cause or contribute to the injury of the skier or others;

(5) To wear retention straps, ski brakes, or other devices to prevent runaway skis or snowboards;

(6) Before beginning to ski from a stationary position or before entering a ski slope or trail from the side, to avoid moving skiers already on the ski slope or trail;

(7) To not move uphill on any passenger tramway or use any ski slope or trail while such person's ability to do so is impaired by the consumption of alcohol or by the use of any narcotic or other drug or while such person is under the influence of alcohol or any narcotic or any drug;

(8) If involved in a collision with another skier or person, to not leave the vicinity of the collision before giving his name and current address to an employee of the ski area operator, a member of the ski patrol, or the other skier or person with whom the skier collided, except in those cases when medical treatment is required; in which case, said information shall be provided as soon as practical after the medical treatment has been obtained. If the other person involved in the collision is unknown, the skier shall leave

the personal identification required by this subsection with the ski area operator;

(9) Not to embark upon or disembark from a passenger tramway except at an area that is designated for such purpose;

(10) Not to throw or expel any object from a passenger tramway;

(11) Not to perform any action that interferes with the operation or running of a passenger tramway;

(12) Not to use such tramway unless ~~he~~ the skier has the ability to use it with reasonable safety;

(13) Not to engage willfully or negligently in any type conduct that contributes to or causes injury to another person or his properties;

(14) Not to embark upon a passenger tramway without the authority of the ski area ~~operator.~~operator;

(15) If using freestyle terrain, to know the range of the skier's abilities to negotiate the terrain and to avoid conditions and obstacles beyond the limits of such ability that a visible inspection should have revealed.

(c) A ski area operator shall have the following responsibilities:

(1) To mark all trails and maintenance vehicles and to furnish such vehicles with flashing or rotating lights that shall be in operation whenever the vehicles are working or moving in the ski area;

(2) To mark with a visible sign or other warning implement the location of any hydrant or similar equipment that is used in snowmaking operations and located anywhere in the ski area;

(3) To indicate the relative degree of difficulty of a slope or trail by appropriate signs. Such signs are to be prominently displayed at the base of a slope where skiers embark on a passenger tramway serving the slope or trail, or at the top of a slope or trail. The signs must be of the type that have been approved by the National Ski Areas Association and are in current use by the industry;

(4) To post at or near the top of or entrance to, any designated slope or trail, signs giving reasonable notice of unusual conditions on the slope or trail;

(5) To provide adequate ski patrols;

(6) To mark clearly any hidden rock, hidden stump, or any other hidden hazard known by the ski area operator to exist;

(7) To inspect the winter sports slopes, alpine and Nordic ski trails, and freestyle terrains that are open to the public at least twice daily and maintain a log recording: (i) the time of the inspection and the name of the inspector(s); and (ii) the general surface conditions, based on industry standards, for the entire ski area at the time of the inspections;

(8) To post, in a conspicuous manner, the general surface conditions for the entire ski area twice daily; and

~~(7)~~(9) Not to engage willfully or negligently in any type conduct that contributes to or causes injury to another person or his properties.

"§ 99C-3. Violation constitutes negligence.

A violation of any responsibility placed on the skier, passenger or ski area operator as set forth in G.S. 99C-2, to the extent such violation proximately causes injury to any person or damage to any property, shall constitute negligence on the part of the person violating the provisions of that section.

"§ 99C-4. Competition.

The ski area operator shall, prior to the beginning of a competition, allow each competitor a reasonable visual inspection of the course or area where the competition is to be held. The

competitor shall be held to assume risk of all course conditions including, but not limited to, weather and snow conditions, course construction or layout, and obstacles which a visual inspection should have revealed. No liability shall attach to a ski area operator for injury or death of any competitor proximately caused by such assumed risk.

"**§ 99C-5. Operation of passenger tramway.**

The operation of a passenger tramway shall not constitute the operation of a common carrier."

SECTION 2. This act becomes effective October 1, 2009.

HOUSE BILL 334:
Revise NC Ski Safety Statutes

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Judiciary I	**Date:**	May 4, 2009
Introduced by:	Reps. Tarleton, Goforth, Frye, Rapp	**Prepared by:**	Bill Patterson
Analysis of:	PCS to First Edition H334-CSMH-1		Committee Counsel

SUMMARY: House Bill 334 (PCS) would impose additional duties upon skiers and would impose additional inspection and reporting obligations upon ski area operators.

CURRENT LAW: Chapter 99C of the General Statutes imposes certain duties upon ski area operators and skiers, and makes violation of those duties negligence if it proximately causes injury to any person or damage to any property. Currently, Chapter 99C does not specifically address activities such as snowboarding or the use of terrain modified by the addition of jumps, rails, half pipes, bumps and other features resulting in so-called "freestyle terrain."

BILL ANALYSIS: House Bill 334 (PCS) would modify the current law by defining "skier" to include any person participating in "winter sports," and by defining "winter sports" as "any use of skis, snowboards, snowshoes, or any other device for skiing, sliding, jumping, or traveling on snow or ice." The PCS defines "ski area" to include "winter sports" slopes, "alpine and Nordic ski trails," and "freestyle terrain," and defines "freestyle terrain" as "constructed and natural features in ski areas intended for winter sports including, but not limited to, terrain parks and terrain park features such as jumps, rails, fun boxes, half pipes, quarter pipes, and freestyle bump terrain."

The PCS would revise G.S. 99C(2)(b) to require skiers generally to keep a proper lookout to avoid "obvious hazards and inherent risks, including variations in terrain, snow, or ice conditions, bare spots and rocks, trees and other forms of forest growth or forest debris" and to require skiers using freestyle terrain "to know the range of the skier's abilities to negotiate the terrain and to avoid conditions and obstacles beyond the limits of such ability that a visible inspection should have revealed."

The PCS would also revise G.S. 99C(2)(c) to require ski area operators to inspect and record the condition of the winter sports slopes, alpine and Nordic ski trails, and freestyle terrains that are open to the public, and to post the general surface conditions for the entire ski area, twice daily.

The PCS removed language that would have deemed skiers to have assumed the inherent, obvious and necessary risks of skiing and winter sports, and that would have deemed skiers using freestyle terrain to have assumed the risk of all terrain conditions which a visible inspection should have revealed. In its place, the PCS added provisions, discussed above, imposing upon skiers the duty to keep a proper lookout, to know their ability to negotiate terrain, and to avoid conditions and obstacles that are beyond the limits of that ability.

EFFECTIVE DATE: This act becomes effective October 1, 2009.

H334-SMTG-36(CSMH-1) v1

HOUSE BILL 1090:
UI/Severance Modifications

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Appropriations	**Date:**	May 3, 2009
Introduced by:	Rep. Wainwright	**Prepared by:**	Kory Goldsmith Committee Counsel
Analysis of:	First Edition		

SUMMARY: House Bill 1090 would allow a person who is receiving severance pay to be considered unemployed for purposes of collecting unemployment insurance benefits provided that person met the other criteria for determining employment..

CURRENT LAW: G.S. 96-8(10) defines what constitutes total (separated) and partial (attached) unemployment. Separated unemployment occurs when an individual is out of work for an indefinite period and no longer has any attachment to the payroll or work force of any employing unit. Attached unemployment occurs when an individual retains an attachment to the payroll and work force of an employer, but works less than three customarily scheduled workdays (or less than 60% of the customarily scheduled work hours) during a payroll week because the employer could not provide full-time work. Attached unemployment is also referred to as a "temporary layoff".

G.S. 96-8(10)c. provides that the following individuals will not be considered to be unemployed, if during the calendar week, the individual receives any of the following as a result to separation from employment:

- Wages in lieu of notice
- Accrued vacation pay
- Terminal leave pay
- Severance pay
- Separation pay (unless the individual is attending an institution of higher education, a secondary school, or an approved vocational, educational or training program)
- Dismissal payments or wages by whatever name.

BILL ANALYSIS: House Bill 1090 amends G.S. 96-8(10) to provide that an individual who receives severance pay may be considered unemployed, provided the individual meets the other criteria for determining unemployment.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: The Social Security Act of 1935 and Chapter 96 of the General Statutes of North Carolina (the Employment Security Law) provide the basic framework for administering the unemployment insurance program in North Carolina. The unemployment insurance program in North Carolina is part of a national system designed to provide temporary economic benefits to eligible workers. Eligible workers are individuals who (1) lost their jobs through no fault of their own, (2) worked during a specified time period and received a minimum amount of wages during that time period, (3) are able and available for work, and (4) are actively seeking new employment. All benefits and administrative costs of the unemployment insurance program are paid by employers through State Unemployment Tax Act (SUTA) and the Federal Unemployment Tax Act (FUTA) payments. Quarterly revenues from a SUTA and FUTA based on a percentage of each liable employer's payroll provide funds

which can be used only to pay unemployment benefits to eligible workers and to administer the unemployment insurance program.

H1090-SMRC-25(e1) v1

HOUSE BILL 1090

Short Title:	UI/Severance Modifications.	(Public)
Sponsors:	Representatives Wainwright; Faison, Lucas, and Parmon.	
Referred to:	Insurance, if favorable, Appropriations.	

April 7, 2009

A BILL TO BE ENTITLED

AN ACT AMENDING THE DEFINITION OF TOTAL AND PARTIAL UNEMPLOYMENT RELATING TO THE TREATMENT OF SEVERANCE PAY UNDER THE EMPLOYMENT SECURITY LAWS OF NORTH CAROLINA.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 96-8(10) reads as rewritten:

"(10) Total and partial unemployment.

a. For the purpose of establishing a benefit year, an individual shall be deemed to be unemployed:

1. If ~~he~~ the individual has payroll attachment but, because of lack of work during the payroll week for which ~~he~~ the individual is requesting the establishment of a benefit year, ~~he~~ the individual worked less than the equivalent of three customary scheduled full-time days in the establishment, plant, or industry in which ~~he~~ the individual has payroll attachment as a regular employee. If a benefit year is established, it shall begin on the Sunday preceding the payroll week ending date.

2. If ~~he~~ the individual has no payroll attachment on the date ~~he~~ the individual reports to apply for unemployment insurance. If a benefit year is established, it shall begin on the Sunday of the calendar week with respect to which the claimant met the reporting requirements provided by Commission regulation.

b. For benefit weeks within an established benefit year, a claimant shall be deemed to be:

1. Totally unemployed, irrespective of job attachment, if ~~his~~ a claimant's earnings for such week, including payments defined in subparagraph c below, would not reduce ~~his~~ the claimant's weekly benefit amount as prescribed by G.S. 96-12(c).

2. Partially unemployed, if ~~he~~ the claimant has payroll attachment but because of lack of work during the payroll week for which ~~he~~ the claimant is requesting benefits ~~he~~ the claimant worked less than three customary scheduled full-time days in the establishment, plant, or industry in which ~~he~~ the claimant is employed and whose earnings from such employment (including payments defined in

subparagraph c below) would qualify ~~him~~ the claimant for a reduced payment as prescribed by G.S. 96-12(c).

3. Part-totally unemployed, if the claimant had no job attachment during all or part of such week and whose earnings for odd jobs or subsidiary work (including payments defined in subparagraph c below) would qualify ~~him~~ the claimant for a reduced payment as prescribed by G.S. 96-12(c).

c. No individual shall be considered unemployed if, with respect to the entire calendar week, ~~he~~ the individual is receiving, has received, or will receive as a result of ~~his~~ the individual's separation from employment, remuneration in the form of (i) wages in lieu of notice, (ii) accrued vacation pay, (iii) terminal leave pay, ~~(iv) severance pay, (v)~~ (iv) separation pay, or ~~(vi)~~(v) dismissal payments or wages by whatever name. Provided, however, if such payment is applicable to less than the entire week, the claimant may be considered to be unemployed as defined in subsections a and b of this paragraph. Sums received by any individual for services performed as an elected official who holds an elective office, as defined in G.S. 128-1.1(d), or as a member of the N. C. National Guard, as defined in G.S. 127A-3, or as a member of any reserve component of the United States Armed Forces shall not be considered in determining that individual's employment status under this subsection. ~~Provided further, however, that an individual shall be considered to be unemployed as to receipt of severance pay for any week the individual is registered at or attending any institution of higher education as defined in G.S. 96-8(5)j., or secondary school as defined in G.S. 96-8(5)q., or Commission approved vocational, educational, or training programs as defined in G.S. 96-13.~~

d. An individual's week of unemployment shall be deemed to commence only after his registration at an employment office, except as the Commission may by regulation otherwise prescribe.

e. No substitute teacher or other substitute school personnel shall be considered unemployed for days or weeks when not called to work unless the individual is or was a permanent school employee regularly employed as a full-time substitute during the period of time for which the individual is requesting benefits."

SECTION 2. This act is effective when it becomes law.

HOUSE BILL 1084:
Revise LPG Dealer Requirements

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Commerce, Small Business, and Entrepreneurship	**Date:**	May 4, 2009
Introduced by:	Rep. Hill	**Prepared by:**	Bill Patterson Committee Counsel
Analysis of:	PCS to First Edition H1084-CSTG-17		

SUMMARY: House Bill 1084 (PCS) increases the insurance requirements for liquefied petroleum gas dealers who transport LP gas, requires inspection of LP gas containers and installations by the Agriculture Commissioner, and increases civil penalties for dealer violations.

CURRENT LAW: Article 5 of Chapter 119 of the General Statutes sets minimum safety standards for the design, construction, location, installation, and operation of equipment used in handling, storing, measuring, transporting, distributing, and utilizing liquefied petroleum ("LP") gas. Current law requires all LP gas dealers to register with the Commissioner of Agriculture annually and to maintain comprehensive general liability insurance in the amount of $100,000 and, "when applicable," comprehensive automobile liability insurance in the amount of $100,000.. Dealers who sell but do not fill LP gas containers having less than 50 pounds water capacity are currently exempt from these requirements. The Commissioner is not currently required to inspect LP gas containers or installations. Dealers who violate Article 5 are currently subject to a civil penalty of $100 for the first violation, $300 for a second violation, and $500 for a third or subsequent violation.

BILL ANALYSIS:

Section 1 of the PCS to House Bill 1084 would require all dealers who transport LP gas (defined as "Class A dealers") to maintain at least $1 million in both general liability insurance and motor vehicle insurance, regardless of the size of the containers they retail. Dealers selling LP gas in containers of at least 50 gallons water capacity, but not filling or transporting them, would be required to register and maintain $100,000 in general liability insurance. Dealers would be required to register with the Commissioner of Agriculture once rather than annually. Verification of the required insurance coverage would be a prerequisite to the Commissioner's issuance or renewal of a dealer's registration.

Section 2 of the PCS would require the Commissioner to conduct inspections of LP gas containers and facilities.

Section 3 of the PCS would increase the civil penalties to $300 for the first violation, $500 for a second violation, and $1,000 for a third or subsequent violation, and would eliminate the current requirement that the Commissioner give the violator notice of the violation and 45 days to correct or cease it before assessing a civil penalty.

Section 4 of the PCS would correct a misspelling of the word "liquefied."

The PCS deleted the original bill's provision for automatic expiration of registration upon the termination, expiration or cancellation of the required insurance coverage, and also deleted the original bill's reporting requirement for accidents involving the transport, storage or transfer of LP gas.

EFFECTIVE DATE: This act becomes effective October 1, 2009.

H1084-SMTG-35(CSTG-17) v6

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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HOUSE BILL 1084
PROPOSED COMMITTEE SUBSTITUTE H1084-CSTG-17 [v.2]

5/4/2009 4:39:22 PM

Short Title: Revise LPG Dealer Requirements. (Public)

Sponsors:

Referred to:

April 7, 2009

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LP GAS LAW TO CREATE CLASSES OF DEALERS FOR THE PURPOSE OF INSURANCE REQUIREMENTS, TO CLARIFY THE AUTHORITY TO CONDUCT INSPECTIONS, TO INCREASE CIVIL PENALTIES, AND TO MAKE TECHNICAL CHANGES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 119-56 reads as rewritten:

"**§ 119-56. Registration of dealers; liability insurance or substitute required.**

A person shall not hold himself out or commence operation as a dealer without first having registered as ~~herein provided~~ provided in this section. A dealer shall ~~annually on or before January 1 of each year~~ register with the Commissioner on a form to be furnished by the Commissioner. Such form shall give the name and address of the dealer, the place or places of and type or types of business ~~[of]~~of such dealer, and such other pertinent information as the Commissioner may deem necessary. Verification of the insurance coverage required by this section or of proof of alternative means of financial responsibility permitted by this section shall be submitted to the Commissioner as a condition of the issuance of any registration or renewal of such registration.

There shall be two classes of dealers:

(1) A class A dealer is one who engages in the transportation of liquefied petroleum gas.

(2) A class B dealer is one who does not engage in the transportation of liquefied petroleum gas.

~~A dealer shall obtain and maintain comprehensive general liability insurance including product liability of one hundred thousand dollars ($100,000) combined single limits and, when applicable, comprehensive automobile liability insurance of one hundred thousand dollars ($100,000) combined single limits.~~ A class A dealer shall obtain and maintain general liability insurance, including product liability, of one million dollars ($1,000,000) and motor vehicle liability insurance of one million dollars ($1,000,000) combined single limit. A class B dealer shall obtain and maintain general liability insurance, including product liability, of one hundred thousand dollars ($100,000). Verification of said insurance coverage shall be made in a manner satisfactory to the Commissioner. The Commissioner may from time to time request in writing that a dealer provide within 10 days of such request verification of said insurance coverage or proof of alternative means of financial responsibility. In lieu of insurance, the dealer may file and maintain a bond, certificate of deposit or irrevocable letter of credit in a form satisfactory

to the Commissioner which provides protection for the public in the same amounts and to the same extent as said insurance.

The provisions of this section shall not apply to a dealer who retails liquefied petroleum gas in containers of less than 50 pounds water capacity and which retailing does not involve the filling or transportation of such containers."

SECTION 2. G.S. 119-57 reads as rewritten:

"**§ 119-57. Administration of Article; rules and regulations given force and effect of law.**

It shall be the duty of the Commissioner to administer all the provisions of this Article and all the rules and regulations made and promulgated under this Article; to conduct inspections of liquefied petroleum gas containers and installations; to investigate for violations of this Article and the rules and regulations adopted pursuant to the provisions thereof, and to prosecute violations of this Article or of such rules and regulations adopted pursuant to the provisions thereof."

SECTION 3. G.S. 119-59 reads as rewritten:

"**§ 119-59. Sanctions for violations.**

(a) Criminal. – A dealer who violates a provision of this Article or a rule adopted under it is guilty of a Class 1 misdemeanor.

(b) Injunction. – The Commissioner or an agent of the Commissioner may apply to any superior court judge and the court may temporarily restrain or preliminarily or permanently enjoin any violation of this Article or a rule adopted under it.

(c) Civil Penalty. – The Commissioner may assess a civil penalty against any person who violates a provision of this Article or a rule adopted under it. The penalty may not exceed ~~one hundred dollars ($100.00)~~three hundred dollars ($300.00) for the first violation, ~~three hundred dollars ($300.00)~~five hundred dollars ($500.00) for a second violation, and ~~five hundred dollars ($500.00)~~one thousand dollars ($1,000) for a third or subsequent violation. In determining the amount of a penalty, the Commissioner shall consider the degree and extent of harm or potential harm that has resulted or could have resulted from the violation. ~~The Commissioner may not assess a civil penalty against a person until the Commissioner has notified the person of the alleged violation and has given the person at least 45 days to correct or cease the alleged violation. A notice may be served by any means authorized by G.S. 1A-1, Rule 4.~~ The clear proceeds of civil penalties assessed pursuant to this subsection shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2.

(d) Registration. – The Commissioner may deny, suspend, or revoke the registration of a dealer who violates a provision of this Article or a rule adopted under it."

SECTION 4. G.S. 119-61 reads as rewritten:

"**§ 119-61. Replacement data plates for ~~liquified~~ liquefied petroleum gas tanks.**

A ~~liquified~~ liquefied petroleum gas tank of 120 gallons or more that is subject to the American Society of Mechanical Engineers (ASME) Code must have a data plate indicating that it was built in accordance with that Code. The Commissioner may issue a data plate to replace a rusting or partially detached data plate on a ~~liquified~~ liquefied petroleum gas tank. The Commissioner shall charge a person to whom a replacement data plate is issued a fee of twenty dollars ($20.00) for the plate. Fees collected under this section shall be credited to the Department of Agriculture and Consumer Services and applied to the cost of issuing replacement data plates."

SECTION 5. This act becomes effective October 1, 2009.

HOUSE BILL 1162:
DOI Disaster Powers Apply to SHP-AB

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Appropriations	**Date:**	May 4, 2009
Introduced by:	Reps. Wray, Goforth	**Prepared by:**	Ben Popkin
Analysis of:	PCS to First Edition H1162-CSRD-38		Committee Counsel

SUMMARY: ***House Bill 1162 would add the State Health Plan to the definition of 'insurance company' in G.S. 58-2-46(2) so that Plan enrollees would be allowed to defer premium or debt payments for 30 days whenever a state of disaster has been proclaimed or declared for the State or the area where the enrollee resides. In addition to payments, this provision applies 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."***

The Proposed Committee Substitute makes a technical change to correct a statutory reference.

CURRENT LAW: G.S. 58-2-46 "State of disaster; automatic stay of proof of loss requirements; premium and debt deferrals; loss adjustments for separate windstorm policies" provides for deferrals or stays of payments or other time limited actions required by policy, contract provision, or otherwise, in the event that one of the following has occurred:

- A state of disaster has been proclaimed for the State or for an area within the State under G.S. 166A-6 (proclamation by Governor or by General Assembly resolution); or
- A major disaster declaration has been issued by the President of the United States for the State or for an area within the State under the Stafford Act (42 U.S.C. 5121).

G.S. 58-2-46(2) provides for a deferral period of 30 days from the last day the premium or debt payment was due under the terms of the contract or policy, and extends the deferral 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..."

The deferral applies to time limitations imposed on both insured and insurer, and may be extended by the Commissioner of Insurance "...depending on the nature and severity of the proclaimed or declared disaster."

BILL ANALYSIS: House Bill 1162 would add the State Health Plan to the list of entities currently covered by this statute's deferral provision – service corporations, HMOs, MEWAs, surplus lines insurers, and underwriting associations, premium finance companies, and collection agencies.

EFFECTIVE DATE: This act becomes effective July 1, 2009.

H1162-SMRD-82(CSRD-38) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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HOUSE BILL 1162
PROPOSED COMMITTEE SUBSTITUTE H1162-CSRD-38 [v.1]

5/4/2009 12:00:43 PM

Short Title: DOI Disaster Powers Apply to SHP-AB. (Public)

Sponsors:

Referred to:

April 8, 2009

A BILL TO BE ENTITLED

AN ACT AT THE REQUEST OF THE INSURANCE COMMISSIONER TO PROVIDE TEACHERS AND STATE EMPLOYEES AND THEIR DEPENDENTS THE SAME PROTECTION IN DISASTER SITUATIONS AS OTHER INSURED PERSONS IN THIS STATE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-2-46 reads as rewritten:

"**§ 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:

...

(2) As used in this subdivision, "insurance company" includes a service corporation, HMO, MEWA, surplus lines insurer, the State Health Plan for Teachers and State Employees, together with any optional plans or programs operating under Part 2 of Article 3A of Chapter 135 of the General Statutes, 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. 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.

..."

SECTION 2. This act becomes effective July 1, 2009.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: House Bill 1162 (First Edition)

SHORT TITLE: DOI Disaster Powers Apply to SHP-AB.

SPONSOR(S): Representatives Goforth and Wray

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY:

April 7, 2009
H 1162. DOI DISASTER POWERS APPLY TO SHP. Filed 4/7/09. AT THE REQUEST OF THE INSURANCE COMMISSIONER TO PROVIDE TEACHERS AND STATE EMPLOYEES AND THEIR DEPENDENTS THE SAME PROTECTION IN DISASTER SITUATIONS AS OTHER INSURED PERSONS IN THIS STATE.
Amends GS 58-2-46(2) to expand the definition of insurance company, as used in subdivision (2) relating to the option of customers deferring insurance premiums or debt payments during the proclamation or declaration of a state of disaster for the state or an area within the state, to include the State Health Plan for Teachers and State Employees, together with any optional plans or programs operating under Part 2 of Article 3 of GS Chapter 135. Effective July 1, 2009
Source: Bill Digest H.B. 1162 (04/07/0200).

EFFECTIVE DATE: July 1, 2009

ESTIMATED IMPACT ON STATE:

Aon Consulting, the consulting actuary for the State Health Plan for the Teachers and State Employees, estimates that the bill will have a negligible financial impact on the Plan.

Hartman & Associates, the consulting actuary for the General Assembly's Fiscal Research Division, estimates that the bill will not have a material financial impact on the Plan.

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2008, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.6 billion for FY 2008-09. The Plan's PPO benefit design includes three alternative benefit levels offered to plan members. The three alternative benefit levels include the following:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums;

2) The "Standard" 80/20 plan; and

3) The "Plus" 90/10 plan with enhanced benefits via lower out-of pocket requirements as compared to the other PPO plan alternatives offered.

As of July 1, 2009, the State will continue to finance the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts will be derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage will be paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.5 billion for FY 2009-10 and $2.7 billion for FY 2010-11. The Plan's PPO benefit design will include two alternative benefit levels listed below:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums; and

2) The "Standard" 80/20 plan.

The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under both plans is offered on a fully contributory basis.

Financial Condition

Financial Projection (Revised Summer 2008) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year were projected to be $2.3 billion from premium collections, $53.9 million from Medicare Part D subsidies, and $2.7 million from investment earnings, for a total of slightly over $2.3 billion in receipt income for the year. Projected disbursements from the Plan were expected to be $2.4 billion in claim-payment expenses and $168.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating loss was projected to be approximately $264.4 million for the fiscal year, assuming a 9% annual claims growth trend.

Projected operating losses were expected to deplete the Plan's cash balance of $139.8 million and leave it without sufficient operating resources to continue operations for the fiscal year.

Financial Projection (Revised April 2009) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year are projected to be $2.3 billion from premium collections, $49.0 million from Medicare Part D subsidies, $3.3 million from investment earnings, and $250.0 million from a direct General Fund appropriation from the Rainy Day Fund (Savings Reserve Account) for a total of approximately $2.6 billion in receipt income for the year. The $250 million from a direct General Fund appropriation was provided by Session Law 2009-16 (Senate Bill 287) to finance a shortfall in funds available to pay health care benefits, administrative costs, and adequately fund the Plan's beginning cash balance on July 1, 2009. Projected disbursements from the Plan are expected to be $2.4 billion in claim-payment expenses and $180.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating income is projected to be approximately $7.1 million for the fiscal year, assuming a 9% annual claims growth trend.

Financial Projection 2009-11 Biennium (April 2009) – Session Law 2009-16 (Senate Bill 287) appropriates funds from various sources, authorizes annual premium rate increases, makes various benefit and provider related changes to achieve financial savings, and directs other various changes to the Plan. The enacted law also appropriates the sum of $250 million from the Savings Reserve Account ("Rainy Day Fund") of the General Fund for the 2008-09 fiscal year. The following summarized financial projections by fiscal year for the 2009-11 biennium assume the changes enacted in Session Law 2009-16 (Senate Bill 287).

For the fiscal year beginning July 1, 2009, the Plan is projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year are projected to be $2.4 billion from premium collections, $56.3 million from Medicare Part D subsidies, and $8.0 million from investment earnings for a total of approximately $2.5 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.3 billion in claim-payment expenses and $185.6 million in administration and claims-processing expenses for projected total expenses of nearly $2.5 billion for FY 2008-09. The Plan's net operating income is projected to be approximately $14.8 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan is projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year are projected to be $2.7 billion from premium collections, $50.4 million from Medicare Part D subsidies, and $8.8 million from investment earnings for a total of approximately $2.7 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.5 billion in claim-payment expenses and $191.7 million in administration and

claims-processing expenses for projected total expenses of nearly $2.7 billion for FY 2010-11. The Plan's net operating income is projected to be approximately $30.6 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Other Information

Historically, the Plan has applied a premium increase in October of the first fiscal year of a biennium. However, the annual premium increases authorized in Session Law 2009-16 (Senate Bill 287) changes that methodology to an annual increase at the beginning of each fiscal year of the 2009-11 biennium.

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment Data as of December 31, 2008

I. No. of Participants	Basic	Standard	Plus	Total	Percent of Total
Actives					
Employees	11,623	271,243	47,687	330,553	49.6%
Dependents	20,454	115,875	28,156	164,485	24.7%
Sub-total	32,077	387,118	75,843	495,038	74.2%
Retired					
Employees	1,726	127,081	17,967	146,774	22.0%
Dependents	1,117	14,935	3,476	19,528	2.9%
Sub-total	2,843	142,016	21,443	166,302	24.9%
Former Employees with Continuation Coverage					
Employees	60	1,349	344	1,753	0.3%
Dependents	61	501	182	744	0.1%
Sub-total	121	1,850	526	2,497	0.4%
Firefighters, Rescue Squad & National Guard					
Employees	-	3	2	5	0.0%
Dependents	-	3	-	3	0.0%
Sub-total	-	6	2	8	0.0%
Local Governments					
Employees	72	1,577	319	1,968	0.3%
Dependents	141	637	218	996	0.1%
Sub-total	213	2,214	537	2,964	0.4%
Total					
Employees	13,481	401,253	66,319	481,053	72.1%
Dependents	21,773	131,951	32,032	185,756	27.9%
Grand Total	**35,254**	**533,204**	**98,351**	**666,809**	**100%**
Percent of Total	**5.3%**	**80.0%**	**14.7%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	2,684	328,635	49,246	380,565
Employee Child(ren)	4,958	36,903	8,589	50,450
Employee Spouse	2,274	18,145	4,469	24,888
Employee Family	3,565	17,570	4,015	25,150
Total	**13,481**	**401,253**	**66,319**	**481,053**

Percent Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	19.9%	81.9%	74.3%	79.1%
Employee Child(ren)	36.8%	9.2%	13.0%	10.5%
Employee Spouse	16.9%	4.5%	6.7%	5.2%
Employee Family	26.4%	4.4%	6.1%	5.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Enrollment Data Continued

III. Enrollment by Sex	Basic	Standard	Plus	Total
Female	18,837	334,917	61,752	415,506
Male	16,417	198,287	36,599	251,303
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Sex	Basic	Standard	Plus	Total
Female	53.4%	62.8%	62.8%	62.3%
Male	46.6%	37.2%	37.2%	37.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	17,390	136,277	27,211	180,878
30 to 44	8,125	107,375	17,315	132,815
45 to 54	5,164	94,548	18,277	117,989
55 to 64	3,195	102,901	23,452	129,548
65 & Over	1,380	92,103	12,096	105,579
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	49.3%	25.6%	27.7%	27.1%
30 to 44	23.0%	20.1%	17.6%	19.9%
45 to 54	14.6%	17.7%	18.6%	17.7%
55 to 64	9.1%	19.3%	23.8%	19.4%
65 & Over	3.9%	17.3%	12.3%	15.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	49,534	12,080	61,614
Medicare Eligible	97,240	7,448	104,688
Total	**146,774**	**19,528**	**166,302**

Percent by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.7%	61.9%	37.0%
Medicare Eligible	66.3%	38.1%	63.0%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, "House Bill 1162: An Act to Provide Teachers and State Employees and Their Dependents the Same Protection in Disaster Situations as Other Insured Persons in This State", April 30, 2009, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "House Bill 1162 DOI Disaster Powers Apply to State Health Plan", April 29, 2009, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Marilyn Chism, Director
Fiscal Research Division

DATE: May 4, 2009

Signed Copy Located in the NCGA Principal Clerk's Offices

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1294
PROPOSED COMMITTEE SUBSTITUTE H1294-CSRC-21 [v.3]

5/4/2009 10:26:10 PM

Short Title: NC Risk Pool Premiums/Notice Requirements. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE NORTH CAROLINA HEALTH INSURANCE RISK POOL TO PROVIDE PREMIUM SUBSIDIES IF FUNDS ARE AVAILABLE AND TO REQUIRE INSURERS TO NOTIFY APPLICANTS FOR HEALTH INSURANCE COVERAGE ABOUT THE EXISTENCE OF THE POOL.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-180(e) reads as rewritten:

"(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 acting upon the approval or authorization of 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.

(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.

(4a) Provide premium subsidies if funds are available for individuals with incomes up to three hundred percent (300%) of the federal poverty guidelines.

(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) Establish policies, conditions, and procedures for reinsuring risks of participating health insurers, as defined in G.S. 58-68-25(a), 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.

(8) Employ and fix the compensation of employees.

(9) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public.

(10) Provide for reinsurance for the Pool.

(11) Issue additional types of health insurance policies to provide optional coverage, including Medicare supplemental insurance coverage.

(12) Provide for and employ cost containment measures and requirements including preadmission screening, second surgical opinion, concurrent utilization review, disease management, individual case management, health and wellness programs including a smoking cessation initiative, and other commonly used benefit plan design features for the purpose of making health insurance coverage offered by the Pool more cost-effective.

(13) 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.

(14) Adopt bylaws, policies, and procedures as may be necessary or convenient for the implementation of this Part and the operation of the Pool."

SECTION 2. Article 3 of Chapter 58 is amended to add a new section to read:

"**§ G.S. 58-3-276. Notice relating to the North Carolina Health Insurance Risk Pool.**

(a) An insurer shall provide a written notice of the existence of the North Carolina Health Insurance Risk Pool to an applicant for individual health insurance coverage upon the insurer making a determination that any of the following apply:

(1) The applicant is eligible for coverage by the Pool as provided in G.S. 58-50-195(a)(1) or (2).

(2) The applicant is an "eligible individual" as defined in G.S. 58-68-60(b).

(3) The applicant 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 notice required in subsection (a) of this section shall be issued to an applicant no later than 10 business days after the insurer reaches a determination under subsection (a) of this section. An insurer may issue a single notice relating to multiple applicants located at a single address provided the notice lists the name of each individual affected separately.

(c) The Commissioner may adopt rules to implement this section, including rules establishing the language, content, format, and methods of distribution of the notice required by this section.

(d) For purposes of this section:

(1) "Applicant" means any person who seeks to contract for individual health insurance coverage, including any dependent for which application is made and about whom an independent underwriting decision is made by an insurer.

(2) "Health insurance coverage" is as defined in G.S. 58-50-175(10)

(3) "Insurer" is as defined in G.S. 58-50-175(13)."

SECTION 3. Section 2 applies to applications for health insurance coverage made on or after October 1, 2009. The remainder of this act is effective when it becomes law.

HOUSE BILL 1294:
NC Risk Pool Clarifications

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Judiciary II	**Date:**	May 4, 2009
Introduced by:	Rep. Dockham	**Prepared by:**	Kory Goldsmith Committee Counsel
Analysis of:	PCS to First Edition H1294-CSRC-21		

SUMMARY: ***House Bill 1294 would allow the Board of Directors of the High Risk Insurance Pool to provide premium subsidies to individuals with income levels up to 300% of the federal poverty guidelines, if funds are available. It would also require insurers to notify applicants for health insurance coverage about the existence of the High Risk Insurance Pool.***

CURRENT LAW: The Board must review on a regular basis methods for providing a premium subsidy to individuals with income levels up to 300% of the federal poverty guidelines. The Board must report this information to the General Assembly annually. There are no current requirements that insurers notify applicants for health insurance coverage of the existence of the High Risk Insurance Pool.

EFFECTIVE DATE: The notice requirement applies to applications received on or after October 1, 2009. The remainder of the bill is effective when it becomes law.

BACKGROUND: The 2009 federal poverty guidelines are provided below.

The 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in family	**Poverty guideline**
1	$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010
For families with more than 8 persons, add $3,740 for each additional person.	

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1392
Second Edition Engrossed 4/21/09
PROPOSED COMMITTEE SUBSTITUTE H1392-CSRC-20 [v.1]

5/3/2009 11:09:24 AM

Short Title: NC Risk Pool Changes/Out-of-State Services. (Public)

Sponsors:

Referred to:

April 13, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE NORTH CAROLINA HEALTH INSURANCE RISK POOL TO NEGOTIATE RATES FOR SERVICES PROVIDED TO PERSONS COVERED UNDER THE POOL BY OUT-OF-STATE PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-190(d) reads as rewritten:

"**§ 58-50-190. Risk Pool rates and policy forms.**

...

(d) ~~Provider~~ Except as otherwise provided in this subsection for services rendered outside of North Carolina, provider reimbursement rates under Pool coverage shall be limited to the rates allowed for providers under the Medicare Program for those services covered by Medicare. The Board shall establish reimbursement rates for services for which Medicare has not established an allowed rate. Providers rendering medical care to an insured shall accept payment of the amount established under this subsection, including any applicable deductible, coinsurance, or co-payment amounts, as payment in full for services rendered. For providers rendering emergency services to an insured outside this State, the Pool is authorized to negotiate and settle such claims at reimbursement rates that may exceed the rates allowed under the Medicare program.

...."

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

HOUSE BILL 1392:
NC Risk Pool Changes/Out-of-State Services

2009-2010 General Assembly

Committee:	House Insurance	**Date:**	May 3, 2009
Introduced by:	Rep. Insko	**Prepared by:**	Kory Goldsmith Committee Counsel
Analysis of:	PCS to Second Edition H1392-CSRC-20		

SUMMARY: ***House Bill 1392 would authorize the North Carolina Health Insurance Risk Pool to negotiate and settle claims for Medicare-covered emergency services provided outside North Carolina to an insured. The negotiated reimbursement rate may exceed the rates allowed for those services under Medicare.***

The Proposed Committee Substitute makes a technical change by substituting a defined term for language in the 2nd Edition.

CURRENT LAW: Subsection (d) of G.S. 58-50-190 "Risk Pool rates and policy forms" limits provider reimbursement rates under Pool coverage to "...the rates allowed for providers under the Medicare Program for those services covered by Medicare." The Board of Directors of the Pool may establish rates for services for which Medicare has not established an allowed rate.

When individuals insured by the High Risk Insurance Pool require out-of-state emergency services, the providers can bill the Pool for up to the Medicare rate for the service, and also bill the insured for any remaining balance. The Pool has no current authority to pay any portion of the balance or to negotiate a reduction in the balance.

BILL ANALYSIS: House Bill 1392 would amend G.S. 58-50-190(d) to authorize the Pool to negotiate and settle claims at reimbursement rates that may exceed Medicare rates, for emergency services provided to Pool-insured individuals outside of North Carolina.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: The North Carolina Health Insurance Risk Pool was created in 2007 and began offering coverage on January 1, 2009 for the purpose of providing "...affordable, individual health insurance coverage for North Carolinians who do not have access to an employer health plan and face higher premiums due to a pre-existing medical condition."[1]

Ben Popkin, counsel to House Health, substantially contributed to this summary.

H1392-SMRC-24(CSRC-20) v1

[1] http://www.inclusivehealth.org/pages/6/About-Us/

ATTACHMENT #2

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 1294 DATE 5/5/09

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

COMMITTEE SUBSTITUTE ✓

(Rep.) Brubaker
Sen.)

1 moves to amend the bill on page 1, line 27
2 ( ) WHICH CHANGES THE TITLE
3 by rewriting the line to read:
4 "guidelines and the Board deems it
5 fiscally prudent to do so.".
6
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18
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SIGNED _____

ADOPTED ✓ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

ATTACHMENT #1

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Beverly McCallum	DOC Prob.
Viola Spencer	SEANC DOC
~~Anonymous~~	~~None~~
Ardis Watkins	SEANC
Cheryl Perkins	Seanc
Michelle Hodges	SEANC
Allen Griffin	SEANC
Tommy Griffin	SEANC
Ron Woodson	Seanc
Betsy Vetter	AAA
John Bowdish	AstraZeneca

VISITOR REGISTRATION SHEET

House Committee on Insurance

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jud Bone	Bone & Asso.
Jayne Smithkin	NC Propane Gas Association
David McLeod	NCDACS
Stephen Benjamin	NCDA & CS
Richard Fredenburg	NCDA & CS
Dirk Taylor	NCAT
[illegible]	BCS
[illegible]	NCSAA
David Bone	MWC
DORANNA Anderson	SEANC
Kathy Cope	SEANC

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cam Cover	BPMHC
David Ebbom	SEANC
B.C. Hart	SEANC
Bonita Poole	SEANC
Eileen Dannacker	SEANC
Daniel Rahm	K+L GATES
TED Hamby	NC DOI
Tom Harris	SEANC
K Wright	BCBSNC
Will Culpepper	Moore + Van Allen
Mark Fleming	BCBSNC

Ken Wright - BCBSNC

VISITOR REGISTRATION SHEET

House Committee on Insurance

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	JDAL, PA
Christine Cruz	Wake Med
	NMRS
Mildred Spann	NCDOC
Colleen Kocheret	KLG

VISITOR REGISTRATION SHEET

House Committee on Insurance

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Shirley W. Ballard	Seanc
Suzanne Beasley Malysz	SEANC
Jaye Allen	SEANC
Patricia K Jenkins	SEANC
Amy McConkey	Smith Anderson
Barbara Conder	BBCOR
Rose Williams	NC. DOI
	ESC
	Insurance
Jordan Schrader	Asheville Citizen-Times

INSURANCE House Pages MAY 5 2009

Name of Committee: _____ **Date**: _____

1. Name: Brittany Brisson
   County: Bladen
   Sponsor: William Brisson
2. Name: Katharyn Thompson
   County: Buncombe
   Sponsor: Stam
3. Name: _____
   County: _____
   Sponsor: _____
4. Name: _____
   County: _____
   Sponsor: _____
5. Name: _____
   County: _____
   Sponsor: _____

Sgt-At-Arms

1. Name: CHARLES WILLIAMS
2. Name: ROD FINGER
3. Name: MARTHA GADISON
4. Name: BOB ROSSI

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 1090 A BILL TO BE ENTITLED AN ACT AMENDING THE DEFINITION OF TOTAL AND PARTIAL UNEMPLOYMENT RELATING TO THE TREATMENT OF SEVERANCE PAY UNDER THE EMPLOYMENT SECURITY LAWS OF NORTH CAROLINA.

☒ With a favorable report and recommendation that the 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 _____.

_____ The bill/resolution is re-referred to the Committee on _____.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 1162 A BILL TO BE ENTITLED AN ACT AT THE REQUEST OF THE INSURANCE COMMISSIONER TO PROVIDE TEACHERS AND STATE EMPLOYEES AND THEIR DEPENDENTS THE SAME PROTECTION IN DISASTER SITUATIONS AS OTHER INSURED PERSONS IN THIS STATE.

☒ 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/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.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for
HB 1294 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE NORTH CAROLINA HEALTH INSURANCE RISK POOL TO PROVIDE PREMIUM SUBSIDIES IF FUNDS ARE AVAILABLE.

☒ With a favorable report as to the committee substitute bill, which changes the title, unfavorable as to the original bill, and recommendation that the committee substitute bill be re-referred to the Committee on JUDICIARY II.

(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.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for
HB 1392 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE NORTH CAROLINA HEALTH INSURANCE RISK POOL TO NEGOTIATE RATES FOR SERVICES PROVIDED TO PERSONS COVERED UNDER THE POOL BY OUT-OF-STATE PROVIDERS.

☒ 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.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 1084 A BILL TO BE ENTITLED AN ACT TO AMEND THE LP GAS LAW TO CREATE CLASSES OF DEALERS FOR THE PURPOSE OF INSURANCE REQUIREMENTS, TO CLARIFY THE AUTHORITY TO CONDUCT INSPECTIONS, TO REQUIRE THE REPORTING OF LP GAS ACCIDENTS, TO INCREASE CIVIL PENALTIES, AND TO MAKE TECHNICAL CHANGES.

☒ With a favorable report as to the committee substitute bill, which changes the title, unfavorable as to the original bill, and recommendation that the committee substitute bill be re-referred to the Committee on COMMERCE, SMALL BUSINESS, AND ENTREPRENEURSHIP.

(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.

Mary Capps (Rep. Wray)

n: Ann Jordan (Rep. Goforth)
t: Monday, May 04, 2009 11:03 AM
Subject: Meeting Notice for May 5.doc

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

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

DAY & DATE: **Tuesday, May 5, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

HB 334 – REVISE NC SKI SAFETY STATUTES – Reps. Tarleton, Goforth, Frye and Rapp

1084 – REVISE LPG DEALER REQUIREMENTS – Rep. Hill

HB 1090 – UI/SEVERANCE MODIFICATIONS – Reps. Wainwright, Faison, Lucas and Parmon

HB 1162 – DOI DISASTER POWERS APPLY TO SHP – AB – Reps. Wray, Goforth; Faison and Lucas

HB 1294 – NC RISK POOL CLARIFICATIONS - Reps. Dockham, England and Insko

HB 1392 – NC RISK POOL CHANGES/OUT-OF-STATE SERVICES – Reps. Insko, Harrison, Holliman and Lucas

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at:**2:00 p.m.**on **April 29, 2009**.

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

05/04/2009

MINUTES

HOUSE COMMITTEE ON INSURANCE

May 7, 2009

The House Committee on Insurance met at 11:00 AM on Thursday, May 7, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael Wray; Vice Chairs: M. Dickson, and M. Setzer. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Cole, Current, Faison, Gibson, Holliman, Howard, Hughes, Lewis, Pierce and Wainwright.

Chairman Wray called the meeting to order and welcomed visitors. He recognized Sgt-At Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachments)

Chairman Wray recognized Rep. Goforth to explain HB 1160 – Fire and Rescue Pension Fund Additions. Rep. Cole made a motion for the PCS to be before the committee. Rep. Goforth explained that 10 members of the Asheville Regional Airport Fire Department had been paying into the pension fund for 10 years. This bill allowed those employees to make a lump sum payment of $10.00 for each month of service not credited and may continue as a member of the Pension Fund. Rep. Faison made a motion for a favorable report. Motion carried.

Chairman Wray recognized Rep. Folwell to explain HB 438 – State Health Plan/Calendar Year. Rep. Folwell said this bill will allow the Teachers & State Employees Comprehensive Major Medical Plan to change its' plan year from a fiscal year to a calendar year. Rep. Faison moved for a favorable report. Motion carried.

Chairman Wray recognized Rep. Tarleton to explain HB 14 – Chiropractic Services/Insurance. Because the action in 2007 was not properly done this bill reinstates co-pays to chiropractors. He said this was a patient bill. Rep. Faison offered an amendment to include OT and PT to the bill at the same co-pay. Mr. William Potter said that without the amendment Chiropractic doctors would have an unfair advantage. Rep. Blust asked to be excused from voting. On a vote of 9 to 5 the amendment carried. Rep. Howard's amendment will need a fiscal note and was not accepted. Rep. Lewis offered an amendment that substituted on Page 1, Line 14-16 the words "insured for chiropractic services that is higher than the co-payment amount charged under the State Health Plan for Teachers and State Employees". Rep. Tarleton said he had no problem with the amendment. Amendment and bill passed.

Chairman Wray recognized Rep. Folwell to explain HB 1022 – Workers' Compensation/Duration of Total Disability. He said that this bill would be us in line with other states. Upon further discussion it was determined that a fiscal note would be needed and was requested.

The meeting adjourned at 11:45.

Representative Michael Wray, Chairman

Ann Jordan – Committee Assistant

HOUSE INSURANCE COMMITTEE

May 7, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

HB 1494 – REVISE UM/UIM COVERAGE REQUIREMENTS – Reps. Goforth, Insko, Lucas and Tarleton

HB 1160 – FIREFIGHTERS' RELIEF FUND ADDITIONS – AB – Rep. Wray and Goforth

HB 438 – STATE HEALTH PLAN/CALENDAR YEAR – Reps. Folwell, Holliman, Blackwell and Blue

HB 14 – CHIROPRACTIC SERVICES/INSURANCE – Rep. Tarleton and Goforth

HB 1485 – INSURANCE/HEALTH CARE PROVIDER RELATIONSHIP – Reps. Steen, Barnhart, Neumann and England

HB 1022 – WORKERS' COMP/DURATION OF TOTAL DISABILITY – Rep. Goforth, Folwell, Hill and Rhyne

Adjourn

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1160
PROPOSED COMMITTEE SUBSTITUTE H1160-PCS30332-LL-26

Short Title: Fire and Rescue Pension Fund Additions-AB. (Public)

Sponsors:

Referred to:

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO ALLOW CERTAIN FIREFIGHTERS THE OPPORTUNITY TO CONTINUE AS MEMBERS OF THE FIREMEN'S AND RESCUE SQUAD WORKERS' PENSION FUND BY MAKING RETROACTIVE PAYMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. Notwithstanding any other provision of law, any member who was a firefighter employed by the Asheville Regional Airport Fire Department on April 1, 2005, and who has not received credit for periods of service with the Firemen's and Rescue Squad Workers' Pension Fund since that time, may receive credit for that service upon making a lump sum payment of ten dollars ($10.00) for each month of service not credited and may continue as a member of the Pension Fund as long as the firefighter is continuously employed by the Asheville Regional Airport Fire Department.

SECTION 2. This act is effective when it becomes law.

HOUSE BILL 1160

Short Title:	Firefighters' Relief Fund Additions-AB.	(Public)
Sponsors:	Representatives Wray, Goforth (Primary Sponsors); Glazier, Harrison, and Wainwright.	
Referred to:	Insurance, if favorable, Finance.	

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO ALLOW CERTAIN FIREFIGHTERS, WHO WERE PREVIOUSLY CERTIFIED BY THE INSURANCE COMMISSIONER FOR MEMBERSHIP IN THE FIREFIGHTERS' RELIEF FUND, THE OPPORTUNITY TO BE COVERED BY THE FIREFIGHTERS' RELIEF FUND BY MAKING RETROACTIVE PAYMENTS WITH INTEREST.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-86-45 reads as rewritten:

"**§ 58-86-45. Additional retroactive membership.**

~~(a) Any fireman or rescue squad worker who is now eligible and is a member of a fire department or rescue squad chartered by the State of North Carolina and who has not previously elected to become a member may make application through the board of trustees for membership in the fund on or before March 31, 2001. The person shall make a lump sum payment of ten dollars ($10.00) per month retroactively to the time he first became eligible to become a member, plus interest at an annual rate of eight percent (8%), for each year of his retroactive payments. Upon making the lump sum payment, the person shall be given credit for all prior service in the same manner as if he had made application for membership at the time he first became eligible. Any member who made application for membership subsequent to the time he was first eligible and did not receive credit for prior service may receive credit for this prior service upon lump sum payment of ten dollars ($10.00) per month retroactively to the time he first became eligible, plus interest at an annual rate of eight percent (8%), for each year of his retroactive payments. Upon making this lump sum payment, the date of membership shall be the same as if he had made application for membership at the time he was first eligible. Any fireman or rescue squad worker who has applied for prior service under this subsection shall have until June 30, 2001, to pay for this prior service and, if this payment is not made by June 30, 2001, he shall not receive credit for this service, except as provided in subsection (a1) of this section.~~

(a1) ~~Effective July 1, 1993, any~~Any fireman or rescue squad worker who is a current or former member of a fire department or rescue squad chartered by the State of North Carolina may purchase credit for any periods of service to any chartered fire department or rescue squad not otherwise creditable by making a lump sum payment to the Annuity Savings Fund equal to the full liability of the service credits calculated on the basis of the assumptions used for purposes of the actuarial valuation of the system's liabilities, which payment shall take into account the retirement allowance arising on account of the additional service credit commencing at the earliest age at which the member could retire on a retirement allowance, as

determined by the board of trustees upon the advice of the consulting actuary, plus an administrative fee to be set by the board of trustees.

(b) An eligible fireman or rescue squad worker who is not yet 35 years old and has not previously elected to become a member may apply to the board of trustees for membership in the fund at any time. Upon becoming a member, the worker must make a lump sum payment of ten dollars ($10.00) per month retroactively to the time the worker first became eligible to become a member, plus interest at an annual rate to be set by the board for each year of retroactive payments. Upon making this lump sum payment, the worker shall be given credit for all prior service in the same manner as if the worker had applied for membership upon first becoming eligible.

A member who is not yet 35 years old, who applied for membership after first becoming eligible, and who did not receive credit for prior service may receive credit for the prior service upon making a lump sum payment of ten dollars ($10.00) for each month since the worker first became eligible, plus interest at an annual rate to be set by the board for each year of retroactive payments. Upon making this lump sum payment, the date of membership shall be the same as if the worker had applied for membership upon first becoming eligible.

Any members who were firemen with the Asheville Regional Airport fire department in Buncombe County on November 12, 1981, and were certified by the Commissioner, who apply for membership on or after August 1, 2008, and who did not receive credit for prior service may receive credit for the prior service upon making a lump sum payment of ten dollars ($10.00) for each month since the workers first became eligible, plus interest at an annual rate to be set by the board for each year of retroactive payments. Upon making this lump sum payment, the date of membership shall be the same as if the workers had applied for membership on November 12, 1981. Any monies previously paid to the fund by the firemen shall be credited to this lump sum."

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

RETIREMENT

BILL NUMBER: House Bill 1160 (Second Edition)

SHORT TITLE: Firefighters' Relief Fund Additions-AB.

SPONSOR(S): Representatives Goforth and Wray

FUNDS AFFECTED: General Fund

SYSTEM OR PROGRAM AFFECTED: Firemen and Rescue Squad Workers' Pension Fund

EFFECTIVE DATE: When it becomes law

BILL SUMMARY: Allows the firemen that were employed with the Asheville Regional Airport Fire Department in Buncombe County and also were contributing members of the Firemen's and Rescue Squad Workers' Pension Fund as of April 2005 to continue to make contributions to the Pension Fund. There were some mistakes made in 1981 by the Department of Insurance relating to the certification of a fire department. The error was discovered in 2001 but due to reporting mistakes, the Pension Fund did not stop any contribution until April 2005.

ESTIMATED IMPACT ON STATE: The Fund's actuary, Buck Consultants, estimates the accrued liability will increase about $100,000 and the required annual contributions will be as follows:

	2009-10	2010-11	2011-12	2012-13	2013-14
Total Cost	$15,000	$15,000	$15,000	$15,000	$15,000

The General Assembly's actuary, Hartman & Associates, LLC, estimates the accrued liability will increase by $83,000 to be offset by about $4,000 in contributions that the members will pay. The annual cost will be as follows:

	2009-10	2010-11	2011-12	2012-13	2013-14
Accrued Liability	$12,300	$12,300	$12,300	$12,300	$12,300
Normal Cost	$1,700	$1,700	$1,700	$1,700	$1,700
Total Cost	$14,000	$14,000	$14,000	$14,000	$14,000

ASSUMPTIONS AND METHODOLOGY:

Firemen and Rescue Squad Workers' Pension Fund

The cost estimates of the System's Actuary are based on the employee data, actuarial assumptions and actuarial methods used to prepare the June 30, 2008 actuarial valuation of the fund. The data included 36,160 active members, 10,509 retired members in receipt of annual pensions totaling $21.4 million and actuarial value of assets equal to $317 million. Significant actuarial assumptions used include (a) an investment return rate of 7.25%, (b) the 1974 George B. Buck Mortality Table for deaths after

retirement and (c) rates of separation from active service based on Fund experience. The actuarial cost method used was the entry age method with open-end unfunded accrued liability and a frozen unfunded liquidation period of nine years. Detailed information concerning these assumptions and methods is shown in the actuary's report, which is available upon request from Stanley Moore.

SOURCES OF DATA: System Actuary – Buck Consultants
General Assembly Actuary - Hartman & Associates, LLC

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910. The above information is provided in accordance with North Carolina General Statute 120-114 and applicable rules of the North Carolina Senate and House of Representatives.

PREPARED BY: Stanley Moore

APPROVED BY: Marilyn Chism, Director
Fiscal Research Division

DATE: May 7, 2009

Official
Fiscal Research Division
Publication

Signed Copy Located in the NCGA Principal Clerk's Offices

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

RETIREMENT

REVISED

BILL NUMBER: House Bill 1160 (Proposed Committee Substitute)

SHORT TITLE: Firefighters' Relief Fund Additions-AB.

SPONSOR(S): Representatives Goforth and Wray

FUNDS AFFECTED: General Fund

SYSTEM OR PROGRAM AFFECTED: Firemen and Rescue Squad Workers' Pension Fund

EFFECTIVE DATE: When it becomes law

BILL SUMMARY: Allows the firemen that were employed with the Asheville Regional Airport Fire Department in Buncombe County and also were contributing members of the Firemen's and Rescue Squad Workers' Pension Fund as of April 2005 to continue to make contributions to the Pension Fund. There were some mistakes made in 1981 by the Department of Insurance relating to the certification of a fire department. The error was discovered in 2001 but due to reporting mistakes, the Pension Fund did not stop any contribution until April 2005.

ESTIMATED IMPACT ON STATE: The Fund's actuary, Buck Consultants, estimates the accrued liability will increase about $100,000 and the required annual contributions will be as follows:

	2009-10	2010-11	2011-12	2012-13	2013-14
Total Cost	$15,000	$15,000	$15,000	$15,000	$15,000

The General Assembly's actuary, Hartman & Associates, LLC, estimates the accrued liability will increase by $83,000 to be offset by about $4,000 in contributions that the members will pay. The annual cost will be as follows:

	2009-10	2010-11	2011-12	2012-13	2013-14
Accrued Liability	$12,300	$12,300	$12,300	$12,300	$12,300
Normal Cost	$1,700	$1,700	$1,700	$1,700	$1,700
Total Cost	$14,000	$14,000	$14,000	$14,000	$14,000

ASSUMPTIONS AND METHODOLOGY:

Firemen and Rescue Squad Workers' Pension Fund

The cost estimates of the System's Actuary are based on the employee data, actuarial assumptions and actuarial methods used to prepare the June 30, 2008 actuarial valuation of the fund. The data included 36,160 active members, 10,509 retired members in receipt of annual pensions totaling $21.4 million

and actuarial value of assets equal to $317 million. Significant actuarial assumptions used include (a) an investment return rate of 7.25%, (b) the 1974 George B. Buck Mortality Table for deaths after retirement and (c) rates of separation from active service based on Fund experience. The actuarial cost method used was the entry age method with open-end unfunded accrued liability and a frozen unfunded liquidation period of nine years. Detailed information concerning these assumptions and methods is shown in the actuary's report, which is available upon request from Stanley Moore.

SOURCES OF DATA: System Actuary – Buck Consultants
General Assembly Actuary - Hartman & Associates, LLC

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910. The above information is provided in accordance with North Carolina General Statute 120-114 and applicable rules of the North Carolina Senate and House of Representatives.

PREPARED BY: Stanley Moore

APPROVED BY:

Marilyn Chism, Director
Fiscal Research Division

DATE: May 6, 2009

buckconsultants
an ACS company

May 6, 2009

Mr. David Vanderweide
Policy Director
State of North Carolina
Department of State Treasurer
Retirement Systems Division
325 North Salisbury Street
Raleigh, NC 27603-1385

Re: House Bill 1160

Dear Mr. Vanderweide:

We have received your request of May 4 regarding House Bill 1160, which affects the Firemen's and Rescue Squad Workers' Pension Fund (FRSWPF).

This proposed legislation appears to allow members who were employees of the Asheville Regional Airport Fire Department on April 1, 2005, to receive credit for past service upon paying $10 per month for such past service. This proposed legislation also provides that these employees may continue as members of FRSWPF as long as they are continuously employed by the Asheville Regional Airport Fire Department.

Based on the results of the June 30, 2008 valuation and the data submitted on May 4, this proposed legislation would not materially increase the liabilities (less than 0.03% or about $100,000) or the required contribution (less than 0.20% or about $15,000 per year) of FRSWPF.

Our cost estimate for this proposed change is based on the June 30, 2008, valuation and does not reflect the asset experience that occurred during the second half of 2008. The asset experience that occurred during the second half of 2008 will result in a significant increase in the required contributions for the 2010 - 2011 fiscal year.

I am an Enrolled Actuary, a Fellow of the Society of Actuaries, and a Member of the American Academy of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

14911 Quorum Drive, Suite 200 • Dallas, TX 75254-7534
972.628.6800 • 972.628.6801 (fax)

If you have any questions or need additional assistance, please let us know.

Very truly yours,

Richard A. Mackesey, FSA, EA, MAAA
Principal, Consulting Actuary

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HARTMAN & ASSOCIATES, LLC

ACTUARIAL CONSULTING

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Phone: (336) 731-4038
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668 Link Road
Lexington, NC 27295

May 4, 2009

Mr. Stanley Moore
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: House Bill 1160 Proposed Committee Substitute: An Act to Allow Certain Firefighters the Opportunity to Continue as Members of the FRSW By Making Retroactive Payments

Dear Mr. Moore:

The proposed committee substitute to this bill provides that any member who was a firefighter of the Asheville Regional Airport Fire Department on April 1, 2005, and who has not received credit for periods of service with the Fireman's and Rescue Squad Workers' (FRSW) Pension Fund since that time, may receive credit for that service by making a lump sum payment of ten dollars for each month of service not credited. The firefighter may continue as a member of the FRSW as long as he is continuously employed with the Asheville Regional Airport Fire Department. This act is effective when it becomes law.

Firefighters of the Asheville Regional Airport Fire Department were eligible to participate in the FRSW and received service credit prior to April 1, 2005 if the member contributed the required contribution of ten dollars per month. Since that time, these members have earned no credits since this is a non-certified department. To be eligible for a retirement pension under the FRSW, a member must have attained age 55 and have 20 years of service credit.

This bill would allow these members to purchase past service credits and then earn additional service, potentially qualifying them for a retirement allowance from the FRSW. This produces a cost to the FRSW.

I estimate the additional accrued liability in the FRSW under this bill would be approximately $83,000 as of June 30, 2009. This would be partially offset by lump sum payments of approximately $4,000. Amortizing the net increase over nine years produces an annual cost of $12,300. In addition, applying the FRSW normal cost rate to these members gives an additional cost of $1,700, for a total annual cost of $14,000.

This estimate is based on the most recent actuarial valuation of the FRSW as of June 30, 2008 and data you provided for nine firefighters affected by this bill. I assumed all nine members are still employed with the fire department and that all elect to make the lump sum payment for the past service credit. I assumed these members would only be eligible for a refund of employee contributions in the absence of this bill.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, FCA, EA
Consulting Actuary

MVH/mt

NORTH CAROLINA GENERAL ASSEMBLY
Legislative Services Office
George R. Hall, Legislative Services Officer

Fiscal Research Division
300 N. Salisbury Street, Suite 619
Raleigh, NC 27603-5925
Tel. 919-733-4910 Fax 919-715-3589

Marilyn Chism
Director

May 4, 2009

MEMORANDUM

TO: Representative Bruce Goforth

FROM: Stanley Moore
Fiscal Research Division

SUBJECT: Committee Substitute for House Bill 1160

In order to be a member of the Firemen's and Rescue Squad Workers' Pension Fund, the fire department, that a fireman is a member of, must be certified by the Department of Insurance. In 1981, then Insurance Commission, John Ingram, wrote to the Asheville Airport Fire Department and told them they were a certified fire department. This letter was in error.

So members of the fire department joined the Firemen's and Rescue Squad Workers' Pension Fund and made contributions. The error of the Insurance Commissioner was discovered in 2001 but somehow in the method that firemen are reported to the Pension Fund, this was not acted upon until April 2005. Members of the department were then stopped from making any further contributions after that date.

The proposed committee substitute for House Bill 1160 will allow those members who were member in April 2005 to continue to make contributions and receive credit in the Firemen's and Rescue Squad Workers' Pension Fund until such time as they qualify for benefits. No other members of the department can join the Fund, regardless of when they were hired, either prior to April 2005 or after April 2005. Only those that elected to be a member of the Pension Fund and were making contributions in April 2005 can continue and the reason for this is the department is still not a certified department. But those members were acting in good faith based on the letter that was in error, when they joined the Pension Fund.

By copy of this memo, I am asking the Director of the Retirement Systems Division of the Department of State Treasurer if he can add any additional information or if I have made a mistake, he can clarify the facts.

If you have questions, please let me know.

cc: Michael Williamson

HOUSE BILL 438

Short Title:	State Health Plan/Calendar Year.	(Public)
Sponsors:	Representatives Folwell, Holliman, Blackwell, Blue (Primary Sponsors); Blust, Bryant, Cleveland, Current, Dockham, Dollar, Earle, England, Glazier, Gulley, Harrison, Hurley, Justice, Langdon, Lucas, Samuelson, Starnes, and Wray.	
Referred to:	Insurance, if favorable, Appropriations.	

March 9, 2009

A BILL TO BE ENTITLED

AN ACT TO ALLOW THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN TO CHANGE ITS PLAN YEAR FROM A FISCAL YEAR TO A CALENDAR YEAR.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 135-45.1(21) reads as rewritten:

"**§ 135-45.1. General definitions.**

As used in this Article unless the context clearly requires otherwise, the following definitions apply:

...

"(21) Plan year. – ~~The period beginning July 1 and ending on June 30 of the succeeding calendar year.~~An annual period established by the Executive Administrator and Board of Trustees under G.S. 135-44.2A.

...."

SECTION 1.(b) Part 2 of Article 3A of Chapter 135 of the General Statutes is amended by adding a new section to read:

"**§ 135-44.2A. Plan year.**

(a) The plan year shall be July 1 through June 30 unless changed to a calendar year by the Executive Administrator and Board of Trustees after consultation with the Committee on Employee Hospital and Medical Benefits. If changed, the initial transition plan year after the change may be either six months or 18 months.

(b) The plan year may be changed under this section only if the Plan has sufficient funds available to fund the transition costs without altering premium rates and benefit levels on account of the change."

SECTION 1.(c) Except in G.S. 135-44.5, the Revisor of Statutes shall delete the term "fiscal year" wherever it appears in Parts 1 through 3 of Article 3A of Chapter 135 of the General Statutes and substitute the term "plan year."

SECTION 2. This act is effective when it becomes law.

HOUSE BILL 438:
State Health Plan/Calendar Year

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Appropriations	**Date:**	April 13, 2009
Introduced by:	Reps. Folwell, Holliman, Blackwell, Blue	**Prepared by:**	Bill Patterson . Committee Counsel
Analysis of:	First Edition		

SUMMARY: House Bill 438 would authorize the Executive Director and Board of Trustees of the State Health Plan to change the plan year from a fiscal year to a calendar year, if the change will not alter premium rates and benefit levels.

CURRENT LAW: Under current law, the Teachers' and State Employees' Comprehensive Major Medical Plan (the "State Health Plan") is operated on a fiscal year basis, from July 1 of each year to June 30 of the succeeding year.

BILL ANALYSIS: House Bill 438 would define the State Health Plan's "plan year" under G.S. 135-45.1 to be an annual period established by the Plan's Executive Administrator and Board of Trustees, and would amend G.S. 135-44.2A, to authorize the Executive Director and Board of Trustees, in consultation with the joint Committee on Employee Hospital and Medical Benefits, to change the plan year to a calendar year, if the Plan has sufficient funds to permit such change to be made without altering premium rates or benefit levels. The bill would also provide that if changed, the initial transition plan year after the change could be either six months or eighteen months in duration.

EFFECTIVE DATE: This act is effective when it becomes law.

H438-SMTG-18(e1) v2

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

REVISED

BILL NUMBER: House Bill 438 (First Edition)

SHORT TITLE: State Health Plan/Calendar Year.

SPONSOR(S): Representatives Folwell, Holliman, Blackwell, and Blue

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY: Section 1(a) of the bill amends G.S. 135-45.1 to change the definition of plan year from the current July 1 to June 30 fiscal year basis to an annual period established by the Plan's Executive Administrator and Board of Trustees under a new statutory section under G.S. 135-44.2A.

Section 1(b) of the bill creates a new statutory section under G.S. 135-44.2A to conform with the changes in Section 1(a) by allowing a July 1 to June 30 fiscal year based plan year unless changed to a January 1 to December 31 calendar year based plan year by the Plan's Executive Administrator and Board of Trustees. The section also specifies that the transition year from a fiscal year to a calendar year based plan year be either a six-month or 18 month transition plan year. This section further requires that a potential change from a fiscal year plan year to a calendar year based plan year be subject to the Plan having sufficient funds to finance the transition without altering premiums or benefits. There is also a reporting requirement to the General Assembly's Committee on Employee and Hospital Medical benefits.

EFFECTIVE DATE: When it becomes law.

ESTIMATED IMPACT ON STATE:

The proposed bill provides discretionary authority to the Executive Administrator and Board of Trustees to change the Plan's 12 month plan year from a fiscal year to a calendar year. Under the provisions of the bill, if the Executive Administrator and Board of Trustees do not take action to transition the Plan to a calendar year based plan year, then there is estimated to be no financial impact to the Plan.

If the Executive Administrator and Board of Trustees elect to transition the Plan to a calendar year based plan year, then there is projected to be varying financial impacts to the Plan under several transition plan year scenarios. For purposes of describing the potential impacts of migrating to a calendar year based plan year, three separate transition plan year scenarios were estimated. A description and analysis of those respective scenarios are provided in the following pages.

There are two financial components to evaluate when making a transition from a fiscal year to a calendar year based plan year.

First, there are potential one-time costs or savings respectively to the Plan and plan members from the initial period of time used to transition from a fiscal year to a calendar year. Since the current July to June fiscal year is offset by six-months from a January to December calendar year period, then an initial six-month or 18 month transition plan year period of time must be used by the Plan to get to a calendar year based plan year. During the initial transition period, if there are costs to the Plan, then there will be a one-time average benefit savings to plan members. Conversely, a savings to the Plan during the transition period results in a one-time average benefit cost to plan members.

Any projected costs or savings result from having to adjust plan member out-of-pocket annual deductibles, co-insurance maximums, and prescription drug maximums to proportionately match either a six-month or 18-month transition period. For the six-month transition plan year plan member out-of-pocket requirements for deductible, co-insurance maximums, and prescription drug co-pay limits are assumed to be 50% of normal annual limits. For an 18 month transition plan year, these same out-of-pocket limits are assumed to be 150% of normal annual limits. The normal annual limits are assumed to be those enacted in Session Law 2009-16 (Senate Bill 287) for annual deductible and co-insurance maximums, and for annual out-of-pocket prescription drug maximums the amount specified in G.S. 135-45.6 (b). The table below provides assumed out-of-pocket requirements assuming normal limits, and those under respective six-month and 18 month transition plan years, as of July 1, 2009.

	PPO Basic			PPO Standard		
Plan Member Out-of-Pocket Costs	**July 1, 2009**	**6-months**	**18-months**	**July 1, 2009**	**6-months**	**18-months**
Annual Deductible						
In-network	$800	$400	$1,200	$600	$300	$900
Out-of-network	$1,600	$800	$2,400	$1,200	$600	$1,800
Coinsurance Maximum						
In-network	$3,250	$1,625	$4,875	$2,750	$1,375	$4,125
Out-of-network	$6,500	$3,250	$9,750	$5,500	$2,750	$8,250
Prescription Drugs Annual Maximum	$2,500	$1,250	$3,750	$2,500	$1,250	$3,750

The second financial component is the additional cash reserves required to ensure the Plan's cash balance is adequate to operate over a 30-month period instead of a 24-month standard funding period for the Plan. Currently, the Plan is funded for the 24-month period from July 1, 2009 to June 30, 2011 to coincide with the 2009-11 biennium, and to keep the Plan's claims stabilization reserve level funded until September 30, 2011. These required cash reserves are in addition to the projected costs or savings impact that may occur from an initial six month or 18 month transition plan year. These additional reserves, along with the annual premium increases, benefit changes and other adjustments enacted in Session Law 2009-16 (Senate Bill 287), are projected to provide the Plan with adequate cash to operate until the General Assembly would be expected to enact a potential future premium increase and possible benefit changes effective January 1, 2012 during the next biennium (i.e., 2011-13 biennium).

Scenario Examples

Provided below are separate financial estimates that assume three different transition plan year scenarios for potentially moving the Plan to a calendar based plan year. Scenario 1 assumes a six-month transition plan year from July 1, 2009 to December 31, 2009, with a calendar year based plan year beginning on January 1,

2010. Scenario 2 assumes a six-month transition plan year from July 1, 2010 to December 31, 2010, with a calendar year based plan year beginning on January 1, 2011. Scenario 3 assumes an 18 month transition plan year from July 1, 2009 to December 31, 2010, with a calendar year based plan year beginning on January 1, 2011.

Each of these scenarios estimates the costs or savings from the transition plan year, the additional cash required to extend the financial time period from 24 months to 30 months, and a total amount of additional cash that would have to be accumulated to implement the transition plan year and the additional six-months for the financial time period.

Scenario 1: Six-month Transition Plan Year from July 1, 2009 to December 31, 2009, then begin calendar year based plan year on January 1, 2010.

1. Estimated Cost or Savings Impact to the Plan: The consulting actuary for the Plan, Aon Consulting, estimates an increased cost of $22.8 million to the Plan under this specific scenario for the 2009-11 biennium. The consulting actuary for the General Assembly's Fiscal Research Division estimates the cost to the Plan under this specific scenario to be approximately $19.5 million for the same time period.

2. Estimated Cash Accumulation Required to Fund Plan an Additional Six-months: Based on a projection from Aon Consulting, consulting actuary for the Plan, the Plan will have to accumulate an additional $68.6 million in cash by June 30, 2011 to fund the additional six-months added to the funding period. The estimate is based on the additional cash required to fund the Plan an extra six-months (i.e., July 1, 2011 to December 31, 2011) over and above the 24 months projected to fund the Plan in Session Law 2009-16 (Senate Bill 287) using the assumptions, projected enrollment and other data used to estimate the Plan's funding requirements for the 2009-11 biennium.

3. Estimated Total Cash Accumulation Required to Fund a Transition to a Calendar Year Plan Year under Scenario 1: Assuming a cost of $22.8 million for the six-month transition period as projected by Aon Consulting, and the estimated $68.7 million in additional cash requirements to extend the funding period by six months, the Plan will have to accumulate total cash of $91.4 million based on the assumptions, projected enrollment and other data used in the projection for Session Law 2009-16 (Senate Bill 287) for the 2009-11 biennium.

Scenario 2: Six-month Transition Plan Year from July 1, 2010 to December 31, 2010, then begin calendar year based plan year on January 1, 2011.

1. Estimated Cost or Savings Impact to the Plan: The consulting actuary for the Plan, Aon Consulting, estimates an increased cost of $24.2 million to the Plan under this specific scenario for the 2009-11 biennium. The consulting actuary for the General Assembly's Fiscal Research Division estimates the cost to the Plan under this specific scenario to be approximately $20.0 million for the same time period.

2. Estimated Cash Accumulation Required to Fund Plan an Additional Six-months: Based on a projection from Aon Consulting, consulting actuary for the Plan, the Plan will have to accumulate an additional $69.4 million in cash by June 30, 2011 to fund the additional six-months added to the funding period. The estimate is based on the additional cash required to fund the Plan an extra six-months (i.e., July 1, 2011 to December 31, 2011) over and above the 24 months projected to fund

the Plan in Session Law 2009-16 (Senate Bill 287) using the assumptions, projected enrollment and other data used to estimate the Plan's funding requirements for the 2009-11 biennium.

3. Estimated Total Cash Accumulation Required to Fund a Transition to a Calendar Year Plan Year under Scenario 1: Assuming a cost of $24.2 million for the six-month transition period as projected by Aon Consulting, and the estimated $69.4 million in additional cash requirements to extend the funding period by six months, the Plan will have to accumulate total cash of $93.6 million based on the assumptions, projected enrollment and other data used in the projection for Session Law 2009-16 (Senate Bill 287) for the 2009-11 biennium.

Scenario 3: 18-month Transition Plan Year from July 1, 2009 to December 31, 2010, then begin calendar year based plan year on January 1, 2011.

1. Estimated Cost or Savings Impact to the Plan: The consulting actuary for the Plan, Aon Consulting, estimates a savings of $16.7 million to the Plan under this specific scenario for the 2009-11 biennium. The consulting actuary for the General Assembly's Fiscal Research Division estimates a savings to the Plan under this specific scenario to be approximately $22.1 million for the same time period.

2. Estimated Cash Accumulation Required to Fund Plan an Additional Six-months: Based on a projection from Aon Consulting, consulting actuary for the Plan, the Plan will have to accumulate an additional $66.0 million in cash by June 30, 2011 to fund the additional six-months added to the funding period. The estimate is based on the additional cash required to fund the Plan an extra six-months (i.e., July 1, 2011 to December 31, 2011) over and above the 24 months projected to fund the Plan in Session Law 2009-16 (Senate Bill 287) using the assumptions, projected enrollment and other data used to estimate the Plan's funding requirements for the 2009-11 biennium.

3. Estimated Total Cash Accumulation Required to Fund a Transition to a Calendar Year Plan Year under Scenario 1: Assuming a savings of $16.7 million for the six-month transition period as projected by Aon Consulting, and the estimated $66.0 million in additional cash requirements to extend the funding period by six months, the Plan will have to accumulate total cash of $49.3 million based on the assumptions, projected enrollment and other data used in the projection for Session Law 2009-16 (Senate Bill 287) for the 2009-11 biennium.

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Currently, per Session Law 2009-16 (Senate Bill 287), the Plan is authorized to implement an 8.9% annual premium increase effective July 1, 2009, and then again on July 1, 2010 by the same annual rate of increase. Without a transition to a calendar year based plan year, the Plan would be expected to have a potential premium rate increase on July 1, 2011 at the beginning of the next biennium (i.e., 2011-13 biennium). If the Plan moves to a calendar year based plan year, then the Plan's first premium increase of the 2011-13 biennium is assumed to be six months into the biennium, or on January 1, 2012. This assumption is made with the expectation that future annual premium rate increases and benefit changes will align with a calendar year based plan year.

Accumulated cash requirements were estimated by the Plan's consulting actuary, Aon Consulting, by comparing and calculating the difference in cash requirements between the following:

1) The estimated reduction in the Plan's projected $187 million Stabilization Reserve by extending the Plan's financial period to December 31, 2011, assuming the financial requirements and other assumptions projected for Session Law 2009-16 (Senate Bill 287); and

2) Estimating, by each calendar year transition scenario, the cash requirements projected for Session Law 2009-16 (Senate Bill 287) plus adding the additional cash requirements of each respective calendar year transition scenario where the Plan's Stabilization Reserve is held approximately equivalent to $187 million on December 31, 2011.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2008, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.6 billion for FY 2008-09. The Plan's PPO benefit design includes three alternative benefit levels offered to plan members. The three alternative benefit levels include the following:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums;

2) The "Standard" 80/20 plan; and

3) The "Plus" 90/10 plan with enhanced benefits via lower out-of pocket requirements as compared to the other PPO plan alternatives offered.

As of July 1, 2009, the State will continue to finance the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts will be derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage will be paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.5 billion for FY 2009-10 and $2.7 billion for FY 2010-11. The Plan's PPO benefit design will include two alternative benefit levels listed below:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums; and

2) The "Standard" 80/20 plan.

The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under both plans is offered on a fully contributory basis.

Financial Condition

Financial Projection (Revised Summer 2008) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year were projected to be $2.3 billion from premium collections, $53.9 million from Medicare Part D subsidies, and $2.7 million from investment earnings, for a total of slightly over $2.3 billion in receipt income for the year. Projected disbursements from the Plan were expected to be $2.4 billion in claim-payment expenses and $168.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating loss was projected to be approximately $264.4 million for the fiscal year, assuming a 9% annual claims growth trend.

Projected operating losses were expected to deplete the Plan's cash balance of $139.8 million and leave it without sufficient operating resources to continue operations for the fiscal year.

Financial Projection (Revised April 2009) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year are projected to be $2.3 billion from premium collections, $49.0 million from Medicare Part D subsidies, $3.3 million from investment earnings, and $250.0 million from a direct General Fund appropriation from the Rainy Day Fund (Savings Reserve Account) for a total of approximately $2.6 billion in receipt income for the year. The $250 million from a direct General Fund appropriation was provided by Session Law 2009-16 (Senate Bill 287) to finance a shortfall in funds available to pay health care benefits, administrative costs, and adequately fund the Plan's beginning cash balance on July 1, 2009. Projected disbursements from the Plan are expected to be $2.4 billion in claim-payment expenses and $180.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating income is projected to be approximately $7.1 million for the fiscal year, assuming a 9% annual claims growth trend.

Financial Projection 2009-11 Biennium (April 2009) – Session Law 2009-16 (Senate Bill 287) appropriates funds from various sources, authorizes annual premium rate increases, makes various benefit and provider related changes to achieve financial savings, and directs other various changes to the Plan. The enacted law also appropriates the sum of $250 million from the Savings Reserve Account ("Rainy Day Fund") of the General Fund for the 2008-09 fiscal year. The following summarized financial projections by fiscal year for the 2009-11 biennium assume the changes enacted in Session Law 2009-16 (Senate Bill 287).

For the fiscal year beginning July 1, 2009, the Plan is projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year are projected to be $2.4 billion from premium collections, $56.3 million from Medicare Part D subsidies, and $8.0 million from investment earnings for a total of approximately $2.5 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.3 billion in claim-payment expenses and $185.6 million in administration and claims-processing expenses for projected total expenses of nearly $2.5 billion for FY 2008-09. The Plan's net operating income is projected to be approximately $14.8 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan is projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year are projected to be $2.7 billion from premium collections, $50.4 million from Medicare Part D subsidies, and $8.8 million from investment earnings for a total of approximately $2.7 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.5 billion in claim-payment expenses and $191.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.7 billion for FY 2010-11. The Plan's net operating income is projected to be approximately $30.6 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Other Information

Historically, the Plan has applied a premium increase in October of the first fiscal year of a biennium. However, the annual premium increases authorized in Session Law 2009-16 (Senate Bill 287) changes that methodology to an annual increase at the beginning of each fiscal year of the 2009-11 biennium.

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment Data as of December 31, 2008

I. No. of Participants	Basic	Standard	Plus	Total	Percent of Total
Actives					
Employees	11,623	271,243	47,687	330,553	49.6%
Dependents	20,454	115,875	28,156	164,485	24.7%
Sub-total	32,077	387,118	75,843	495,038	74.2%
Retired					
Employees	1,726	127,081	17,967	146,774	22.0%
Dependents	1,117	14,935	3,476	19,528	2.9%
Sub-total	2,843	142,016	21,443	166,302	24.9%
Former Employees with Continuation Coverage					
Employees	60	1,349	344	1,753	0.3%
Dependents	61	501	182	744	0.1%
Sub-total	121	1,850	526	2,497	0.4%
Firefighters, Rescue Squad & National Guard					
Employees	-	3	2	5	0.0%
Dependents	-	3	-	3	0.0%
Sub-total	-	6	2	8	0.0%
Local Governments					
Employees	72	1,577	319	1,968	0.3%
Dependents	141	637	218	996	0.1%
Sub-total	213	2,214	537	2,964	0.4%
Total					
Employees	13,481	401,253	66,319	481,053	72.1%
Dependents	21,773	131,951	32,032	185,756	27.9%
Grand Total	**35,254**	**533,204**	**98,351**	**666,809**	**100%**
Percent of Total	**5.3%**	**80.0%**	**14.7%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	2,684	328,635	49,246	380,565
Employee Child(ren)	4,958	36,903	8,589	50,450
Employee Spouse	2,274	18,145	4,469	24,888
Employee Family	3,565	17,570	4,015	25,150
Total	**13,481**	**401,253**	**66,319**	**481,053**

Percent Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	19.9%	81.9%	74.3%	79.1%
Employee Child(ren)	36.8%	9.2%	13.0%	10.5%
Employee Spouse	16.9%	4.5%	6.7%	5.2%
Employee Family	26.4%	4.4%	6.1%	5.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Enrollment Data Continued

III. Enrollment by Sex	Basic	Standard	Plus	Total
Female	18,837	334,917	61,752	415,506
Male	16,417	198,287	36,599	251,303
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Sex	Basic	Standard	Plus	Total
Female	53.4%	62.8%	62.8%	62.3%
Male	46.6%	37.2%	37.2%	37.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	17,390	136,277	27,211	180,878
30 to 44	8,125	107,375	17,315	132,815
45 to 54	5,164	94,548	18,277	117,989
55 to 64	3,195	102,901	23,452	129,548
65 & Over	1,380	92,103	12,096	105,579
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	49.3%	25.6%	27.7%	27.1%
30 to 44	23.0%	20.1%	17.6%	19.9%
45 to 54	14.6%	17.7%	18.6%	17.7%
55 to 64	9.1%	19.3%	23.8%	19.4%
65 & Over	3.9%	17.3%	12.3%	15.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	49,534	12,080	61,614
Medicare Eligible	97,240	7,448	104,688
Total	**146,774**	**19,528**	**166,302**

Percent by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.7%	61.9%	37.0%
Medicare Eligible	66.3%	38.1%	63.0%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

-Aon Consulting, North Carolina State Health Plan, Financial Projections – October 2008, Total For All Plans – 9% Trend, July 2009 & 2010 Rate Increases, $250 Million Grant, No Plus Option – July 2009, Benefit Option, Pharmacy Initiatives, Chiro PT/OT/ST MH/CD Middle Tier April 23, 2009.

- Aon Consulting, Analysis of the various calendar year scenarios, Emailed spreadsheet reflecting estimated additional cash requirements, May 4, 2009.

-Actuarial Note, Hartman & Associates, "House Bill 438: An Act to Allow the State Health Plan to Change its Plan Year From a Fiscal Year to a Calendar Year", April 23, 2009, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "House Bill 438 (1st Edition) Calendar Year Change", April 23, 2009, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS:

An amendment to G.S. 135-45(g), as amended by Session Law 2009-16 (Senate Bill 287), may be required to permit the Executive Administrator and Board of Trustees with the authority to implement annual deductibles, co-insurance maximums and prescription drug co-pay limits at 50% of the annual limits for a six-month transition plan year, or 150% of the annual limits for an 18 month transition plan year.

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Marilyn Chism, Director
Fiscal Research Division

DATE: May 6, 2009

Signed Copy Located in the NCGA Principal Clerk's Offices

NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

HOUSE BILL H438 (1ST EDITION)

Calendar Year Change

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30305

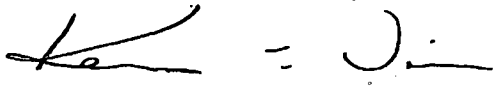
April 2009

ACTUARIAL STATEMENT

The North Carolina State Health Plan for Teachers and State Employees has requested that Aon Consulting prepare an Actuarial Note in response to Senate Bill 438 entitled "An Act To Allow The Teachers' And State Employees' Comprehensive Major Medical Plan To Change Its Plan Year From A Fiscal Year To A Calendar Year."

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.



April 23, 2009

Kenneth C. Vieira, F.S.A., M.A.A.A.
Senior Vice President

Date

April 23, 2009

Kirsten R. Schatten, A.S.A., M.A.A.A.
Assistant Vice President

Date

CHANGE PLAN YEAR FROM A FISCAL YEAR TO CALENDAR YEAR

PLAN CHANGES

The proposed legislation allows the Executive Administrator and Board of Trustees, after consultation with the Committee on Employee Hospital and Medical Benefits, to change the plan year from a fiscal year to a calendar year. It requires sufficient funds to be available and allows either a short plan year (6-months) or long plan year (18-months) to make the transition. Details of the legislation are provided below:

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 135-45.1(21) reads as rewritten:
"§ 135-45.1. General definitions.
As used in this Article unless the context clearly requires otherwise, the following definitions apply:

....

"(21) Plan year. – ~~The period beginning July 1 and ending on June 30 of the succeeding calendar year.~~An annual period established by the Executive Administrator and Board of Trustees under G.S. 135-44.2A.

...."

SECTION 1.(b) Part 2 of Article 3A of Chapter 135 of the General Statutes is amended by adding a new section to read:
"§ 135-44.2A. Plan year.
(a) The plan year shall be July 1 through June 30 unless changed to a calendar year by the Executive Administrator and Board of Trustees after consultation with the Committee on Employee Hospital and Medical Benefits. If changed, the initial transition plan year after the change may be either six months or 18 months.
(b) The plan year may be changed under this section only if the Plan has sufficient funds available to fund the transition costs without altering premium rates and benefit levels on account of the change."

SECTION 1.(c) Except in G.S. 135-44.5, the Revisor of Statutes shall delete the term "fiscal year" wherever it appears in Parts 1 through 3 of Article 3A of Chapter 135 of the General Statutes and substitute the term "plan year".

SECTION 2. This act is effective when it becomes law.

PROJECTED COSTS/(SAVINGS)

Section	Plan Design Change	Based on "Midpoint" Increase (in millions)		
		2009-2010 Fiscal Year Cost	2010-2011 Fiscal Year Cost	Total Biennium Cost
Scenario 1 – Short Plan Year: July-09 to December-09		$21.9	($0.5)	$21.4
Scenario 2 – Short Plan Year: July-10 to December-10		$0.0	$23.7	$23.7
Scenario 3 – Long Plan Year: July-09 to December-10		($53.4)	$36.1	($17.3)

Breakout of these costs by 6-month interval can be found in the pricing section.

Section	Administrative Cost Impact	Based on "Midpoint" Increase (in millions)	
			Total Biennium Cost
Scenario 1 – Short Plan Year: July-09 to December-09			$1.4
Scenario 2 – Short Plan Year: July-10 to December-10			$.5
Scenario 3 – Long Plan Year: July-09 to December-10			$.6

Section	Total Cost	Based on "Midpoint" Increase (in millions)	
			Total Biennium Cost
Scenario 1 – Short Plan Year: July-09 to December-09			$22.8
Scenario 2 – Short Plan Year: July-10 to December-10			$24.2
Scenario 3 – Long Plan Year: July-09 to December-10			($16.7)

PRICING APPROACH AND COMMENTS

The following information was compiled and utilized in determining the projected costs or savings of the benefit component addressed in this actuarial note:

- The plan of benefits includes benefit changes in Senate Bill 287. The largest impact on this bill on the plan year change would be the elimination of the "Plus" option, changes in the deductibles and changes in the out-of-pocket maximums.
- The legislation allows the changes to be made with no benefit or premium changes. This was clarified with Aon to mean no changes when compared to a complete 12-month period. The analysis was performed for three separate scenarios:

Scenario 1 –
Beginning, July 1, 2009, a six month plan year with the calendar year beginning January 1, 2010

Scenario 2 –
Beginning, July 1, 2010, a six month plan year with the calendar year beginning January 1, 2011

Scenario 3 –
Beginning, July 1, 2009, an eighteen month plan year with the calendar year beginning January 1, 2011

- For the short plan year it was assumed that the deductibles and out-of-pocket maximums would be 50% of the annual amounts. This would be either July to December of 2009 or 2010, with the calendar year plan starting January of the following year. The long plan year, July 1, 2009 through December 31, 2010, would have deductibles and out-of-pocket maximums of 150% of the annual amounts. The plan would then have a calendar year program effective January 1, 2011.
- The change would be for both Medicare and Non-Medicare eligible members.
- Aon utilized claims distribution reports generated by BCBSNC. The data was for fiscal year 2008. This distribution still had a significant membership level in the indemnity plan. This report required conversion of claims to PPO equivalent distributions, moving members into their most recent elections. The distributions were then trended at 9% per year and the numbers were reconciled to projected financials. This has been the primary source for the benefit impact calculations required of SB287.
- The claimants were adjusted 5% to reflect a more accurate exposure number. It was also assumed that only 90% of the deductible was realized through parameter pricing. For the 6-month period, the members were also migrated between allowed brackets to best reflect the emerging experience.
- An additional report was received from BCBSNC showing the incurred deductibles and coinsurance paid for Fiscal Year 2009 on a monthly basis. We then completed these numbers for Fiscal Year 2009 and also backed into what the first 6-month period produced. The distribution used above, processed with the current plan parameters, produced values within 0.1% of the numbers generated in this report. This report validated that our distributions were reasonable and our adjustments appropriate.
- The resulting distributions were trended through Fiscal Year 2012 in 6-month periods at a 9% annual rate. The assumption was that the eligible amount would not change between scenarios, just the adjudication of the applicable scenario cost sharing. We focused our cost estimates on projecting the deductible and coinsurance amounts over each period. Having these differences would translate into the cost of the change on the State Health Plan.
- Projections for each scenario by 6-month interval are shown on the following pages.

Scenario 1

- This scenario assumes a 6-month short plan year effective July 1, 2009. The deductibles and out-of-pocket maximums were assumed to be 50% of calendar year amounts. The plan year would then become a calendar year effective January 1, 2010. The projected cost sharing on an incurred basis is displayed below:

Fiscal Year	6-month period	Baseline	Plan Year Change	Period Diff	Fiscal Year
FY10	July-Dec	$ 164,229,275	$ 121,415,552	$ (42,813,723)	
FY10	Jan-June	$ 136,632,080	$ 168,016,110	$ 31,384,030	$ (11,429,693)
FY11	July-Dec	$ 171,767,155	$ 139,472,547	$ (32,294,608)	
FY11	Jan-June	$ 142,296,392	$ 175,802,524	$ 33,506,132	$ 1,211,524
FY12	July-Dec	$ 179,713,627	$ 145,352,598	$ (34,361,030)	
FY12	Jan-June	$ 148,321,450	$ 183,891,905	$ 35,570,455	$ 1,209,425

A positive difference indicates that the employee will pay more cost sharing, resulting in a savings to the plan. A negative difference indicates that the employee is paying less cost sharing, a cost to the plan.

- The plan operates on a paid basis and the above numbers would need to reflect two-months of claims processing lag. These numbers were adjusted to a paid basis and are detailed below:

Fiscal Year	6-month period	Baseline	Plan Year Change	Period Diff	Fiscal Year
FY10	July-Dec	$ 109,486,183	$ 80,943,701	$ (28,542,482)	
FY10	Jan-June	$ 145,831,145	$ 152,482,591	$ 6,651,446	$ (21,891,037)
FY11	July-Dec	$ 160,055,463	$ 148,987,068	$ (11,068,395)	
FY11	Jan-June	$ 152,119,980	$ 163,692,532	$ 11,572,552	$ 504,157
FY12	July-Dec	$ 167,241,216	$ 155,502,573	$ (11,738,642)	
FY12	Jan-June	$ 158,785,509	$ 171,045,469	$ 12,259,960	$ 521,317

- Note that timing is an important issue in the savings/(cost) reported in this actuarial note

Scenario 2

- This scenario assumes a 6-month short plan year effective July 1, 2010. The deductibles and out-of-pocket maximums were assumed to be 50% of calendar year amounts. The plan year would then become a calendar year effective January 1, 2011. The projected cost sharing on an incurred basis is displayed below:

Fiscal Year	6-month period	Baseline	Plan Year Change	Period Diff	Fiscal Year
FY10	July-Dec	$ 164,229,275	$ 164,229,275	$ -	
FY10	Jan-June	$ 136,632,080	$ 136,632,080	$ -	$ -
FY11	July-Dec	$ 171,767,155	$ 125,771,434	$ (45,995,720)	
FY11	Jan-June	$ 142,296,392	$ 175,802,524	$ 33,506,132	$ (12,489,589)
FY12	July-Dec	$ 179,713,627	$ 145,352,598	$ (34,361,030)	
FY12	Jan-June	$ 148,321,450	$ 183,891,905	$ 35,570,455	$ 1,209,425

A positive difference indicates that the employee will pay more cost sharing, resulting in a savings to the plan. A negative difference indicates that the employee is paying less cost sharing, a cost to the plan.

- The plan operates on a paid basis and the above numbers would need to reflect two-months of claims processing lag. These numbers were adjusted to a paid basis and are detailed below:

Fiscal Year	6-month period	Baseline	Plan Year Change	Period Diff	Fiscal Year
FY10	July-Dec	$ 109,486,183	$ 109,486,183	$ -	
FY10	Jan-June	$ 145,831,145	$ 145,831,145	$ -	$ -
FY11	July-Dec	$ 160,055,463	$ 129,391,650	$ (30,663,814)	
FY11	Jan-June	$ 152,119,980	$ 159,125,494	$ 7,005,514	$ (23,658,299)
FY12	July-Dec	$ 167,241,216	$ 155,502,573	$ (11,738,642)	
FY12	Jan-June	$ 158,785,509	$ 171,045,469	$ 12,259,960	$ 521,317

- Note that timing is an important issue in the savings/(cost) reported in this actuarial note

Scenario 3

- This scenario assumes an 18-month long plan year effective July 1, 2009. The deductibles and out-of-pocket maximums were assumed to be 150% of calendar year amounts. The plan year would then become a calendar year effective January 1, 2011. The projected cost sharing on an incurred basis is displayed below:

Fiscal Year	6-month period	Baseline	Plan Year Change	Period Diff	Fiscal Year
FY10	July-Dec	$ 164,229,275	$ 197,329,679	$ 33,100,404	
FY10	Jan-June	$ 136,632,080	$ 167,124,661	$ 30,492,581	$ 63,592,985
FY11	July-Dec	$ 171,767,155	$ 103,191,643	$ (68,575,512)	
FY11	Jan-June	$ 142,296,392	$ 175,802,524	$ 33,506,132	$ (35,069,380)
FY12	July-Dec	$ 179,713,627	$ 145,352,598	$ (34,361,030)	
FY12	Jan-June	$ 148,321,450	$ 183,891,905	$ 35,570,455	$ 1,209,425

A positive difference indicates that the employee will pay more cost sharing, resulting in a savings to the plan. A negative difference indicates that the employee is paying less cost sharing, a cost to the plan.

- The plan operates on a paid basis and the above numbers would need to reflect two-months of claims processing lag. These numbers were adjusted to a paid basis and are detailed below:

Fiscal Year	6-month period	Baseline	Plan Year Change	Period Diff	Fiscal Year
FY10	July-Dec	$ 109,486,183	$ 131,553,119	$ 22,066,936	
FY10	Jan-June	$ 145,831,145	$ 177,193,000	$ 31,361,855	$ 53,428,791
FY11	July-Dec	$ 160,055,463	$ 124,502,649	$ (35,552,814)	
FY11	Jan-June	$ 152,119,980	$ 151,598,897	$ (521,083)	$ (36,073,897)
FY12	July-Dec	$ 167,241,216	$ 155,502,573	$ (11,738,642)	
FY12	Jan-June	$ 158,785,509	$ 171,045,469	$ 12,259,960	$ 521,317

- Note that timing is an important issue in the savings/(cost) reported in this actuarial note

- Administrative cost requirements were projected for each scenario. The costs include all materials and services required for enrollment and implementation. These costs vary based on timeframes.
- Aon also performed an analysis to determine the impact of a calendar year change on the Retiree Drug Subsidy received by Centers for Medicare and Medicaid Services (CMS) for coverage of Medicare-eligible members. The analysis concluded there would be no impact on the Retiree Drug Subsidy.

HARTMAN & ASSOCIATES, LLC

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668 Link Road
Lexington, NC 27295

April 23, 2009

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: House Bill 438: An Act to Allow the State Health Plan to Change its Plan Year From a Fiscal Year to a Calendar Year

Dear Mr. Trogdon:

Currently, the plan year for the North Carolina State Health Plan for Teachers and State Employees (the "Plan") is defined as the fiscal year. This bill amends G.S. 135-45.1 and adds G.S. 135-44.2A to provide that the plan year may be changed to the calendar year. The bill provides authority for the Executive Administrator and Board of Trustees to make the change, with the initial transition year being either six months or 18 months. The plan year may be changed only if the Plan has sufficient funds to cover the transition costs without altering premium rates and benefit levels. This act is effective when it becomes law.

I have estimated the financial impact on the Plan under the following three scenarios:

1. Change to a calendar plan year effective January 1, 2010, with a six-month plan year from July 1, 2009 through December 31, 2009. During the short year, the member deductible, coinsurance, and prescription drug out-of-pocket limits would be one-half the stated amounts for each benefit option.
2. Change to a calendar plan year effective January 1, 2011, with a six-month plan year from July 1, 2010 through December 31, 2010. Again, during the short year, the member deductible, coinsurance, and prescription drug out-of-pocket limits would be one-half the stated amounts for each benefit option.
3. Change to a calendar plan year effective January 1, 2011, with an eighteen-month plan year from July 1, 2009 through December 31, 2010. During the long year, the member deductible, coinsurance, and prescription drug out-of-pocket limits would be 150% of the stated amounts for each benefit option.

The primary financial impact on the Plan from the plan year change will occur during fiscal years containing the transition to a calendar year. During the transition period, a Plan member's deductible and coinsurance expense may vary from the current limits based on the time period in which claims are incurred during the fiscal year. This timing of a member's claims, combined with the increased or decreased cost sharing limits, can create a loss or gain to the Plan.

Based on my analysis of the Plan claims data, I estimate the following impact on the Plan for the next two fiscal years for each scenario. For later fiscal years, the change to a calendar year would impact the timing of Plan payments and investment income, but the net financial impact is expected to be minimal.

Net Cost of Change to Calendar Year				
Scenario	Component	FY 2010	FY 2011	Total
Short Year 7/1/09 - 12/31/09	Net Claims	$18,180,000	$ 0	$18,180,000
	Admin Expense	1,355,000	0	1,355,000
	Total	$19,535,000	$ 0	$19,535,000
Short Year 7/1/10 - 12/31/10	Net Claims	$ 0	$19,541,000	$19,541,000
	Admin Expense	0	450,000	450,000
	Total	$ 0	$19,991,000	$19,991,000
Long Year 7/1/09 - 12/31/10	Net Claims	$(63,287,000)	$40,606,000	$(22,681,000)
	Admin Expense	1,257,000	(632,000)	625,000
	Total	$(62,030,000)	$39,974,000	$(22,056,000)

I note that while there is no overall expected cost of changing the Plan year after fiscal year 2011, the change will impact the Plan's cash flow. Because of the operation of deductible and coinsurance limits, member cost sharing is greater in the first half of a Plan year than in the second half of the Plan year. Changing the Plan year to a calendar year will shift the period of higher member cost sharing (and thus lower Plan payments) from the first half of each fiscal year to the second half. As a result, the Plan's claim payments will increase in the first half of each fiscal year, with a corresponding reduction in the latter half. I have estimated the cash flow impact at approximately $22 million for each six-month period, increasing with the annual claims trend.

Additionally, with changing to a calendar plan year, premium rate increases are expected to occur as of the beginning of each calendar year instead of each fiscal year. The rate increase effective July 1, 2009 should be adjusted to cover the costs for the transition years shown above. On an ongoing basis, the Plan must determine the appropriate rate for calendar year periods considering the cash flow issues.

The estimates shown above are based on analysis of claims information for the Plan. I have assumed that the benefit changes from Senate bill 287 are in place July 1, 2009. Members currently covered under the PPO Plus option are assumed to elect the PPO Standard option. The administrative costs are estimates provided by the Plan. The data and assumptions used in this analysis are outlined in Attachment #1.

Projected costs include a two-week claim payment lag for prescription drugs and 45-day lag for medical services. The projections assume the Plan membership remains constant at the December 2008 level of 666,809. Additional claims during the six-month transition year

scenarios have been increased with a 10% risk factor to account for claims shift to the period with lower member cost sharing.

Data for this analysis was primarily based on claims for fiscal years 2008 and 2009 to date. I note that the validity of this data is limited due to movement of members from the Indemnity plan to the PPO options during this period. We still do not have data for a complete plan year with all members covered under the PPO benefit terms and provisions. This movement effects utilization patterns and claim distributions that are key to this analysis. Thus, actual results could differ significantly from these projections.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, FCA, EA
Consulting Actuary

MVH/mt

Actuarial Assumptions and Data

Data Sources:

State Health Plan for Teachers and State Employees
- Charge Summary
- Coinsurance and Deductible Levels – Full Population
- Coinsurance and Deductible Levels – Closed Population
- Report of Charges Subject to Deductible by Half Year
- Financial Reconciliation Report

The above reports were available for Fiscal Year 2008 and Fiscal Year 2009 through February. Reports are on both a paid and an incurred basis.

SHP Distribution of Participants by Age and Gender
State of NC Rx Drug Pull – 1st half FY2009
State of NC Rx Drugs – FY 2007/FY2008

Data Summary:

Distribution of Claims Active Members			
Allowed	Percent of Members		
Charges </=	Standard	Basic	Plus
$0	62.55%	64.71%	40.24%
$100	2.30%	2.71%	2.55%
$200	2.34%	4.07%	2.80%
$300	2.07%	1.58%	2.57%
$400	1.78%	0.90%	2.23%
$500	1.45%	1.36%	1.67%
$600	1.09%	0.90%	1.52%
$700	0.96%	1.36%	1.54%
$800	1.02%	0.90%	1.45%
$900	0.92%	1.58%	1.30%
$1,000	0.85%	0.23%	1.25%
$1,500	3.83%	3.62%	5.16%
$2,000	2.56%	1.58%	4.23%
$2,500	1.73%	2.49%	2.97%
$3,000	1.42%	0.90%	2.49%
$5,000	3.54%	2.94%	6.33%
$10,000	4.91%	4.75%	9.15%
$20,000	3.05%	2.04%	6.18%
$9,999,999	1.64%	1.36%	4.38%
Total	100.00%	100.00%	100.00%

Includes only claims subject to deductible and coinsurance
Separate distributions used for Medicare and non-Medicare retirees

Portion of Member Liability Incurred in First Half of Plan Year								
	Deductible					Coinsurance		
Status	Basic	Standard	Plus	Total		Basic	Standard	Plus	Total
Active	54.9%	59.4%	66.0%	59.3%		49.3%	49.8%	54.4%	49.9%
NM Retiree	55.6%	62.0%	68.2%	61.9%		46.4%	51.0%	53.3%	50.4%
Med Retiree	50.5%	52.8%	64.1%	53.2%		44.6%	38.6%	44.3%	38.9%
Total	53.0%	57.2%	64.7%	58.6%		47.0%	47.8%	53.0%	49.4%

Baseline Projected Annual Member Cost Sharing	
Deductible	$137,305,000
Coinsurance	$169,574,000

Membership:

Distribution by Option and Status				
Status	Standard	Basic	Plus	Total
Active Employee	380,833	31,204	75,109	487,146
Medicare Eligible Retiree	90,918	1,350	11,604	103,872
Non-Medicare Retirees	50.910	1,472	9,667	62,049
Total	522,661	34,026	96,380	653,067

This represents the average membership within each category for the second quarter of Fiscal Year 2009.

Plan Parameters:

In-Network Member Cost Sharing Limits		
	Deductible/Coinsurance Max	
Scenario	Standard	Basic
6-Month Year	$300/1,375	$400/1,625
12-Month Year	$600/2,750	$800/3,250
18-Month Year	$900/4,125	$1,200/4,875

House Bill 438: State Health Plan/Change to Calendar Year

Sponsors: Representatives Folwell, Holliman, Blackwell, Blue

The following individuals /organizations have endorsed House Bill 438:

1. **North Carolina Association of Educators**
2. **State Employees Association of North Carolina**
3. **North Carolina Retired Governmental Employees Association**
4. **North Carolina Retired School Personnel Association**

HOUSE BILL 14

Short Title:	Chiropractic Services/Insurance.	(Public)
Sponsors:	Representatives Tarleton, Goforth (Primary Sponsors); Cole, Cotham, Earle, McLawhorn, Moore, Spear, E. Warren, and Wray.	
Referred to:	Rules, Calendar, and Operations of the House.	

February 2, 2009

A BILL TO BE ENTITLED

AN ACT TO REENACT A LAW CONCERNING HEALTH BENEFIT PLAN CO-PAYMENTS FOR CHIROPRACTIC SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-30(a3) reads as rewritten:

"(a3) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 unless a comparable limitation is imposed on the medically necessary treatment if performed or authorized by any other duly licensed physician. An insurer shall not impose as a limitation on treatment or level of coverage a co-payment amount charged to the insured for chiropractic services that is higher than the co-payment amount charged to the insured for the services of a duly licensed primary care physician for a comparable medically necessary treatment or condition."

SECTION 2. This act becomes effective October 1, 2009, and applies to policies issued or renewed on or 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.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 14 DATE 5/7/09

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

COMMITTEE SUBSTITUTE _____

(Rep.) Faison
Sen.)

moves to amend the bill on page 1, line ~~1~~ 3

(X) WHICH CHANGES THE TITLE

by rewriting the line to read:

"CO-PAYMENTS FOR CHIROPRACTIC, ~~&~~ OCCUPATIONAL THERAPY, AND PHYSICAL THERAPY SERVICES.";

and on page 1, lines 16-17, by inserting the following between the lines:

"SECTION 2. G.S. 58-50-30 is amended by adding a new subsection to read:

(a4) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health ~~insurance~~ Maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter provides coverage for medically necessary treatment, the insurer shall not impose as a limitation on treatment or level

SIGNED _____

ADOPTED ✓ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 14 DATE _____

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

COMMITTEE SUBSTITUTE _____

Rep.) Faison
Sen.)

1 moves to amend the bill on page _____, line _____
2 ( ) WHICH CHANGES THE TITLE
3 by _____
4 of coverage a co-payment amount for services
5 performed by a duly licensed occupational
6 therapist acting within the scope of
7 practice authorized under G.S. 90-270.67
8 or by a duly licensed physical therapist
9 acting within the scope of practice
10 authorized under G.S. 90-270.24 that
11 is higher than the co-payment amount
12 charged to the insured for services
13 of a duly licensed primary care
14 physician for a comparable
15 medically necessary treatment."
16
17 and to renumber the remaining
18 Sections accordingly.
19

SIGNED _____

ADOPTED ✓ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 14 DATE 5/7/09

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

COMMITTEE SUBSTITUTE _____

(Rep. / Sen.) Lewis

moves to amend the bill on page 1, line(s) 14-16

(X) WHICH CHANGES THE TITLE

by deleting the ~~lines~~ lines and substituting:

"insured for chiropractic services that is higher than the co-payment amount charged under the State Health Plan for Teachers and State Employees.";

~~and~~

and on page 1, line 2, by deleting the word(s) "REENACTING" and substitute "AMENDING THE".

and to Amend Amendment #1, ~~by~~ page 2, ~~line~~ by deleting lines 12-15 and rewriting the lines to read:

"charged to the ~~insured~~ insured for occupational therapy ~~service~~ or physical therapy that is higher than the co-payment amount charged under the State Health Plan for Teachers and State Employees.".

SIGNED T.R. Lewis

ADOPTED X FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

2009 GENERAL ASSEMBLY OF NORTH CAROLINA

AMENDMENT

Sponsor: _____

Date: _____

Amend HB 14 Chiropractic Services/Insurance

-- On page 1, line 3: Amends Title,

after "CHIROPRACTIC", add ", OCCUPATIONAL THERAPY, AND PHYSICAL THERAPY";

-- On page 1, line 17,

by renumbering current "SECTION 2" as "SECTION 3"; and

-- On page 1, after line 16,

By adding a new section, to read as follows:

"SECTION 2. A new G.S. 58-50-30 (a4) is enacted, to read as follows:

'(a4) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter provides coverage for medically necessary treatment, the insurer shall not impose as a limitation on treatment or level of coverage a co-payment amount for services performed by a duly licensed occupational therapist acting within the scope of practice authorized under G. S. 90-270.67 or by a duly licensed physical therapist acting within the scope of practice authorized under G.S 90-270.24 that is higher than the co-payment amount charged to the insured for services of a duly licensed primary care physician for a comparable medically necessary treatment.'"

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1022*
PROPOSED COMMITTEE SUBSTITUTE H1022-CSLR-14 [v.6]

5/1/2009 12:42:28 PM

Short Title: Workers' Comp./Temp. Total Disability Limit. (Public)

Sponsors:

Referred to:

April 2, 2009

A BILL TO BE ENTITLED

AN ACT RELATING TO THE DURATION OF THE COMPENSATION FOR TEMPORARY TOTAL DISABILITY UNDER THE WORKERS' COMPENSATION ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 97-29 reads as rewritten:

"**§ 97-29. ~~Compensation rates~~ Rates and duration of compensation for total incapacity.**

(a) Except as ~~hereinafter otherwise provided,~~ provided by subsection (f) of this section, where the incapacity for work resulting from the injury is total, the employer shall pay or cause to be paid, as hereinafter provided, to the injured employee during such total disability a weekly compensation equal to sixty-six and two-thirds percent (66 2/3%) of his or her average weekly wages, but not more than the amount established annually to be effective October 1 as provided herein, nor less than thirty dollars ($30.00) per week.

(b) In cases of total and permanent disability, compensation, including medical compensation, shall be paid for by the employer during the lifetime of the injured employee. If death results from the injury then the employer shall pay compensation in accordance with the provisions of G.S. 97-38.

(c) The weekly compensation payment for members of the North Carolina national guard and the North Carolina State Defense Militia shall be the maximum amount established annually in accordance with the last paragraph of this section per week as fixed herein. The weekly compensation payment for deputy sheriffs, or those acting in the capacity of deputy sheriffs, who serve upon a fee basis, shall be thirty dollars ($30.00) a week as fixed herein.

(d) An officer or member of the State Highway Patrol shall not be awarded any weekly compensation under the provisions of this section for the first two years of any incapacity resulting from an injury by accident arising out of and in the course of the performance by him of his official duties if, during such incapacity, he continues to be an officer or member of the State Highway Patrol, but he shall be awarded any other benefits to which he may be entitled under the provisions of this Article.

(e) Notwithstanding any other provision of this Article, on July 1 of each year, a maximum weekly benefit amount shall be computed. The amount of this maximum weekly benefit shall be derived by obtaining the average weekly insured wage in accordance with G.S. 96-8(22), by multiplying such average weekly insured wage by 1.10, and by rounding such figure to its nearest multiple of two dollars ($2.00), and this said maximum weekly benefit shall be applicable to all injuries and claims arising on and after January 1 following such

computation. Such maximum weekly benefit shall apply to all provisions of this Chapter and shall be adjusted July 1 and effective January 1 of each year as herein provided.

(f) Temporary total disability compensation shall continue for a period lasting until the longer of (i) when the injured employee is eligible by age for full benefits under the Social Security Act, 42 U.S.C. 401, et seq., or (ii) a period of 300 weeks from the date of injury."

SECTION 2. This act is effective when it becomes law and applies to claims filed on or after that date.

HOUSE BILL 1022*

Short Title:	Workers' Comp./Duration of Total Disability.	(Public)
Sponsors:	Representatives Goforth, Folwell, Hill, Rhyne (Primary Sponsors); Hurley, Owens, and Rapp.	
Referred to:	Insurance, if favorable, Judiciary II.	

April 2, 2009

A BILL TO BE ENTITLED

AN ACT RELATING TO THE DURATION OF THE COMPENSATION FOR TOTAL DISABILITY UNDER THE WORKERS' COMPENSATION ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 97-29 reads as rewritten:

"**§ 97-29. ~~Compensation rates~~ Rates and duration of compensation for total incapacity.**

(a) Except as hereinafter otherwise provided, where the incapacity for work resulting from the injury is total, the employer shall pay or cause to be paid, as hereinafter provided, to the injured employee during such total disability a weekly compensation equal to sixty-six and two-thirds percent (66 2/3%) of his average weekly wages, but not more than the amount established annually to be effective October 1 as provided herein, nor less than thirty dollars ($30.00) per week.

In cases of total and permanent disability, compensation, including medical compensation, shall be paid for by the employer during the lifetime of the injured employee. If death results from the injury then the employer shall pay compensation in accordance with the provisions of G.S. 97-38.

The weekly compensation payment for members of the North Carolina national guard and the North Carolina State Defense Militia shall be the maximum amount established annually in accordance with the last paragraph of this section per week as fixed herein. The weekly compensation payment for deputy sheriffs, or those acting in the capacity of deputy sheriffs, who serve upon a fee basis, shall be thirty dollars ($30.00) a week as fixed herein.

An officer or member of the State Highway Patrol shall not be awarded any weekly compensation under the provisions of this section for the first two years of any incapacity resulting from an injury by accident arising out of and in the course of the performance by him of his official duties if, during such incapacity, he continues to be an officer or member of the State Highway Patrol, but he shall be awarded any other benefits to which he may be entitled under the provisions of this Article.

Notwithstanding any other provision of this Article, on July 1 of each year, a maximum weekly benefit amount shall be computed. The amount of this maximum weekly benefit shall be derived by obtaining the average weekly insured wage in accordance with G.S. 96-8(22), by multiplying such average weekly insured wage by 1.10, and by rounding such figure to its nearest multiple of two dollars ($2.00), and this said maximum weekly benefit shall be applicable to all injuries and claims arising on and after January 1 following such computation. Such maximum weekly benefit shall apply to all provisions of this Chapter and shall be adjusted July 1 and effective January 1 of each year as herein provided.

(b) Total disability compensation shall continue until the injured employee reaches the age of retirement or for the 300 week period specified for benefits under G.S. 97-30, whichever period is longer, but in neither event shall the total disability compensation be for a period less than specified for payment of a listed impairment under G.S. 97-31. For the purposes of this subsection, the 'age of retirement' means 65 years of age."

SECTION 2. This act is effective when it becomes law and applies to claims filed on or after that date.

HOUSE BILL 1022:
Workers' Comp./Duration of Total Disability

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Judiciary II	**Date:**	May 4, 2009
Introduced by:	Reps. Goforth, Folwell, Hill, Rhyne	**Prepared by:**	Bill Patterson
Analysis of:	PCS to First Edition (H1022-CSLR-14)		Committee Counsel

SUMMARY: House Bill 1022 would amend the Workers Compensation Act to limit the duration of temporary total disability compensation benefits by terminating such benefits when the employee becomes eligible by age for full Social Security benefits or after 300 weeks, whichever is longer.

[As introduced, this bill was identical to S975, as introduced by Sen. Apodaca, which is currently in Senate Commerce.]

CURRENT LAW: Under the North Carolina Workers Compensation Act, an injured employee is eligible for several types of benefits, including indemnity (wage-replacement) and medical benefits.

Under G.S. 97-25[1], an injured employee is entitled to medical compensation, but under G.S. 97-25.1, this right terminates two years after the employer's last payment of medical or indemnity compensation, unless the employee applies for additional medical compensation before this period expires and the Industrial Commission approves this request, or unless the Commission orders such additional medical compensation on its own motion. The Commission is required to order the payment of future medical compensation where it finds that there is a substantial risk of its necessity.

In addition to medical compensation, an employee whose injury has resulted in a loss of wage-earning capacity is entitled to weekly compensation under either G.S. 97-29 or G.S. 97-30.

Under G.S. 97-29, for a total loss of wage-earning capacity, the employee is entitled to receive weekly compensation in the amount of 2/3 of his or her average weekly wage for as long as that loss lasts, with no limitation on the duration of the benefits. If the total incapacity is permanent, the employee is entitled to receive this compensation for life.

Under G.S. 97-30, for a partial loss of wage-earning capacity, the employee is entitled to receive weekly compensation in the amount of 2/3 of the difference in average weekly wage before and after the injury, for as long as the partial loss of wage-earning capacity lasts, but subject to a maximum of 300 weeks.

Under G.S. 97-31, if an employee has a specific physical impairment that falls under the schedule of injuries set forth in that section, he or she is presumed to have suffered a loss of wage-earning capacity. In that case, the employee is entitled to weekly compensation during the "healing period" and, in addition, a lump-sum payment according to the schedule of injuries set forth in the statute.

BILL ANALYSIS: House Bill 1022 (PCS) would amend G.S. 97-29 to limit the weekly indemnity compensation payable to an employee whose total incapacity is temporary, rather than permanent, by terminating such compensation after 300 weeks, or when the employee is eligible by age for full Social Security benefits[2], whichever period is longer. The bill would not affect an employee's right to receive

[1] All statutes referenced herein are reprinted in full at the end of this summary.

[2] Full retirement age had been 65 for many years. However, beginning with people born in 1938 or later, that age gradually increases until it reaches 67 for people born after 1959. A chart showing the steps in which the age will increase is reprinted at the end of this summary.

weekly compensation if the employee's total incapacity has been determined by the Commission to be permanent. The bill also would not alter the employee's existing right to benefits for permanent partial disability benefits under G.S. 97-30, or to medical benefits under G.S. 97-25. The bill's termination of weekly compensation could potentially affect the employee's right to medical compensation by triggering the start of the two-year period under G.S. 97-25.1, after which the employee would lose the right to those benefits unless, during that period, the employee receives injury-related medical treatment or the Commission orders otherwise.

EFFECTIVE DATE: This act is effective when it becomes law and applies to claims filed on or after that date.

H1022-SMTG-37(CSLR-14) v3

§ 97-25. Medical treatment and supplies.

Medical compensation shall be provided by the employer. In case of a controversy arising between the employer and employee relative to the continuance of medical, surgical, hospital, or other treatment, the Industrial Commission may order such further treatments as may in the discretion of the Commission be necessary.

The Commission may at any time upon the request of an employee order a change of treatment and designate other treatment suggested by the injured employee subject to the approval of the Commission, and in such a case the expense thereof shall be borne by the employer upon the same terms and conditions as hereinbefore provided in this section for medical and surgical treatment and attendance.

The refusal of the employee to accept any medical, hospital, surgical or other treatment or rehabilitative procedure when ordered by the Industrial Commission shall bar said employee from further compensation until such refusal ceases, and no compensation shall at any time be paid for the period of suspension unless in the opinion of the Industrial Commission the circumstances justified the refusal, in which case, the Industrial Commission may order a change in the medical or hospital service.

If in an emergency on account of the employer's failure to provide the medical or other care as herein specified a physician other than provided by the employer is called to treat the injured employee, the reasonable cost of such service shall be paid by the employer if so ordered by the Industrial Commission.

Provided, however, if he so desires, an injured employee may select a physician of his own choosing to attend, prescribe and assume the care and charge of his case, subject to the approval of the Industrial Commission.

§ 97-25.1. Limitation of duration of medical compensation.

The right to medical compensation shall terminate two years after the employer's last payment of medical or indemnity compensation unless, prior to the expiration of this period, either: (i) the employee files with the Commission an application for additional medical compensation which is thereafter approved by the Commission, or (ii) the Commission on its own motion orders additional medical compensation. If the Commission determines that there is a substantial risk of the necessity of future medical compensation, the Commission shall provide by order for payment of future necessary medical compensation.

§ 97-29. Compensation rates for total incapacity.

Except as hereinafter otherwise provided, where the incapacity for work resulting from the injury is total, the employer shall pay or cause to be paid, as hereinafter provided, to the injured employee during such total disability a weekly compensation equal to sixty-six and two-thirds percent (66 2/3%) of his average weekly wages, but not more than the amount established annually to be effective October 1 as provided herein, nor less than thirty dollars ($30.00) per week.

In cases of total and permanent disability, compensation, including medical compensation, shall be paid for by the employer during the lifetime of the injured employee. If death results from the injury then the employer shall pay compensation in accordance with the provisions of G.S. 97-38.

The weekly compensation payment for members of the North Carolina national guard and the North Carolina State Defense Militia shall be the maximum amount established annually in accordance with the last paragraph of

this section per week as fixed herein. The weekly compensation payment for deputy sheriffs, or those acting in the capacity of deputy sheriffs, who serve upon a fee basis, shall be thirty dollars ($30.00) a week as fixed herein.

An officer or member of the State Highway Patrol shall not be awarded any weekly compensation under the provisions of this section for the first two years of any incapacity resulting from an injury by accident arising out of and in the course of the performance by him of his official duties if, during such incapacity, he continues to be an officer or member of the State Highway Patrol, but he shall be awarded any other benefits to which he may be entitled under the provisions of this Article.

Notwithstanding any other provision of this Article, on July 1 of each year, a maximum weekly benefit amount shall be computed. The amount of this maximum weekly benefit shall be derived by obtaining the average weekly insured wage in accordance with G.S. 96-8(22), by multiplying such average weekly insured wage by 1.10, and by rounding such figure to its nearest multiple of two dollars ($2.00), and this said maximum weekly benefit shall be applicable to all injuries and claims arising on and after January 1 following such computation. Such maximum weekly benefit shall apply to all provisions of this Chapter and shall be adjusted July 1 and effective January 1 of each year as herein provided.

§ 97-30. Partial incapacity.

Except as otherwise provided in G.S. 97-31, where the incapacity for work resulting from the injury is partial, the employer shall pay, or cause to be paid, as hereinafter provided, to the injured employee during such disability, a weekly compensation equal to sixty-six and two-thirds percent (66 2/3%) of the difference between his average weekly wages before the injury and the average weekly wages which he is able to earn thereafter, but not more than the amount established annually to be effective October 1 as provided in G.S. 97-29 a week, and in no case shall the period covered by such compensation be greater than 300 weeks from the date of injury. In case the partial disability begins after a period of total disability, the latter period shall be deducted from the maximum period herein allowed for partial disability. An officer or member of the State Highway Patrol shall not be awarded any weekly compensation under the provisions of this section for the first two years of any incapacity resulting from an injury by accident arising out of and in the course of the performance by him of his official duties if, during such incapacity, he continues to be an officer or member of the State Highway Patrol, but he shall be awarded any other benefits to which he may be entitled under the provisions of this Article.

§ 97-31. Schedule of injuries; rate and period of compensation.

In cases included by the following schedule the compensation in each case shall be paid for disability during the healing period and in addition the disability shall be deemed to continue for the period specified, and shall be in lieu of all other compensation, including disfigurement, to wit:

(1) For the loss of a thumb, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 75 weeks.

(2) For the loss of a first finger, commonly called the index finger, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 45 weeks.

(3) For the loss of a second finger, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 40 weeks.

(4) For the loss of a third finger, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 25 weeks.

(5) For the loss of a fourth finger, commonly called the little finger, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 20 weeks.

(6) The loss of the first phalange of the thumb or any finger shall be considered to be equal to the loss of one half of such thumb or finger, and the compensation shall be for one half of the periods of time above specified.

(7) The loss of more than one phalange shall be considered the loss of the entire finger or thumb: Provided, however, that in no case shall the amount received for more than one finger exceed the amount provided in this schedule for the loss of a hand.

(8) For the loss of a great toe, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 35 weeks.

(9) For the loss of one of the toes other than a great toe, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 10 weeks.

(10) The loss of the first phalange of any toe shall be considered to be equal to the loss of one half of such toe, and the compensation shall be for one half of the periods of time above specified.

(11) The loss of more than one phalange shall be considered as the loss of the entire toe.

(12) For the loss of a hand, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 200 weeks.

(13) For the loss of an arm, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 240 weeks.

(14) For the loss of a foot, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 144 weeks.

(15) For the loss of a leg, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 200 weeks.

(16) For the loss of an eye, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 120 weeks.

(17) The loss of both hands, or both arms, or both feet, or both legs, or both eyes, or any two thereof, shall constitute total and permanent disability, to be compensated according to the provisions of G.S. 97-29. The employee shall have a vested right in a minimum amount of compensation for the total number of weeks of benefits provided under this section for each member involved. When an employee dies from any cause other than the injury for which he is entitled to compensation, payment of the minimum amount of compensation shall be payable as provided in G.S. 97-37.

(18) For the complete loss of hearing in one ear, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 70 weeks; for the complete loss of hearing in both ears, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 150 weeks.

(19) Total loss of use of a member or loss of vision of an eye shall be considered as equivalent to the loss of such member or eye. The compensation for partial loss of or for partial loss of use of a member or for partial loss of vision of an eye or for partial loss of hearing shall be such proportion of the periods of payment above provided for total loss as such partial loss bears to total loss, except that in cases where there is eighty-five per centum (85%), or more, loss of vision in any eye, this shall be deemed "industrial blindness" and compensated as for total loss of vision of such eye.

(20) The weekly compensation payments referred to in this section shall all be subject to the same limitations as to maximum and minimum as set out in G.S. 97-29.

(21) In case of serious facial or head disfigurement, the Industrial Commission shall award proper and equitable compensation not to exceed twenty thousand dollars ($20,000). In case of enucleation where an artificial eye cannot be fitted and used, the Industrial Commission may award compensation as for serious facial disfigurement.

(22) In case of serious bodily disfigurement for which no compensation is payable under any other subdivision of this section, but excluding the disfigurement resulting from permanent loss or permanent partial loss of use of any member of the body for which compensation is fixed in the schedule contained in this section, the Industrial Commission may award proper and equitable compensation not to exceed ten thousand dollars ($10,000).

(23) For the total loss of use of the back, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 300 weeks. The compensation for partial loss of use of the back shall be such proportion of the periods of payment herein provided for total loss as such partial loss bears to total loss, except that in cases where there is seventy-five per centum (75%) or more loss of use of the back, in which event the injured employee shall be deemed to have suffered "total industrial disability" and compensated as for total loss of use of the back.

(24) In case of the loss of or permanent injury to any important external or internal organ or part of the body for which no compensation is payable under any other subdivision of this section, the Industrial Commission may award proper and equitable compensation not to exceed twenty thousand dollars ($20,000).

Steps in Which the Full Retirement Age is Increasing

Year of Birth	Full Retirement Age
1937 or earlier	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943--1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

Note: Persons born on January 1 of any year should refer to the full retirement age for the previous year.

(Source: http://www.socialsecurity.gov/pubs/ageincrease.htm)

H.B. 1022 - Workers' Comp./Duration of Total Disability

H.B. 1022 responds to an increasingly significant cost issue threatening the viability of North Carolina's workers' compensation system. To ensure the integrity of the system, H.B. 1022 would place a reasonable limitation on the duration of indemnity benefits for *Temporary* Total Disability payments so that the payments would expire when the recipient reaches the age of 65 or 300 weeks (nearly 6 years), whichever is longer.

Temporary Total Disability ("TTD") benefits are paid when a worker is *temporarily* unable to earn wages. Current North Carolina law places no limitation on these supposedly temporary benefits.

North Carolina's system is not competitive with other states where reasonable limits on TTD payments are in place:

State	Total Weeks of Benefits
NC	No Max on TTD
SC	500 Weeks
VA	500 Weeks
TN	400 Weeks
GA	400 Weeks

H.B. 1022 *does not* affect the duration of Temporary Partial Disability (TPD) and Permanent Partial Disability (PPD) payments.

Medical costs would continue to be paid during the employee's entire lifetime.

The Workers' Compensation system was never intended to be a *de facto* retirement system. The unlimited payment of TTD benefits creates such a system and is in direct conflict with the fundamental concepts and policy goals of the Workers' Compensation Act.

Employers Coalition of North Carolina
Connie Wilson, Lobbyist
919-274-0557
Connie@lobbync.com

OVER

Coalition to Update Worker's Comp TTD

- Employers Coalition of North Carolina
- Western Carolina Industries
- The Employers Association
- Capital Associated Industries
- National Federation Independent Business
- NC Automobile Dealers Association
- Carolinas Associated General Contractors
- Manufacturers & Chemical Industry Council
- Embarq
- NC Automobile Dealers Association
- NC Retail Merchants Association
- Duke Energy
- NC Association Self Insurers
- NC Association Defense Attorneys
- Key Risk Management Services
- North Carolina Chamber of Commerce
- NC Forestry Association
- North Carolina Trucking Association
- NC Homebuilders Association
- A T & T
- Carolina Asphalt Pavement Association

Rep. Dale R. Folwell
74th District- Winston-Salem
(919) 733-5787
306A1 LOB

OVER →

Coalition to Update Worker's Comp TTD

- Employers Coalition of North Carolina
- Western Carolina Industries
- The Employers Association
- Capital Associated Industries
- National Federation Independent Business
- NC Automobile Dealers Association
- Carolinas Associated General Contractors
- Manufacturers & Chemical Industry Council
- Embarq
- NC Automobile Dealers Association
- NC Retail Merchants Association
- NC Association Self Insurers
- NC Association Defense Attorneys
- Key Risk Management Services
- North Carolina Chamber of Commerce
- North Carolina Trucking Association
- NC Homebuilders Association
- A T & T
- Carolina Asphalt Pavement Association

ATTACHMENT #1

VISITOR REGISTRATION SHEET

House Committee on Insurance

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	JD/ALPA
Bill Wilson	AARP
Sue Stovall	NCATA
	NCPTA
Todd Barlow	NCAJ
Ted Hamby	NC DOI
Rose Williams	NC DOT
	WCSR
David Vanderweide	NCDST
DAVID BARNES	Poyner Spruill
	State Health Plan
Carol Durrell	State Health Plan

VISITOR REGISTRATION SHEET

House Committee on Insurance — 5/7/09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	AFPNC
Daniel Boliek	K&L Gates
Steve Woodson	NCFB
R. Perry	D.O.J.
C. Cardwell	DOJ
John Williams Jr.	Attorney 3310 Crossdale Dr. Durham
Heidi Chapman	100 Europa Dr #520 Chapel Hill, NC
Gina Cammarano	Jernigan Law Firm PO Box 847 Raleigh NC
Henry Patterson	Patterson Harkey LLP
F.M. Lors	R. Farmlink AIS Carg
Preston Howard	MCIC
Gwendolyn Thompson	BBOR

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joe Stewart	NC Chamber
Lisa Martin	NC Home Builders
Bill Scoggin	KCG
[illegible]	NMRS
Annette Newkirk	Governor's Office
Eric Troyer	302 S. Main St Cary NC
Kathy Hawkins	Progress Energy
Rene Wimbish	Rep Folwell's LA
Ed Pauley	Wallace & Graham. 525 N Main St Salisbury, NC
W H Potter Jr	NCPTA & NCDC
Mary Foreman	NCAE

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bo A Sheumm	NCFA
Mike Signon	Brooks Stevens & Pope Raleigh
Lynn Teague	NMRS
BOB HERRONS	PCI
Gary Bolt	BCBSNC
Mark Flem	BCBS NC
Lori Ann Harris	LAHA
Michael A Thompson	Dominion
Debra DeCamillis	UNC. IOG
Amy McConkey	Smith Anderson
ROS BLACK	Teamsters

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Burton Craige	NCAJ
Chip Bigger	NCMS
Scott Gardner	Duke Energy
Colleen Kochanek	NCCEP
Dana Simpson	SA
Dana Simpson	SA
RW Kaylor	Kaylor Law Firm
John Goodman	NC Chamber
Donald Anderson	PFPWC
[illegible]	[illegible]
[illegible]	NCBA

House Pages

Name of Committee: Insurance Date: 5-7-09

1. Name: Brittany Brisson
   County: Bladen
   Sponsor: William Brisson
2. Name: Jeremy Strickland
   County: Sampson
   Sponsor: David Lewis
3. Name:
   County:
   Sponsor:
4. Name:
   County:
   Sponsor:
5. Name:
   County:
   Sponsor:

Sgt-At-Arms

1. Name: James Worth
2. Name: Young Bae
3. Name: Bob Rossi
4. Name:

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 14 A BILL TO BE ENTITLED AN ACT TO REENACT A LAW CONCERNING HEALTH BENEFIT PLAN CO-PAYMENTS FOR CHIROPRACTIC SERVICES.

☒ With a favorable report as to the committee substitute bill, which changes the title, unfavorable as to the original bill, and recommendation that the committee substitute bill be re-referred to the Committee on HEALTH.

(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.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 1160 . A BILL TO BE ENTITLED AN ACT TO ALLOW CERTAIN FIREFIGHTERS, WHO WERE PREVIOUSLY CERTIFIED BY THE INSURANCE COMMISSIONER FOR MEMBERSHIP IN THE FIREFIGHTERS' RELIEF FUND, THE OPPORTUNITY TO BE COVERED BY THE FIREFIGHTERS' RELIEF FUND BY MAKING RETROACTIVE PAYMENTS WITH INTEREST.

☒ With a favorable report as to the committee substitute bill, which changes the title, unfavorable as to the original bill, and recommendation that the 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.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for
HB 438 A BILL TO BE ENTITLED AN ACT TO ALLOW THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN TO CHANGE ITS PLAN YEAR FROM A FISCAL YEAR TO A CALENDAR YEAR.

☒ With a favorable report and recommendation that the 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 _____.

_____ The bill/resolution is re-referred to the Committee on _____.

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION
Removed HB 535

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

DAY & DATE: **Thursday, May 7, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

HB 14 – CHIROPRACTIC SERVICES/INSURANCE – Rep. Tarleton and Goforth

HB 535 – HEALTH INSURANCE COVERAGE/LYMPHEDEMA – Rep. Cotham

HB 1160 – FIREFIGHTERS' RELIEF FUND ADDITIONS – AB – Rep. Wray and Goforth

HB 1485 – INSURANCE/HEALTH CARE PROVIDER RELATIONSHIP – Reps. Steen, Barnhart, Neumann and England

HB 1494 – REVISE UM/UIM COVERAGE REQUIREMENTS – Reps. Goforth, Insko, Lucas and Tarleton

HB 1022 – WORKERS' COMP/DURATION OF TOTAL DISABILITY – Rep. Goforth, Folwell, Hill and Rhyne

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at: **3:00** on **May 5, 2009.**

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

MINUTES

HOUSE COMMITTEE ON INSURANCE
May 11, 2009

The House Committee on Insurance met at 3:00 PM on Monday, May 11, 2009, in Room 544. The following Representatives attended, Chairmen Bruce Goforth and Michael H. Wray; Vice Chair: J. Dockham. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Current, Faison, Gibson, Holliman, Howard, Hughes, Lewis, Pierce and Wainwright.

Chairman Goforth called the meeting to order and welcomed visitors. He recognized Sgt-At-Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachment #1)

Chairman Goforth called upon Rep. Neumann to explain HB 1485 Insurance/Health Care Provider Relationship. Rep. Holliman was recognized for a motion to have a PCS before the Committee. Rep. Neumann stated the bill will clarify language between the insurance and the health care providers by adding new language for the recovery of overpayments. Rep. Holliman moved for a favorable report of the PCS, unfavorable as to original bill, and recommendation that the committee substitute bill be re-referred to the Judiciary Committee II. Motion carried.

Chairman Goforth turned the meeting over to Chairman Wray who recognized Rep. Folwell to continue discussion from the May 7 meeting on HB 1022-Workers' Comp./Temp.Total Disability Limit. Rep. Folwell stated the bill deals with a part of the Workers Compensation Law regarding temporary total disability. The bill would amend the Workers Compensation Act to limit the duration of temporary total disability compensation benefit by terminating such benefit when the employee becomes eligible by age for full Social Security benefits or after 300 weeks, whichever is longer.

Chairman Wray recognized Ms. Heidi Chapman, Attorney from Chapel Hill, and Board Certified Specialist in Workers Compensation Law. Ms. Chapman stated this proposed bill will arbitrarily cut off benefits at the end of 300 weeks from the date of injury. She shared the attached Workers Compensation State Rankings, Manufacturing Industry Costs and Statutory Benefit Provisions document. (Attachment #2)

After much discussion, Rep. Goforth made a motion for a favorable report to the PCS, unfavorable to the original bill, and recommendation that the committee substitute bill be re-referred to the Judiciary II Committee. Motion carried.

Chairman Wray adjourned the meeting at 3:50 PM.

Representative Bruce Goforth, Chair

Representative Michael H. Wray

Mary Capps, Committee Assistant

HOUSE INSURANCE COMMITTEE

NOTE DAY, ROOM & TIME CHANGE

May 11, 2009
4:00 p.m.
Room 1425 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

HB 1022 – WORKERS' COMP/DURATION OF TOTAL DISABILITY – Rep. Goforth, Folwell, Hill and Rhyne

HB 1485 – INSURANCE/HEALTH CARE PROVIDER RELATIONSHIP – Reps. Steen, Barnhart, Neumann and England

Adjourn

HOUSE BILL 1485:
Insurance/Health Care Provider Relationship

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Judiciary II	**Date:**	April 29, 2009
Introduced by:	Reps. Steen, Barnhart, Neumann, England	**Prepared by:**	Ben Popkin
Analysis of:	PCS to First Edition H1485-CSRD-36		Committee Counsel

SUMMARY: ***House Bill 1485 would extend the notice period required to be given by an insurer seeking recovery of overpayment or offsetting of future payments to a health care provider or facility. The bill would limit recovery of overpayments by insurers to the actual claims for which the insurer can provide specific detail set forth in the bill, unless the insurer provides documented evidence of fraud or other intentional misconduct by the provider, facility or its agents.***

The bill would establish a process for the filing and adjudication of provider or facility appeals disputing the insurer's requested overpayment recovery, and would direct insurers to provide internal appeals processes for adjudicating the disputes within 90 days.

The bill would allow insurers to recover overpayments by offsetting future payments if, within 120 days of the insurer providing notice requesting recovery, "...the provider or facility has not provided a refund of an overpayment or an appeal of an alleged overpayment is still ongoing."

Further, the bill would direct the Department of Insurance to study the advisability of and need for an independent claims review process for disputes between insurers and providers, and report its finding to the General Assembly by April 1, 2010.

The Proposed Committee Substitute maintains the current two year period during which claims for recovery of funds may be made, and extends the time periods for the filing and adjudication of appeals disputing the request for recovery of overpayment, and for insurers to wait before offsetting future payments.

CURRENT LAW/*BILL ANALYSIS*: Subsection (h) of G.S. 58-3-225 "Prompt claim payments under health benefit plans", sets forth the following procedures and timelines for recovery of overpayments by insurers to health care providers or facilities:

- Subsection (h) currently authorizes insurers to recover overpayments to providers or facilities *and* to offset future payments to the providers or facilities pursuant to the section's timelines (insurer must give written notice 30 days prior to recovery or offsetting of payments, both of which may be made within two years of the original claim payment). *The bill would provide that offsetting future payments may be done "...if the matter is not resolved pursuant to this subsection...", which may be no sooner than 120 days after providing the facility or provider with written notice of the demand for recovery of overpayment.*
- Insurer provides written notice at least 30 days before seeking overpayment recovery from or offsetting payments to a health care provider or facility. *The bill would extend this notice to 90 days.*

Subsection (j) of G.S. 58-3-225 provides that violations of the section by an insurer subjects the insurer to sanctions per G.S. 58-2-70 (allows for restitution and monetary penalty of $100-$1,000). *The bill would add demands for recovery of overpayments under subsection (h) of the section made by an insurer in bad faith to the violations punishable under this subsection.*

The bill would add new language to subsection (h) to do the following:

- Limit recovery of overpayments under the subsection to actual claims for which the insurer can provide the health care provider or facility with the patient name and ID number, service date, claim payment amount, and an explanation of the proposed revised payment amount. This requirement is waived if the insurer provides documented evidence of fraud or other intentional misconduct by the provider, facility or its agents.
- Allow providers and facilities to appeal insurers' requests for recovery within 45 days of receiving a request.
- Direct insurers to provide an internal appeals process to adjudicate disputed requests for recovery within 90 days of commencement of the appeal.
- Allow insurers to seek recovery from providers or facilities by offsetting future payments if no refund of overpayment has been made or if an appeal is ongoing 120 days after the insurer has given the provider or facility written notice of its demand for recovery of overpayment.

Section 2 of the bill would direct the Department of Insurance to study the advisability of and need for an independent claims review process for disputes between insurers and providers, and report its findings, including proposed legislation, to the General Assembly by April 1, 2010.

EFFECTIVE DATE: This act is effective when it becomes law. Section 1 of this act applies to reviews by insurers of claims for possible overpayment of claim payments made on or after that date and to health care provider or health care facility demands for refunds from insurers for claims originally adjudicated on or after that date.

H1485-SMRD-79(CSRD-36) v6

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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HOUSE BILL 1485
PROPOSED COMMITTEE SUBSTITUTE H1485-CSRD-36 [v.4]

5/7/2009 9:52:17 AM

Short Title: Insurance/Health Care Provider Relationship. (Public)

Sponsors:

Referred to:

April 13, 2009

A BILL TO BE ENTITLED

AN ACT TO REFORM THE PROCESS FOR RECOVERY OF OVERPAYMENTS TO PROVIDERS BY INSURERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-225 reads as rewritten:

"**§ 58-3-225. Prompt claim payments under health benefit plans.**

...

(h) Subject to the time lines required under this section, the insurer may recover overpayments made to the health care provider or health care facility by making demands for refunds ~~and~~ and, if the matter is not resolved pursuant to this subsection, by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of this section. Not less than ~~30~~ 90 calendar days before an insurer seeks overpayment recovery or offsets future payments, the insurer shall give written notice to the health care provider or health care facility, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments may be made not more than two years after the date of the original claim payment unless the insurer has reasonable belief of fraud or other intentional misconduct by the health care provider or health care facility or its agents, or the claim involves a health care provider or health care facility receiving payment for the same service from a government payor. Recovery of overpayments pursuant to this subsection shall be limited to the actual claims for which the insurer can provide the health care provider or facility with (i) the patient's name and identification number, (ii) the service date, (iii) the payment amount received by the health care provider or facility for the claim, and (iv) an explanation of the proposed revised payment amount which includes at a minimum the change in the code used, the amount of the revised payment, and the reason for the change in code. The requirements in the preceding sentence do not apply if the insurer provides documented evidence of fraud or other intentional misconduct by the health care provider or health care facility or its agents. If a health care provider or health care facility disputes a request for an overpayment recovery by the insurer, then the provider or facility may appeal the request within 45 days of receipt of the request for recovery. The insurer shall provide an internal appeals process for adjudicating such disputes within 90 days of the health care provider or health care facility commencing an appeal. If, within 120 calendar days after an insurer provides a health care provider or health care facility written notice of a demand for recovery of overpayments, the provider or facility has not provided a refund of an overpayment

or an appeal of an alleged overpayment is still ongoing, then the insurer may seek recovery by offsetting future payments.

The health care provider or health care facility may recover underpayments or nonpayments by the insurer by making demands for refunds. Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by the insurer may include applicable interest under this section. The period for which such recoveries may be made may not exceed two years after the date of the original claim adjudication, unless the claim involves a health provider or health care facility receiving payment for the same service from a government payor.

(i) Every insurer shall maintain written or electronic records of its activities under this section, including records of when each claim was received, paid, denied, or pended, and the insurer's review and handling of each claim under this section, sufficient to demonstrate compliance with this section.

(j) A violation of this section by an ~~insurer~~ insurer, including a demand for recovery of overpayments under subsection (h) of this section that is made in bad faith, subjects the insurer to the sanctions in G.S. 58-2-70. The authority of the Commissioner under this subsection does not impair the right of a claimant to pursue any other action or remedy available under law. With respect to a specific claim, an insurer paying statutory interest in good faith under this section is not subject to sanctions for that claim under this subsection.

(k) An insurer is not in violation of this section nor subject to interest payments under this section if its failure to comply with this section is caused in material part by (i) the person submitting the claim, or (ii) by matters beyond the insurer's reasonable control, including an act of God, insurrection, strike, fire, or power outages. In addition, an insurer is not in violation of this section or subject to interest payments to the claimant under this section if the insurer has a reasonable basis to believe that the claim was submitted fraudulently and notifies the claimant of the alleged fraud.

(l) Expired January 1, 2003.

(m) Nothing in this section limits or impairs the patient's liability under existing law for payment of medical expenses."

SECTION 2. The Department of Insurance shall study the advisability of and need for an independent claims review process for disputes between insurers and providers analogous to that provided for appeals by covered persons of noncertification decisions by Part 4 of Article 50 of Chapter 58 of the General Statutes. The Department shall report its findings, including proposed legislation, to the General Assembly no later than April 1, 2010.

SECTION 3. This act is effective when it becomes law. Section 1 of this act applies to reviews by insurers of claims for possible overpayment of claim payments made on or after that date and to health care provider or health care facility demands for refunds from insurers for claims originally adjudicated on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: Proposed Committee Substitute to HB 1485 (H1485-CSRD-36 [v.4]

SHORT TITLE: Insurance/Health Care Provider Relationship.

SPONSOR(S): Representatives Barnhart, England, Steen, and Neumann

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SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY: The Proposed Committee Substitute to HB 1485 amends the prompt payment law, under G.S. 58-3-225, to change requirements with respect to claims payment recoveries involving overpayments between insurers and health care providers and facilities. The proposed changes include increasing the notice requirement an insurer must give a health care provider or facility regarding a potential overpayment recovery and limiting the recovery of overpayments to claims where the insurer can identify the specific patient, date of service, claim amount, etc. The proposed changes would also require an insurer to provide a brief explanation of why a proposed change the in original claim amount paid is necessary. For overpayment recoveries sought by an insurer as a result of documented fraud the requirements proposed do not apply.

The proposed change applies to the Plan by cross reference under G.S. 135-44.4(28) which applies the prompt payment law to the Plan as if it were an insurer regulated under G.S. 58-3-225.

EFFECTIVE DATE: When it becomes law.

ESTIMATED IMPACT ON STATE:

Aon Consulting, the consulting actuary for the State Health Plan for Teachers and State Employees, estimates that the proposed legislation will have a negligible financial impact on the Plan. Aon Consulting states that the Plan's overpayment recoveries will not be affected under the proposed legislation and that expenses related to the proposed disclosure and administrative requirements are expected to be insignificant.

Hartman & Associates, the consulting actuary for the General Assembly's Fiscal Research Division, estimates the proposed legislation will not have a material impact on the Plan since the Plan's ability to collect claims overpayment recoveries within the current two-year statutory period is unaffected.

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Based on information provided by the Plan's Claims Processing Contractor, Blue Cross Blue Shield of North Carolina, the Plan's claims overpayment recovery experience for calendar year 2008 indicates that 14% of total recoveries, or $2.2 million, occur beyond 365 days of the original date of claims payment. For the Plan's claims in the 2008 calendar year subject to an overpayment recovery, approximately $16 million in total overpayment recoveries were collected within the two year period currently allowed under G.S. 58-3-225. Of this total amount an estimated $12 million, or 75% of total recoveries, are cash recoveries and the other 25% is from offsetting future reimbursements to affected providers or facilities (approximately $1.7 million).

Based on information provided by the Plan's staff, the changes in the Proposed Committee Substitute will not adversely affect the Plan's financial condition. This assumption is applied based on the current statutory requirement allowing an insurer a period of up to two years from the date of an original claim to recover a potential overpayment.

Application of the requirements in the Proposed Committee Substitute is assumed to be effective July 1, 2009 and the estimated impacts to the Plan were calculated according to this assumption.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2008, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.6 billion for FY 2008-09. The Plan's PPO benefit design includes three alternative benefit levels offered to plan members. The three alternative benefit levels include the following:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums;

2) The "Standard" 80/20 plan; and

3) The "Plus" 90/10 plan with enhanced benefits via lower out-of pocket requirements as compared to the other PPO plan alternatives offered.

As of July 1, 2009, the State will continue to finance the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts will be derived through premium contributions, investment earnings and other receipts. Premiums for health benefit

coverage will be paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.5 billion for FY 2009-10 and $2.7 billion for FY 2010-11. The Plan's PPO benefit design will include two alternative benefit levels listed below:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums; and

2) The "Standard" 80/20 plan.

The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under both plans is offered on a fully contributory basis.

Financial Condition

Financial Projection (Revised Summer 2008) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year were projected to be $2.3 billion from premium collections, $53.9 million from Medicare Part D subsidies, and $2.7 million from investment earnings, for a total of slightly over $2.3 billion in receipt income for the year. Projected disbursements from the Plan were expected to be $2.4 billion in claim-payment expenses and $168.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating loss was projected to be approximately $264.4 million for the fiscal year, assuming a 9% annual claims growth trend.

Projected operating losses were expected to deplete the Plan's cash balance of $139.8 million and leave it without sufficient operating resources to continue operations for the fiscal year.

Financial Projection (Revised April 2009) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year are projected to be $2.3 billion from premium collections, $49.0 million from Medicare Part D subsidies, $3.3 million from investment earnings, and $250.0 million from a direct General Fund appropriation from the Rainy Day Fund (Savings Reserve Account) for a total of approximately $2.6 billion in receipt income for the year. The $250 million from a direct General Fund appropriation was provided by Session Law 2009-16 (Senate Bill 287) to finance a shortfall in funds available to pay health care benefits, administrative costs, and adequately fund the Plan's beginning cash balance on July 1, 2009. Projected disbursements from the Plan are expected to be $2.4 billion in claim-payment expenses and $180.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating income is projected to be approximately $7.1 million for the fiscal year, assuming a 9% annual claims growth trend.

Financial Projection 2009-11 Biennium (April 2009) – Session Law 2009-16 (Senate Bill 287) appropriates funds from various sources, authorizes annual premium rate increases, makes various benefit and provider related changes to achieve financial savings, and directs other various changes to the Plan. The enacted law also appropriates the sum of $250 million from the Savings Reserve Account ("Rainy Day Fund") of the General Fund for the 2008-09 fiscal year. The following summarized financial projections by fiscal year for the 2009-11 biennium assume the changes enacted in Session Law 2009-16 (Senate Bill 287).

For the fiscal year beginning July 1, 2009, the Plan is projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year are projected to be $2.4 billion from premium collections, $56.3 million from Medicare Part D subsidies, and $8.0 million from investment earnings for a total of approximately $2.5 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.3 billion in claim-payment expenses and $185.6 million in administration and claims-processing expenses for projected total expenses of nearly $2.5 billion for FY 2008-09. The Plan's net operating income is projected to be approximately $14.8 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan is projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year are projected to be $2.7 billion from premium collections, $50.4 million from Medicare Part D subsidies, and $8.8 million from investment earnings for a total of approximately $2.7 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.5 billion in claim-payment expenses and $191.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.7 billion for FY 2010-11. The Plan's operating income is projected to be approximately $30.6 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Other Information

Historically, the Plan has applied a premium increase in October of the first fiscal year of a biennium. However, the annual premium increases authorized in Session Law 2009-16 (Senate Bill 287) changes that methodology to an annual increase at the beginning of each fiscal year of the 2009-11 biennium.

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment Data as of December 31, 2008

I. No. of Participants	Basic	Standard	Plus	Total	Percent of Total
Actives					
Employees	11,623	271,243	47,687	330,553	49.6%
Dependents	20,454	115,875	28,156	164,485	24.7%
Sub-total	32,077	387,118	75,843	495,038	74.2%
Retired					
Employees	1,726	127,081	17,967	146,774	22.0%
Dependents	1,117	14,935	3,476	19,528	2.9%
Sub-total	2,843	142,016	21,443	166,302	24.9%
Former Employees with Continuation Coverage					
Employees	60	1,349	344	1,753	0.3%
Dependents	61	501	182	744	0.1%
Sub-total	121	1,850	526	2,497	0.4%
Firefighters, Rescue Squad & National Guard					
Employees	-	3	2	5	0.0%
Dependents	-	3	-	3	0.0%
Sub-total	-	6	2	8	0.0%
Local Governments					
Employees	72	1,577	319	1,968	0.3%
Dependents	141	637	218	996	0.1%
Sub-total	213	2,214	537	2,964	0.4%
Total					
Employees	13,481	401,253	66,319	481,053	72.1%
Dependents	21,773	131,951	32,032	185,756	27.9%
Grand Total	**35,254**	**533,204**	**98,351**	**666,809**	**100%**
Percent of Total	**5.3%**	**80.0%**	**14.7%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	2,684	328,635	49,246	380,565
Employee Child(ren)	4,958	36,903	8,589	50,450
Employee Spouse	2,274	18,145	4,469	24,888
Employee Family	3,565	17,570	4,015	25,150
Total	**13,481**	**401,253**	**66,319**	**481,053**

Percent Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	19.9%	81.9%	74.3%	79.1%
Employee Child(ren)	36.8%	9.2%	13.0%	10.5%
Employee Spouse	16.9%	4.5%	6.7%	5.2%
Employee Family	26.4%	4.4%	6.1%	5.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Enrollment Data Continued

III. Enrollment by Sex	Basic	Standard	Plus	Total
Female	18,837	334,917	61,752	415,506
Male	16,417	198,287	36,599	251,303
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Sex	Basic	Standard	Plus	Total
Female	53.4%	62.8%	62.8%	62.3%
Male	46.6%	37.2%	37.2%	37.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	17,390	136,277	27,211	180,878
30 to 44	8,125	107,375	17,315	132,815
45 to 54	5,164	94,548	18,277	117,989
55 to 64	3,195	102,901	23,452	129,548
65 & Over	1,380	92,103	12,096	105,579
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	49.3%	25.6%	27.7%	27.1%
30 to 44	23.0%	20.1%	17.6%	19.9%
45 to 54	14.6%	17.7%	18.6%	17.7%
55 to 64	9.1%	19.3%	23.8%	19.4%
65 & Over	3.9%	17.3%	12.3%	15.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	49,534	12,080	61,614
Medicare Eligible	97,240	7,448	104,688
Total	**146,774**	**19,528**	**166,302**

Percent by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.7%	61.9%	37.0%
Medicare Eligible	66.3%	38.1%	63.0%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, "House Bill 1485 Proposed Committee Substitute (H1485-CSRD-36 [v.4]: An Act to Reform the Process For Recovery of Overpayments to Providers By Insurers," May 9, 2009, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "House Bill 1485 Proposed Committee Substitute H1485-CSRD-36 [v.4] Reform Process of Overpayment to Providers", May 11, 2009, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Marilyn Chism, Director
Fiscal Research Division

DATE: May 11, 2009

NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

HOUSE BILL 1485
PROPOSED COMMITTEE SUBSTITUTE
H1485-CSRD-36 [V.4]

REFORM PROCESS OF OVERPAYMENT TO PROVIDERS

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30305

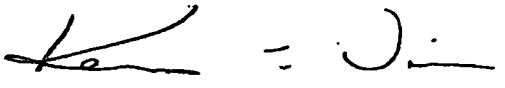
May 2009

ACTUARIAL STATEMENT

The North Carolina State Health Plan for Teachers and State Employees has requested that Aon Consulting prepare an Actuarial Note in response to House Bill 1485 Proposed Committee Substitute H1485-CSRD-36 [v.4] entitled "An Act To Reform The Process For Recovery Of Overpayments To Providers By Insurers."

The Actuarial Note was prepared according to generally accepted actuarial principles and practices; in compliance with General Statute 120-114. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.



May 11, 2009

Kenneth C. Vieira, F.S.A., M.A.A.A.
Senior Vice President

Date

May 11, 2009

Kirsten R. Schatten, A.S.A., M.A.A.A.
Assistant Vice President

Date

REFORM PROCESS OF OVERPAYMENT TO PROVIDERS

PLAN CHANGES

The proposed legislation defines administrative processes and disclosure requirements for the recovery of overpayments made to health care providers or health care facilities. The full text of the bill is attached to this actuarial note.

PROJECTED COSTS

	Based on "Midpoint" Increase (in millions)		
Plan Design Change	2009-2010 Fiscal Year Cost	2010-2011 Fiscal Year Cost	Total Biennium Cost
Changes for recovery of overpayments to providers	Negligible cost impact		

* Based on total projected expenses of $2,486,310,245 and $2,681,918,655 for the 2010 and 2011 fiscal years respectively.

PRICING APPROACH AND COMMENTS

The following information was compiled and utilized in determining the projected costs or savings of each benefit component addressed in this actuarial note:

- No claims cost/savings is projected for recovery of overpayments as the requirements in this bill only change administrative processes and disclosures.
- Implementation of the new requirements will produce administrative costs that have not yet been determined, but are not expected to be significant.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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HOUSE BILL 1485
PROPOSED COMMITTEE SUBSTITUTE H1485-CSRD-36 [v.4]

5/7/2009 9:52:17 AM

Short Title: Insurance/Health Care Provider Relationship. (Public)

Sponsors:

Referred to:

April 13, 2009

A BILL TO BE ENTITLED

AN ACT TO REFORM THE PROCESS FOR RECOVERY OF OVERPAYMENTS TO PROVIDERS BY INSURERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-225 reads as rewritten:

"**§ 58-3-225. Prompt claim payments under health benefit plans.**

...

(h) Subject to the time lines required under this section, the insurer may recover overpayments made to the health care provider or health care facility by making demands for refunds ~~and~~ and, if the matter is not resolved pursuant to this subsection, by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of this section. Not less than ~~30~~ 90 calendar days before an insurer seeks overpayment recovery or offsets future payments, the insurer shall give written notice to the health care provider or health care facility, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments may be made not more than two years after the date of the original claim payment unless the insurer has reasonable belief of fraud or other intentional misconduct by the health care provider or health care facility or its agents, or the claim involves a health care provider or health care facility receiving payment for the same service from a government payor. Recovery of overpayments pursuant to this subsection shall be limited to the actual claims for which the insurer can provide the health care provider or facility with (i) the patient's name and identification number, (ii) the service date, (iii) the payment amount received by the health care provider or facility for the claim, and (iv) an explanation of the proposed revised payment amount which includes at a minimum the change in the code used, the amount of the revised payment, and the reason for the change in code. The requirements in the preceding sentence do not apply if the insurer provides documented evidence of fraud or other intentional misconduct by the health care provider or health care facility or its agents. If a health care provider or health care facility disputes a request for an overpayment recovery by the insurer, then the provider or facility may appeal the request within 45 days of receipt of the request for recovery. The insurer shall provide an internal appeals process for adjudicating such disputes within 90 days of the health care provider or health care facility commencing an appeal. If, within 120 calendar days after an insurer provides a health care provider or health care facility written notice of a demand for recovery of overpayments, the provider or facility has not provided a refund of an overpayment

or an appeal of an alleged overpayment is still ongoing, then the insurer may seek recovery by offsetting future payments.

The health care provider or health care facility may recover underpayments or nonpayments by the insurer by making demands for refunds. Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by the insurer may include applicable interest under this section. The period for which such recoveries may be made may not exceed two years after the date of the original claim adjudication, unless the claim involves a health provider or health care facility receiving payment for the same service from a government payor.

(i) Every insurer shall maintain written or electronic records of its activities under this section, including records of when each claim was received, paid, denied, or pended, and the insurer's review and handling of each claim under this section, sufficient to demonstrate compliance with this section.

(j) A violation of this section by an ~~insurer~~ insurer, including a demand for recovery of overpayments under subsection (h) of this section that is made in bad faith, subjects the insurer to the sanctions in G.S. 58-2-70. The authority of the Commissioner under this subsection does not impair the right of a claimant to pursue any other action or remedy available under law. With respect to a specific claim, an insurer paying statutory interest in good faith under this section is not subject to sanctions for that claim under this subsection.

(k) An insurer is not in violation of this section nor subject to interest payments under this section if its failure to comply with this section is caused in material part by (i) the person submitting the claim, or (ii) by matters beyond the insurer's reasonable control, including an act of God, insurrection, strike, fire, or power outages. In addition, an insurer is not in violation of this section or subject to interest payments to the claimant under this section if the insurer has a reasonable basis to believe that the claim was submitted fraudulently and notifies the claimant of the alleged fraud.

(l) Expired January 1, 2003.

(m) Nothing in this section limits or impairs the patient's liability under existing law for payment of medical expenses."

SECTION 2. The Department of Insurance shall study the advisability of and need for an independent claims review process for disputes between insurers and providers analogous to that provided for appeals by covered persons of noncertification decisions by Part 4 of Article 50 of Chapter 58 of the General Statutes. The Department shall report its findings, including proposed legislation, to the General Assembly no later than April 1, 2010.

SECTION 3. This act is effective when it becomes law. Section 1 of this act applies to reviews by insurers of claims for possible overpayment of claim payments made on or after that date and to health care provider or health care facility demands for refunds from insurers for claims originally adjudicated on or after that date.

HARTMAN & ASSOCIATES, LLC

ACTUARIAL CONSULTING

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668 Link Road
Lexington, NC 27295

May 9, 2009

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: House Bill 1485 Proposed Committee Substitute (H1485-CSRD-36 [v.4]): An Act to Reform the Process For Recovery of Overpayments to Providers By Insurers

Dear Mr. Trogdon:

This proposed committee substitute to the bill amends G.S. 58-3-225 to modify the prompt claim payment requirements for health benefit plans. Under G.S. 135-44.4(28), these provisions apply to the North Carolina State Health Plan for Teachers and State Employees (the "Plan").

Under the prompt payment requirements, an insurer may recover overpayments made to a health care provider or facility by demanding a refund or offsetting future payments. The insurer must give the provider or facility 30 days written notice prior to seeking recovery, and the recovery or offset must be made not more than two years after the date of the original payment. This bill would increase the period for written notice prior to seeking recovery from 30 days to 90 days. The bill also limits recovery of overpayments to claims for which the insurer can provide the name and identification number of the patient, the service date, the payment amount, and an explanation of the revised payment. It also provides certain requirements for settling disputes in payment amounts. This act is effective when it becomes law and applies to demands for overpayment or underpayment made after that date.

Based on information received from the Plan and its claims processor, this bill is not expected to have a material financial impact on the Plan.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, FCA, EA
Consulting Actuary

MVH/mt

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1022*
PROPOSED COMMITTEE SUBSTITUTE H1022-CSLR-14 [v.6]

5/1/2009 12:42:28 PM

Short Title: Workers' Comp./Temp. Total Disability Limit. (Public)

Sponsors:

Referred to:

April 2, 2009

A BILL TO BE ENTITLED

AN ACT RELATING TO THE DURATION OF THE COMPENSATION FOR TEMPORARY TOTAL DISABILITY UNDER THE WORKERS' COMPENSATION ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 97-29 reads as rewritten:

"**§ 97-29. ~~Compensation rates~~ Rates and duration of compensation for total incapacity.**

(a) Except as ~~hereinafter otherwise provided,~~ provided by subsection (f) of this section, where the incapacity for work resulting from the injury is total, the employer shall pay or cause to be paid, as hereinafter provided, to the injured employee during such total disability a weekly compensation equal to sixty-six and two-thirds percent (66 2/3%) of his or her average weekly wages, but not more than the amount established annually to be effective October 1 as provided herein, nor less than thirty dollars ($30.00) per week.

(b) In cases of total and permanent disability, compensation, including medical compensation, shall be paid for by the employer during the lifetime of the injured employee. If death results from the injury then the employer shall pay compensation in accordance with the provisions of G.S. 97-38.

(c) The weekly compensation payment for members of the North Carolina national guard and the North Carolina State Defense Militia shall be the maximum amount established annually in accordance with the last paragraph of this section per week as fixed herein. The weekly compensation payment for deputy sheriffs, or those acting in the capacity of deputy sheriffs, who serve upon a fee basis, shall be thirty dollars ($30.00) a week as fixed herein.

(d) An officer or member of the State Highway Patrol shall not be awarded any weekly compensation under the provisions of this section for the first two years of any incapacity resulting from an injury by accident arising out of and in the course of the performance by him of his official duties if, during such incapacity, he continues to be an officer or member of the State Highway Patrol, but he shall be awarded any other benefits to which he may be entitled under the provisions of this Article.

(e) Notwithstanding any other provision of this Article, on July 1 of each year, a maximum weekly benefit amount shall be computed. The amount of this maximum weekly benefit shall be derived by obtaining the average weekly insured wage in accordance with G.S. 96-8(22), by multiplying such average weekly insured wage by 1.10, and by rounding such figure to its nearest multiple of two dollars ($2.00), and this said maximum weekly benefit shall be applicable to all injuries and claims arising on and after January 1 following such

computation. Such maximum weekly benefit shall apply to all provisions of this Chapter and shall be adjusted July 1 and effective January 1 of each year as herein provided.

(f) Temporary total disability compensation shall continue for a period lasting until the longer of (i) when the injured employee is eligible by age for full benefits under the Social Security Act, 42 U.S.C. 401, et seq., or (ii) a period of 300 weeks from the date of injury."

SECTION 2. This act is effective when it becomes law and applies to claims filed on or after that date.

HOUSE BILL 1022:
Workers' Comp./Duration of Total Disability

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Judiciary II	**Date:**	May 4, 2009
Introduced by:	Reps. Goforth, Folwell, Hill, Rhyne	**Prepared by:**	Bill Patterson Committee Counsel
Analysis of:	PCS to First Edition (H1022-CSLR-14)		

SUMMARY: ***House Bill 1022 would amend the Workers Compensation Act to limit the duration of temporary total disability compensation benefits by terminating such benefits when the employee becomes eligible by age for full Social Security benefits or after 300 weeks, whichever is longer.***

[As introduced, this bill was identical to S975, as introduced by Sen. Apodaca, which is currently in Senate Commerce.]

CURRENT LAW: Under the North Carolina Workers Compensation Act, an injured employee is eligible for several types of benefits, including indemnity (wage-replacement) and medical benefits.

Under G.S. 97-25[1], an injured employee is entitled to medical compensation, but under G.S. 97-25.1, this right terminates two years after the employer's last payment of medical or indemnity compensation, unless the employee applies for additional medical compensation before this period expires and the Industrial Commission approves this request, or unless the Commission orders such additional medical compensation on its own motion. The Commission is required to order the payment of future medical compensation where it finds that there is a substantial risk of its necessity.

In addition to medical compensation, an employee whose injury has resulted in a loss of wage-earning capacity is entitled to weekly compensation under either G.S. 97-29 or G.S. 97-30.

Under G.S. 97-29, for a total loss of wage-earning capacity, the employee is entitled to receive weekly compensation in the amount of 2/3 of his or her average weekly wage for as long as that loss lasts, with no limitation on the duration of the benefits. If the total incapacity is permanent, the employee is entitled to receive this compensation for life.

Under G.S. 97-30, for a partial loss of wage-earning capacity, the employee is entitled to receive weekly compensation in the amount of 2/3 of the difference in average weekly wage before and after the injury, for as long as the partial loss of wage-earning capacity lasts, but subject to a maximum of 300 weeks.

Under G.S. 97-31, if an employee has a specific physical impairment that falls under the schedule of injuries set forth in that section, he or she is presumed to have suffered a loss of wage-earning capacity. In that case, the employee is entitled to weekly compensation during the "healing period" and, in addition, a lump-sum payment according to the schedule of injuries set forth in the statute.

BILL ANALYSIS: House Bill 1022 (PCS) would amend G.S. 97-29 to limit the weekly indemnity compensation payable to an employee whose total incapacity is temporary, rather than permanent, by terminating such compensation after 300 weeks, or when the employee is eligible by age for full Social Security benefits[2], whichever period is longer. The bill would not affect an employee's right to receive

[1] All statutes referenced herein are reprinted in full at the end of this summary.

[2] Full retirement age had been 65 for many years. However, beginning with people born in 1938 or later, that age gradually increases until it reaches 67 for people born after 1959. A chart showing the steps in which the age will increase is reprinted at the end of this summary.

weekly compensation if the employee's total incapacity has been determined by the Commission to permanent. The bill also would not alter the employee's existing right to benefits for permanent partial disability benefits under G.S. 97-30, or to medical benefits under G.S. 97-25. The bill's termination of weekly compensation could potentially affect the employee's right to medical compensation by triggering the start of the two-year period under G.S. 97-25.1, after which the employee would lose the right to those benefits unless, during that period, the employee receives injury-related medical treatment or the Commission orders otherwise.

EFFECTIVE DATE: This act is effective when it becomes law and applies to claims filed on or after that date.

H1022-SMTG-37(CSLR-14) v3

§ 97-25. Medical treatment and supplies.

Medical compensation shall be provided by the employer. In case of a controversy arising between the employer and employee relative to the continuance of medical, surgical, hospital, or other treatment, the Industrial Commission may order such further treatments as may in the discretion of the Commission be necessary.

The Commission may at any time upon the request of an employee order a change of treatment and designate other treatment suggested by the injured employee subject to the approval of the Commission, and in such a case the expense thereof shall be borne by the employer upon the same terms and conditions as hereinbefore provided in this section for medical and surgical treatment and attendance.

The refusal of the employee to accept any medical, hospital, surgical or other treatment or rehabilitative procedure when ordered by the Industrial Commission shall bar said employee from further compensation until such refusal ceases, and no compensation shall at any time be paid for the period of suspension unless in the opinion of the Industrial Commission the circumstances justified the refusal, in which case, the Industrial Commission may order a change in the medical or hospital service.

If in an emergency on account of the employer's failure to provide the medical or other care as herein specified a physician other than provided by the employer is called to treat the injured employee, the reasonable cost of such service shall be paid by the employer if so ordered by the Industrial Commission.
Provided, however, if he so desires, an injured employee may select a physician of his own choosing to attend, prescribe and assume the care and charge of his case, subject to the approval of the Industrial Commission.

§ 97-25.1. Limitation of duration of medical compensation.

The right to medical compensation shall terminate two years after the employer's last payment of medical or indemnity compensation unless, prior to the expiration of this period, either: (i) the employee files with the Commission an application for additional medical compensation which is thereafter approved by the Commission, or (ii) the Commission on its own motion orders additional medical compensation. If the Commission determines that there is a substantial risk of the necessity of future medical compensation, the Commission shall provide by order for payment of future necessary medical compensation.

§ 97-29. Compensation rates for total incapacity.

Except as hereinafter otherwise provided, where the incapacity for work resulting from the injury is total, the employer shall pay or cause to be paid, as hereinafter provided, to the injured employee during such total disability a weekly compensation equal to sixty-six and two-thirds percent (66 2/3%) of his average weekly wages, but not more than the amount established annually to be effective October 1 as provided herein, nor less than thirty dollars ($30.00) per week.

In cases of total and permanent disability, compensation, including medical compensation, shall be paid for by the employer during the lifetime of the injured employee. If death results from the injury then the employer shall pay compensation in accordance with the provisions of G.S. 97-38.

The weekly compensation payment for members of the North Carolina national guard and the North Carolina State Defense Militia shall be the maximum amount established annually in accordance with the last paragraph of

this section per week as fixed herein. The weekly compensation payment for deputy sheriffs, or those acting in the capacity of deputy sheriffs, who serve upon a fee basis, shall be thirty dollars ($30.00) a week as fixed herein.

An officer or member of the State Highway Patrol shall not be awarded any weekly compensation under the provisions of this section for the first two years of any incapacity resulting from an injury by accident arising out of and in the course of the performance by him of his official duties if, during such incapacity, he continues to be an officer or member of the State Highway Patrol, but he shall be awarded any other benefits to which he may be entitled under the provisions of this Article.

Notwithstanding any other provision of this Article, on July 1 of each year, a maximum weekly benefit amount shall be computed. The amount of this maximum weekly benefit shall be derived by obtaining the average weekly insured wage in accordance with G.S. 96-8(22), by multiplying such average weekly insured wage by 1.10, and by rounding such figure to its nearest multiple of two dollars ($2.00), and this said maximum weekly benefit shall be applicable to all injuries and claims arising on and after January 1 following such computation. Such maximum weekly benefit shall apply to all provisions of this Chapter and shall be adjusted July 1 and effective January 1 of each year as herein provided.

§ 97-30. Partial incapacity.

Except as otherwise provided in G.S. 97-31, where the incapacity for work resulting from the injury is partial, the employer shall pay, or cause to be paid, as hereinafter provided, to the injured employee during such disability, a weekly compensation equal to sixty-six and two-thirds percent (66 2/3%) of the difference between his average weekly wages before the injury and the average weekly wages which he is able to earn thereafter, but not more than the amount established annually to be effective October 1 as provided in G.S. 97-29 a week, and in no case shall the period covered by such compensation be greater than 300 weeks from the date of injury. In case the partial disability begins after a period of total disability, the latter period shall be deducted from the maximum period herein allowed for partial disability. An officer or member of the State Highway Patrol shall not be awarded any weekly compensation under the provisions of this section for the first two years of any incapacity resulting from an injury by accident arising out of and in the course of the performance by him of his official duties if, during such incapacity, he continues to be an officer or member of the State Highway Patrol, but he shall be awarded any other benefits to which he may be entitled under the provisions of this Article.

§ 97-31. Schedule of injuries; rate and period of compensation.

In cases included by the following schedule the compensation in each case shall be paid for disability during the healing period and in addition the disability shall be deemed to continue for the period specified, and shall be in lieu of all other compensation, including disfigurement, to wit:

(1) For the loss of a thumb, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 75 weeks.

(2) For the loss of a first finger, commonly called the index finger, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 45 weeks.

(3) For the loss of a second finger, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 40 weeks.

(4) For the loss of a third finger, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 25 weeks.

(5) For the loss of a fourth finger, commonly called the little finger, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 20 weeks.

(6) The loss of the first phalange of the thumb or any finger shall be considered to be equal to the loss of one half of such thumb or finger, and the compensation shall be for one half of the periods of time above specified.

(7) The loss of more than one phalange shall be considered the loss of the entire finger or thumb: Provided, however, that in no case shall the amount received for more than one finger exceed the amount provided in this schedule for the loss of a hand.

(8) For the loss of a great toe, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 35 weeks.

(9) For the loss of one of the toes other than a great toe, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 10 weeks.

(10) The loss of the first phalange of any toe shall be considered to be equal to the loss of one h of such toe, and the compensation shall be for one half of the periods of time above specified.

(11) The loss of more than one phalange shall be considered as the loss of the entire toe.

(12) For the loss of a hand, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 200 weeks.

(13) For the loss of an arm, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 240 weeks.

(14) For the loss of a foot, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 144 weeks.

(15) For the loss of a leg, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 200 weeks.

(16) For the loss of an eye, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 120 weeks.

(17) The loss of both hands, or both arms, or both feet, or both legs, or both eyes, or any two thereof, shall constitute total and permanent disability, to be compensated according to the provisions of G.S. 97-29. The employee shall have a vested right in a minimum amount of compensation for the total number of weeks of benefits provided under this section for each member involved. When an employee dies from any cause other than the injury for which he is entitled to compensation, payment of the minimum amount of compensation shall be payable as provided in G.S. 97-37.

(18) For the complete loss of hearing in one ear, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 70 weeks; for the complete loss of hearing in both ears, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 150 weeks.

(19) Total loss of use of a member or loss of vision of an eye shall be considered as equivalent t the loss of such member or eye. The compensation for partial loss of or for partial loss of us of a member or for partial loss of vision of an eye or for partial loss of hearing shall be such proportion of the periods of payment above provided for total loss as such partial loss bears to total loss, except that in cases where there is eighty-five per centum (85%), or more, loss of vision in any eye, this shall be deemed "industrial blindness" and compensated as for total loss of vision of such eye.

(20) The weekly compensation payments referred to in this section shall all be subject to the same limitations as to maximum and minimum as set out in G.S. 97-29.

(21) In case of serious facial or head disfigurement, the Industrial Commission shall award proper and equitable compensation not to exceed twenty thousand dollars ($20,000). In case of enucleation where an artificial eye cannot be fitted and used, the Industrial Commission may award compensation as for serious facial disfigurement.

(22) In case of serious bodily disfigurement for which no compensation is payable under any other subdivision of this section, but excluding the disfigurement resulting from permanent loss or permanent partial loss of use of any member of the body for which compensation is fixed in the schedule contained in this section, the Industrial Commission may award proper and equitable compensation not to exceed ten thousand dollars ($10,000).

(23) For the total loss of use of the back, sixty-six and two-thirds percent (66 2/3%) of the average weekly wages during 300 weeks. The compensation for partial loss of use of the back shall be such proportion of the periods of payment herein provided for total loss as such partial loss bears to total loss, except that in cases where there is seventy-five per centum (75%) or more loss of use of the back, in which event the injured employee shall be deemed to have suffered "total industrial disability" and compensated as for total loss of use of the back.

(24) In case of the loss of or permanent injury to any important external or internal organ or part of the body for which no compensation is payable under any other subdivision of this section, the Industrial Commission may award proper and equitable compensation not to exceed twenty thousand dollars ($20,000).

Steps in Which the Full Retirement Age is Increasing

Year of Birth	Full Retirement Age
1937 or earlier	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943--1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

Note: Persons born on January 1 of any year should refer to the full retirement age for the previous year.

(Source: http://www.socialsecurity.gov/pubs/ageincrease.htm)

ATTACHMENT #2

Workers Compensation State Rankings
Manufacturing Industry Costs
And
Statutory Benefit Provisions

2008 Edition

comparable cost is calculated by performing the calculation shown in Chart 6 for each of the 45 states, and then taking an average.

Chart 6

Calculation of Countrywide Comparative Cost

Manual Rate	$4.74
Assessments, Payroll Rules, Expense Constants	**+0.10**
Experience Rating	**-0.34**
Premium Discounts, Retrospective and Schedule Rating, Rate Deviations	**-0.53**
Dividends	**-0.07**
Comparative Cost	$3.90

Each state's comparative cost is then divided by the countrywide average comparative cost to produce an index. Chart 7 provides the results for all states.

Chart 7

Workers Compensation Comparative Costs

Rank	State	Index	Rank	State	Index	Rank	State	Index
1	Utah	0.474	16	Rhode Island	0.872	31	New Hampshire	1.090
2	Indiana	0.528	17	Nebraska	0.918	31	Missouri	1.090
3	Virginia	0.533	18	Kansas	0.923	33	Oklahoma	1.195
4	Arizona	0.556	19	Mississippi	0.926	34	Texas	1.197
5	Arkansas	0.579	20	South Carolina+	0.951	35	Hawaii*	1.205
6	Massachusetts	0.582	21	Georgia	0.962	36	Tennessee	1.208
7	Oregon	0.633	22	Minnesota	0.977	37	New York	1.223
8	Colorado	0.728	23	New Mexico	0.979	38	Illinois	1.238
9	South Dakota	0.746	24	Nevada	0.982	39	New Jersey	1.262
10	Maryland	0.790	25	Florida	0.997	40	Connecticut	1.277
11	Idaho	0.797	26	Louisiana*	1.000	41	Montana	1.479
12	Michigan	0.821	27	Kentucky	1.015	42	Delaware	1.536
13	North Carolina	0.831	28	Alabama	1.033	43	California	1.562
14	Wisconsin	0.833	29	Pennsylvania	1.049	44	Alaska	1.654
15	Iowa	0.841	30	Maine	1.056	45	Vermont	1.821

* We were unable to obtain updated information from the Louisiana Workers' Compensation Corporation and the Hawaii Insurance Department.

\+ We have assumed that the latest filed LCMs are applied to the current loss costs; "desk" filings were permitted in South Carolina from mid 2004 through mid 2007.

The term comparative cost, as used in this study, refers to an average cost based upon a uniform payroll distribution among the various states. These costs are useful as a means of comparison rather than as absolute figures. Because the uniform payroll distribution upon which the average comparative

ATTACHMENT #1

VISITOR REGISTRATION SHEET

House Committee on Insurance — 5-11-09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
JOHN GOODMAN	NC CHAMBER
Kathy Hawkins	Progress Energy
Michelle Thompson	Dominion
George Siddall	PBY
Mike Ross	Wallace + Graham, P.A.
Ed Pauley	Wallace + Graham
Jack Williams Jr.	Williams & Chambliss Durham NC 27705
Bill Wilson	AARP
JIM LORE	R. JAMES LORE Atty CARY NC
GEORGE LEVASON	LEVASON & CAMAK RALEIGH
Heidi Cruggman	Heidi G. Cruggman, PLLC Chapel Hill, NC

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rachel S. Lloyd	R. Lloyd & Assoc.
Kelly Graham	NCAE
David Starling	NC Dept of State Treasurer
Renee Wimbish	NCGA
Susan Ivey	NCGA
Paul Pully	NCAJ
Andrew Meehan	NC Elec. Co-ops
Amy McConkey	Smith Anderson
Jon Carr	American Cancer Society
Jessi Hayes	NC HBA
David Boray	MWC

VISITOR REGISTRATION SHEET

House Committee on Insurance — 5-11-09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Meredith Henderson	Industrial Commission 430 N. Salisbury St Dobbs Bldg
Pamela Young	"
Mary Foreman	NCAE
Mike Sigmon	Brooks, Stevens & Pope PA
Carol Burrell	State Health Plan
Evelyn Sheinbaum	OTGR
Bill Scoggin	FCC
Tom Reagan	NMRS
Jim Blackburn	NC Association of County Commissioners
Steve Brewer	EMBARQ
Marty Bocock	" "

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Stevens	NCFA
Robert Pasley	Young Moore
Dana Simpson	SA
S. Camille Payton	Ward Black Law, Greensboro NC
Rose Williams	NCDOI
Ted Hamby	NCDOI
DAVID BARNES	Poyner Spruill

VISITOR REGISTRATION SHEET

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John McMullan	MF+S

House Pages

Name of Committee: Insurance Date: 5-11-09

1. Name: _____

County: _____

Sponsor: _____

2. Name: _____

County: _____

Sponsor: _____

3. Name: _____

County: _____

Sponsor: _____

4. Name: _____

County: _____

Sponsor: _____

5. Name: _____

County: _____

Sponsor: _____

Sgt-At-Arms

Name: MARVIN LEE Marthaladison

2. Name: Trey Raley

3. Name: Martha Parrish

Mary Capps (Rep. Wray)

om: Ann Jordan (Rep. Goforth)
ent: Thursday, May 07, 2009 3:15 PM
Subject: Insurance Meeting Notice for May 11.doc

NORTH CAROLINA HOUSE OF REPRESENTATIVES
INSURANCE COMMITTEE MEETING NOTICE
2009-2010 SESSION

NOTE: ROOM CHANGE

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

DAY & DATE: **Monday, May 11, 2009**

TIME: **3:00 PM**

LOCATION: **Room 544**

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

HB 1022 – WORKERS' COMP/DURATION OF TOTAL DISABILITY – Rep. Goforth, Folwell, Hill and ne

HB 1485 – INSURANCE/HEALTH CARE PROVIDER RELATIONSHIP – Reps. Steen, Barnhart, Neumann and England

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at: **12:30** on **May 7, 2009.**

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 1022 A BILL TO BE ENTITLED AN ACT RELATING TO THE DURATION OF THE COMPENSATION FOR TOTAL DISABILITY UNDER THE WORKERS' COMPENSATION ACT.

☒ With a favorable report as to the committee substitute bill, which changes the title, unfavorable as to the original bill, and recommendation that the committee substitute bill be re-referred to the Committee on JUDICIARY II.

(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.

100

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 1485 A BILL TO BE ENTITLED AN ACT TO REFORM THE PROCESS FOR RECOVERY OF OVERPAYMENTS TO PROVIDERS BY INSURERS.

☒ 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 JUDICIARY II.

(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.

MINUTES

HOUSE COMMITTEE ON INSURANCE
May 13, 2009

The House Committee on Insurance met at 6:15 PM on Wednesday, May 13, 2009, around Chairman Michael H. Wray's Chamber Desk. A quorum was present.

Chairman Wray called the meeting to order. He recognized Rep. Tricia Cotham to explain HB 535 – Health Insurance Coverage/Lymphedema. Chairman Goforth was recognized for a motion to have a PCS before the committee. HB 535 would require health insurers, including the State Health Plan, to provide coverage for the diagnosis and treatment of lymphedema. A motion was made to give a favorable report to the PCS, and it carried.

Chairman Wray adjourned the meeting at 6:20 PM.

Representative Michael H. Wray, Chair

Mary Capps, Committee Assistant

FAV.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 535
PROPOSED COMMITTEE SUBSTITUTE H535-CSSQ-29 [v.1]

5/4/2009 10:48:22 AM

Short Title: Health Insurance Coverage/Lymphedema. (Public)

Sponsors:

Referred to:

March 12, 2009

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH INSURERS, INCLUDING THE STATE HEALTH PLAN, TO PROVIDE COVERAGE FOR THE DIAGNOSIS AND TREATMENT OF LYMPHEDEMA.

The General Assembly of North Carolina enacts:

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

"**§ 58-3-280. Coverage for the diagnosis and treatment of lymphedema.**

(a) Every health benefit plan, as defined in G.S. 58-3-167, shall provide coverage for the diagnosis, evaluation, and treatment of lymphedema. The coverage required by this section shall include benefits for equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education, if the treatment is determined to be medically necessary and is provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within the professional's scope of practice.

(b) The same deductibles, coinsurance, and other limitations as apply to similar services covered under the health benefit plan apply to coverage for the diagnosis, evaluation, and treatment of lymphedema required to be covered under this section. Nothing in this section requires a health benefit plan to provide a separate set of benefit limitations or maximums for the diagnosis, evaluation or treatment of lymphedema.

(c) As used in this section, gradient compression garments:

(1) Require a prescription;

(2) Are custom-fit for the covered individual; and

(3) Do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products."

SECTION 2. G.S. 135-45 is amended by adding the following new subsection to read:

"(h) The Plan shall provide coverage under its Basic and Standard PPO options for the diagnosis and treatment of lymphedema. The coverage shall be the equivalent of coverage under G.S. 58-3-280."

SECTION 3. This act becomes effective January 1, 2010, and applies to all health benefits plans that are delivered, issued for delivery, or renewed on and after that date.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☒Committee Substitute for

HB 535 A BILL TO BE ENTITLED AN ACT TO REQUIRE HEALTH INSURERS, INCLUDING THE STATE HEALTH PLAN, TO PROVIDE COVERAGE FOR THE DIAGNOSIS AND TREATMENT OF LYMPHEDEMA.

☒ 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 _____.

MINUTES
HOUSE COMMITTEE ON INSURANCE
May 28, 2009

The House Committee on Insurance met at 11:00 AM on Thursday, May 28, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael Wray; Vice Chairs: M. Dickson, J. Dockham and M. Setzer. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Cole, Current, Faison, Gibson, Holliman, Howard, Hughes, Lewis, Pierce and Wainwright.

Chairman Wray called the meeting to order and welcomed visitors. He recognized Sgt-At Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachments)

Chairman Wray recognized Rep. Goforth to explain HB 1166 – Insurance Law Changes. Rep. Faison made a motion for the PCS to be before the committee. Rep. Goforth asked Rose William with the Department of Insurance to explain the bill. Ms. Williams said this an agency bill that makes a number of changes to the laws related to licensing property, casualty or personal lines insurance agents, bail bondsmen, surplus line carriers, collection agencies, and insurance premium finance companies. The bill also contains new fees. Rep. Faison made a motion that the bill be passed. Motion carried.

Chairman Wray recognized Sen. Martin Nesbitt to explain SB 957. Sen. Nesbitt said that the bill creates a special enrollment period in the NC Group Health Insurance Continuation Law and provide eligible individuals with the same continuation right as under the Federal American Recover and Reinvestment Act of 2009. It allows for special enrollment for COBRA and uses stimulus funds to pay. Rep. Braxton made a motion for a favorable report. Motion carried.

The meeting adjourned at 11:22 AM.

The meeting adjourned at 11:45.

Representative Michael Wray, Chairman

Ann Jordan – Committee Assistant

HOUSE INSURANCE COMMITTEE

May 28, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

HB 1166 – INSURANCE LAW CHANGES – (AB) -Reps. Goforth, Wray and Lucas

SB 957 – SPECIAL ENTROLLMENT PERIOD/GROUP HEALTH INSURANCE – Sen. Nesbitt

Adjourn

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1166
PROPOSED COMMITTEE SUBSTITUTE H1166-CSRCf-19 [v.4]

5/28/2009 9:08:44 AM

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

Sponsors:

Referred to:

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS CHANGES IN THE LAWS GOVERNING INSURANCE PRODUCERS AND BROKERS, BAIL BONDSMEN, MOTOR CLUBS, PREMIUM FINANCE COMPANIES, AND COLLECTION AGENCIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-33-10 is amended by adding a new subdivision to read:

"(4a) "FINRA" means the Financial Industry Regulatory Authority or any successor entity."

SECTION 2. G.S. 58-33-26(e) reads as rewritten:

"(e) A variable life and variable annuity products license authorizes a resident agent to sell, solicit, or negotiate variable contracts if the agent satisfies the Commissioner that the agent has met the ~~National Association of Securities Dealers~~FINRA requirements of the Secretary of State of North Carolina."

SECTION 3. G.S. 58-33-26(p) reads as rewritten:

"(p) An individual shall not simultaneously hold ~~an agent's~~ a property, casualty, or personal lines insurance license and an adjuster's license in this State. An individual who holds a ~~property and liability~~property, casualty, or personal lines insurance license may apply for an adjuster license without having to take the adjuster examination in G.S. 58-33-30(e) if the individual applies for the adjuster license within 60 days after surrendering the ~~property and liability~~property, casualty, or personal lines insurance license. An individual who holds an adjuster license may apply for a property and liability insurance license without having to take the property and liability insurance agent examination in G.S. 58-33-30(e) if the individual applies for the ~~property and liability~~property, casualty, or personal lines insurance license within 60 days after surrendering the adjuster license."

SECTION 4. Article 33 of Chapter 58 of the General Statutes of North Carolina is amended by adding a new section to read:

"**§ 58-33-48. Criminal history record checks.**

(a) An applicant for a license under this Article shall furnish the Commissioner with a complete set of the applicant's fingerprints in a manner prescribed by the Commissioner and a recent passport size full-face photograph of the applicant. The applicant's fingerprints shall be certified by an authorized law-enforcement officer. The fingerprints of every applicant shall be forwarded to the State Bureau of Investigation for a search of the applicant's criminal history record file, if any. If warranted, the State Bureau of Investigation shall forward a set of the fingerprints to the Federal Bureau of Investigation for a national criminal history record check.

An applicant shall pay the cost of the State and any national criminal history record check of the applicant.

(b) In addition, if an applicant described in subsection (a) of this section is a corporation, partnership, limited liability company, association, or trust, each key person must furnish the Commissioner a complete set of the applicant's fingerprints and a recent passport size full-face photograph of the applicant. The applicant's fingerprints shall be certified by an authorized law enforcement officer. The fingerprints of every applicant shall be forwarded to the State Bureau of Investigation for a search of the applicant's criminal history record file, if any. If warranted, the State Bureau of Investigation shall forward a set of the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. An applicant shall pay the cost of the State and any national criminal history record check of the applicant. As used in this subsection, "key person' means a proposed officer, director, or any other individual who will be in a position to influence the operating decisions of the applicant.

(c) The Commissioner shall keep all information pursuant to this section privileged, in accordance with applicable State law and federal guidelines, and the information shall be confidential and shall not be a public record under Chapter 132 of the General Statutes.

(d) This section does not apply to a person applying for renewal or continuation of a home state insurance producer license or a nonresident insurance producer license."

SECTION 5. G.S. 58-33-32(k) reads as rewritten:

"(k) A producer shall report to the Commissioner any administrative action taken against the producer in another state or by another governmental agency in this State within 30 days after the final disposition of the matter. As used in this subsection, "administrative action" includes enforcement action taken against the producer by the ~~National Association of Securities Dealers.~~FINRA. This report shall include a copy of the order or consent order and other information or documents filed in the proceeding necessary to describe the action."

SECTION 6. G.S. 58-33-35 is repealed.

SECTION 7. G.S. 58-33-40(a) reads as rewritten:

"(a) ~~No~~ Except as provided in subsection (b) of this section, no individual who holds a valid insurance agent's license issued by the Commissioner shall, either directly or for an insurance agency, solicit, negotiate, or otherwise act as an agent for an insurer by which the individual has not been appointed."

SECTION 8. G.S. 58-33-40(b) reads as rewritten:

"(b) Any insurer authorized to transact business in this State may appoint as its agent any individual who holds a valid agent's license issued by the Commissioner. To appoint an individual as its agent, the appointing insurer shall file, in a format approved by the Commissioner, a notice of appointment within 15 days after the date the first insurance application is submitted. ~~Upon the appointment, the~~The individual shall be authorized to act as an agent for the appointing insurer for all kinds of insurance for which the insurer is authorized in this State and for which the appointed agent is licensed in this State, unless specifically limited."

SECTION 9. G.S. 58-33-40 (c) and (h) are repealed.

SECTION 10. G.S. 58-33-46(a)(2) and (a)(6) read as rewritten:

"**§ 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:

...

(2) Violating any insurance law of this or any other state, violating any administrative rule, subpoena, or order of the Commissioner or of another state's insurance regulator, or violating any rule of the ~~National Association of Securities Dealers.~~FINRA.

...

(6) Having been convicted of a ~~felony,~~felony or a misdemeanor involving dishonesty, a breach of trust, or ~~a misdemeanor involving~~ moral turpitude."

SECTION 11. G.S. 58-21-65(f) reads as rewritten:

"(f) A person licensed as a surplus lines licensee under the laws of a state bordering this State may be licensed as a surplus lines licensee under this Article, if: (i) the laws of the bordering state are substantially similar to the provisions of this Article and (ii) the bordering state has a law or regulation substantially similar to this subsection that permits surplus lines licensees licensed under this Article to be licensed by the bordering state and (iii) the person complies with all requirements of this Article and submits himself or herself to the Commissioner's jurisdiction. Nonresident surplus lines licensees shall be licensed in accordance with Article 33 of this Chapter."

SECTION 12. G.S. 58-71-50(a) reads as rewritten:

"(a) An applicant for a license as a bail bondsman or runner shall furnish the Commissioner with a complete set of the applicant's fingerprints in a manner prescribed by the Commissioner and a recent passport size full-face photograph of the applicant. The applicant's fingerprints shall be certified by an authorized law-enforcement officer. The fingerprints of every applicant shall be forwarded to the State Bureau of Investigation for a search of the applicant's criminal history record file, if any. If warranted, the State Bureau of Investigation shall forward a set of the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. An applicant shall pay the cost of the State and any national criminal history record check of the applicant."

SECTION 13. G.S. 58-71-70 reads as rewritten:

"**§ 58-71-70. Examination; fees.**

Each applicant for a license as a professional bondsman, surety bondsman, or runner shall appear in person and take ~~a written~~an examination prepared by the Commissioner testing the applicant's ability and qualifications. Each applicant is eligible for examination 30 days after the date the application is received by the Commissioner. If an applicant is unable to complete the examination requirement within 30 days after notification from the Commissioner of the applicant's eligibility to take the examination, the applicant shall again be subject to the criminal history record check prescribed by G.S. 58-71-50(a) so that current information is available for review with the application. Each examination shall be held at a time and place as designated by the Commissioner. Each applicant shall be given notice of the designated time and place no sooner than 15 days before the examination. The Commissioner may contract with a person to process applications for the examination and administer and grade the examination in the same manner as for agent examinations under Article 33 of this Chapter.

The fee for each examination is twenty-five dollars ($25.00) plus an amount that offsets the cost of any contract for examination services. This examination fee is nonrefundable.

An applicant who fails an examination may take a subsequent examination, but at least one year must intervene between examinations."

SECTION 14. G.S. 58-71-45 reads as rewritten:

"**§ 58-71-45. Terms of licenses.**

A license issued to a bail bondsman or to a runner authorizes the licensee to act in that capacity until the license is suspended or revoked. Upon the suspension or revocation of a license, the licensee shall return the license to the Commissioner. A license of a bail bondsman and a license of a runner shall be renewed on July 1 of each year upon payment of the applicable renewal fee under G.S. 58-71-75. The Commissioner is not required to print renewal licenses. After notifying the Commissioner in writing, a professional bondsman who employs a runner may cancel ~~the runner's license and~~ the runner's authority to act for the professional bondsman."

SECTION 15. G.S. 58-71-140(d) is repealed.

SECTION 16. G.S. 58-71-120 reads as rewritten:

"**§ 58-71-120. Bail bondsman to give notice of discontinuance of business; cancellation of license.**

Any bail bondsman who discontinues writing bail bonds during the period for which ~~he~~ the bail bondsman is licensed shall ~~notify the clerks of the superior court with whom he is registered and~~ return ~~his~~ the license to the Commissioner for cancellation within 30 days after ~~such~~ the discontinuance."

SECTION 17. G.S. 58-70-40(b) reads as rewritten:

"(b) If an individual proprietor, officer, or partner of the collection agency has been convicted in any court of competent jurisdiction for any crime involving dishonesty or breach of trust, the collection agency shall notify the Commissioner in writing of the conviction within 10 days after the date of the conviction. As used in this subsection, "conviction" includes an adjudication of guilt, a plea of guilty, or a plea of nolo contendere. The conviction by a court of competent jurisdiction of any permittee for a violation of this Article shall automatically have the effect of suspending the permit of that permittee until such time that the permit is reinstated by the Commissioner. As used in this subsection, "conviction" includes an adjudication of guilt, a plea of guilty, and a plea of nolo contendere."

SECTION 18. G.S. 58-70-40 is amended by adding a new subsection to read:

"(e) A collection agency shall report to the Commissioner any administrative action taken against the collection agency by another state or by another governmental agency in this State within 30 days after the final disposition of the matter. This report shall include a copy of the order or consent order and other information or documents filed in the proceeding necessary to describe the action."

SECTION 19. Article 35 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-69-60. Notification of criminal or administrative actions.**

(a) If an individual proprietor, officer, or partner of a motor club has been convicted in any court of competent jurisdiction for any crime involving dishonesty or breach of trust, the motor club shall notify the Commissioner in writing of the conviction within 10 days after the date of the conviction. As used in this subsection, "conviction" includes an adjudication of guilt, a plea of guilty, or a plea of nolo contendere.

(b) A motor club shall report to the Commissioner any administrative action taken against the motor club by another state or by another governmental agency in this State within 30 days after the final disposition of the matter. This report shall include a copy of the order or consent order and other information or documents filed in the proceeding necessary to describe the action."

SECTION 20. G.S. 58-35-1(2) reads as rewritten:

"(2) "Insurance premium finance agreement" means a promissory note or other written agreement by which an insured promises or agrees to pay to, or to the order of, an insurance premium finance company the amount advanced or to be advanced under the agreement to an insurer ~~or to an insurance agent,~~ in payment of premiums on an insurance contract, together with a service charge as authorized and limited by this Article."

SECTION 21. Article 35 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-35-22. Notification of criminal or administrative actions.**

(a) If an individual proprietor, officer, or partner of an insurance premium finance company has been convicted in any court of competent jurisdiction for any crime involving dishonesty or breach of trust, the premium finance company shall notify the Commissioner in writing of the conviction within 10 days after the date of the conviction. As used in this

subsection, "conviction" includes an adjudication of guilt, a plea of guilty, or a plea of nolo contendere.

(b) An insurance premium finance company shall report to the Commissioner any administrative action taken against the premium finance company, including any branch office, by another state or by another governmental agency in this State within 30 days after the final disposition of the matter. This report shall include a copy of the order or consent order and other information or documents filed in the proceeding necessary to describe the action."

SECTION 22. G.S. 58-2-69(b) reads as rewritten:

"(b) Every applicant for a license shall inform the Commissioner of the applicant's residential ~~address.~~address and provide the applicant's e-mail address to which the Commissioner can send electronic notifications and other messages. Every licensee shall give written notification to the Commissioner of any change of the licensee's residential or e-mail address within 10 business days after the licensee moves into the licensee's new ~~residence.~~residence or obtains a different e-mail address. This requirement applies if the change of residential address is by governmental action and there has been no actual change of residence location; in which case the licensee shall notify the Commissioner within 10 business days after the effective date of the change. A violation of this subsection is not a ground for revocation, suspension, or nonrenewal of the license or for the imposition of any other penalty by the Commissioner, though a licensee who violates this subsection shall pay an administrative fee of fifty dollars ($50.00) to the Commissioner."

SECTION 23. Sections 17, 18, 19, and 21 of this act become effective October 1, 2009. Section 22 of this act becomes effective January 1, 2010. Section 4 of this act becomes effective October 1, 2010 and applies to applications made on or after that date. The remainder of this act is effective when it becomes law.

HOUSE BILL 1166

Short Title:	Insurance Law Changes.-AB	(Public)
Sponsors:	Representatives Goforth, Wray (Primary Sponsors); and Lucas.	
Referred to:	Insurance, if favorable, Judiciary III.	

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS CHANGES IN THE LAWS GOVERNING INSURANCE PRODUCERS AND BROKERS, BAIL BONDSMEN, MOTOR CLUBS, PREMIUM FINANCE COMPANIES, AND COLLECTION AGENCIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-33-10 is amended by adding a new subdivision to read:

"(4a) "FINRA" means the Financial Industry Regulatory Authority or any successor entity."

SECTION 2. G.S. 58-33-26(e) reads as rewritten:

"(e) A variable life and variable annuity products license authorizes a resident agent to sell, solicit, or negotiate variable contracts if the agent satisfies the Commissioner that the agent has met the ~~National Association of Securities Dealers~~FINRA requirements of the Secretary of State of North Carolina."

SECTION 3. G.S. 58-33-26(m) is repealed.

SECTION 4. G.S. 58-33-26(p) reads as rewritten:

"(p) An individual shall not simultaneously hold ~~an agent's~~ a property, casualty, or personal lines insurance license and an adjuster's license in this State. An individual who holds a ~~property and liability~~property, casualty, or personal lines insurance license may apply for an adjuster license without having to take the adjuster examination in G.S. 58-33-30(e) if the individual applies for the adjuster license within 60 days after surrendering the ~~property and liability~~property, casualty, or personal lines insurance license. An individual who holds an adjuster license may apply for a property and liability insurance license without having to take the property and liability insurance agent examination in G.S. 58-33-30(e) if the individual applies for the ~~property and liability~~property, casualty, or personal lines insurance license within 60 days after surrendering the adjuster license."

SECTION 5. Article 33 of Chapter 58 of the General Statutes of North Carolina is amended by adding a new section to read:

"**§ 58-33-48. Criminal history record checks.**

(a) The Department of Justice may provide a criminal record check to the Commissioner for any person who has applied for or holds a license through the Commissioner under this Article.

(b) In addition, if a person described in subsection (a) of this section is a corporation, partnership, limited liability company, association, or trust, the Department of Justice may provide a criminal history record check to the Commissioner for any person who has control of that person, or who is the qualifying individual or a branch manager of that person.

(c) The Commissioner shall provide or cause to be provided to the Department of Justice, along with the request, the fingerprints of the person, any additional information

required by the Department of Justice, and a form signed by the person consenting to the check of the criminal record and to the use of the fingerprints and other identifying information required by the State or national repositories. The person's fingerprints shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation shall forward a set of the fingerprints to the Federal Bureau of Investigation for a national criminal history check. The Commissioner shall keep all information pursuant to this section privileged, in accordance with applicable State law and federal guidelines, and the information shall be confidential and shall not be a public record under Chapter 132 of the General Statutes. The Department of Justice may charge a fee for each person for conducting the checks of criminal history records authorized by this section.

(d) This section does not apply to a person applying for renewal or continuation of a home state insurance producer license or a nonresident insurance producer license."

SECTION 6. G.S. 58-33-32(k) reads as rewritten:

"(k) A producer shall report to the Commissioner any administrative action taken against the producer in another state or by another governmental agency in this State within 30 days after the final disposition of the matter. As used in this subsection, "administrative action" includes enforcement action taken against the producer by the ~~National Association of Securities Dealers.~~FINRA. This report shall include a copy of the order or consent order and other information or documents filed in the proceeding necessary to describe the action."

SECTION 7. G.S. 58-33-35 is repealed.

SECTION 8. G.S. 58-33-40(a) reads as rewritten:

"(a) ~~No~~ Except as provided in subsection (b) of this section, no individual who holds a valid insurance agent's license issued by the Commissioner shall, either directly or for an insurance agency, solicit, negotiate, or otherwise act as an agent for an insurer by which the individual has not been appointed."

SECTION 9. G.S. 58-33-40(b) reads as rewritten:

"(b) Any insurer authorized to transact business in this State may appoint as its agent any individual who holds a valid agent's license issued by the Commissioner. To appoint an individual as its agent, the appointing insurer shall file, in a format approved by the Commissioner, a notice of appointment with 15 days after the date the first insurance application is submitted. ~~Upon the appointment, the~~The individual shall be authorized to act as an agent for the appointing insurer for all kinds of insurance for which the insurer is authorized in this State and for which the appointed agent is licensed in this State, unless specifically limited."

SECTION 10. G.S. 58-33-40 (c) and (h) are repealed.

SECTION 11. G.S. 58-33-46(a)(2) reads as rewritten:

"(2) Violating any insurance law of this or any other state, violating any administrative rule, subpoena, or order of the Commissioner or of another state's insurance regulator, or violating any rule of the ~~National Association of Securities Dealers.~~FINRA."

SECTION 12. G.S. 58-21-65(f) reads as rewritten:

"(f) A person licensed as a surplus lines licensee under the laws of a state bordering this State may be licensed as a surplus lines licensee under this Article, if: (i) the laws of the bordering state are substantially similar to the provisions of this Article and (ii) the bordering state has a law or regulation substantially similar to this subsection that permits surplus lines licensees licensed under this Article to be licensed by the bordering state and (iii) the person complies with all requirements of this Article and submits himself or herself to the Commissioner's jurisdiction. Nonresident surplus lines licensees shall be licensed in accordance with Article 33 of this Chapter."

SECTION 13. G.S. 58-71-50(a) reads as rewritten:

"(a) An applicant for a license as a bail bondsman or runner shall furnish the Commissioner with a complete set of the applicant's fingerprints in a manner prescribed by the Commissioner and a recent passport size full-face photograph of the applicant. The applicant's fingerprints shall be certified by an authorized law-enforcement officer. The fingerprints of every applicant shall be forwarded to the State Bureau of Investigation for a search of the applicant's criminal history record file, if any. If warranted, the State Bureau of Investigation shall forward a set of the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. An applicant shall pay the cost of the State and any national criminal history record check of the applicant."

SECTION 14. G.S. 58-71-70 reads as rewritten:

"**§ 58-71-70. Examination; fees.**

Each applicant for a license as a professional bondsman, surety bondsman, or runner shall appear in person and take ~~a written~~an examination prepared by the Commissioner testing the applicant's ability and qualifications. Each applicant is eligible for examination 30 days after the date the application is received by the Commissioner. If an applicant is unable to complete the examination requirement within 30 days after notification from the Commissioner of the applicant's eligibility to take the examination, the applicant shall again be subject to the criminal history record check prescribed by G.S. 58-71-50(a) so that current information is available for review with the application. Each examination shall be held at a time and place as designated by the Commissioner. Each applicant shall be given notice of the designated time and place no sooner than 15 days before the examination. The Commissioner may contract with a person to process applications for the examination and administer and grade the examination in the same manner as for agent examinations under Article 33 of this Chapter.

The fee for each examination is twenty-five dollars ($25.00) plus an amount that offsets the cost of any contract for examination services. This examination fee is nonrefundable.

An applicant who fails an examination may take a subsequent examination, but at least one year must intervene between examinations."

SECTION 15. G.S. 58-71-30 reads as rewritten:

"**§ 58-71-30. Arrest of defendant for purpose of surrender.**

For the purpose of surrendering the defendant, the surety may arrest him before the forfeiture of the ~~undertaking, or by his written authority endorsed on a certified copy of the undertaking, may request any judicial officer to order arrest of the defendant.~~undertaking."

SECTION 16. G.S. 58-71-45 reads as rewritten:

"**§ 58-71-45. Terms of licenses.**

A license issued to a bail bondsman or to a runner authorizes the licensee to act in that capacity until the license is suspended or revoked. Upon the suspension or revocation of a license, the licensee shall return the license to the Commissioner. A license of a bail bondsman and a license of a runner shall be renewed on July 1 of each year upon payment of the applicable renewal fee under G.S. 58-71-75. The Commissioner is not required to print renewal licenses. After notifying the Commissioner in writing, a professional bondsman who employs a runner may cancel ~~the runner's license and~~the runner's authority to act for the professional bondsman."

SECTION 17. G.S. 58-71-140(d) is repealed.

SECTION 18. G.S. 58-71-120 reads as rewritten:

"**§ 58-71-120. Bail bondsman to give notice of discontinuance of business; cancellation of license.**

Any bail bondsman who discontinues writing bail bonds during the period for which he is licensed shall ~~notify the clerks of the superior court with whom he is registered and~~ return his license to the Commissioner for cancellation within 30 days after ~~such~~ the discontinuance."

SECTION 19. G.S. 58-70-5(k) reads as rewritten:

"(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,~~A GAAP financial statement setting forth the current assets, fixed assets, current liabilities and positive net worth of the applicant;".

SECTION 20. G.S. 58-70-5(q) reads as rewritten:

"(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.

(2a) "GAAP financial statement" means a financial statement as defined by accounting principles generally accepted in the United States."

SECTION 21. G.S. 58-70-10 reads as rewritten:

"**§ 58-70-10. Application to Commissioner for permit renewal.**

Any person, firm, corporation or association desiring to renew a permit issued pursuant to G.S. 58-70-5 shall make application to the Commissioner ~~of Insurance~~ not less than 30 days ~~prior to~~before the expiration date of the then current permit. Such renewal applicant shall be entitled to a renewal permit upon submission to the Commissioner of Insurance of all the information as required by G.S. 58-70-5; provided, however, it shall be sufficient, wherever applicable, to reference the prior year's application if there has been no change as to any of the required information and it shall not be necessary to submit with a renewal application a new director's resolution. In addition, the applicant shall submit to the Commissioner a copy of a "continuation certificate" or paid receipt for renewal premiums for the collection agency bond for the year for which the renewal permit is applied. The application shall include a calculation in accordance with G.S. 58-70-20, and if the bond is increased, an endorsement by the surety. With a renewal application, the applicant shall submit a ~~balance sheet~~GAAP financial statement for the last fiscal year ending ~~prior to~~before 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."

SECTION 22. G.S. 58-70-40(b) reads as rewritten:

"(b) If an individual proprietor, officer, or partner of the collection agency has been convicted in any court of competent jurisdiction for any crime involving dishonesty or breach of trust, the collection agency shall notify the Commissioner in writing of the conviction within 10 days after the date of the conviction. As used in this subsection, "conviction" includes an adjudication of guilt, a plea of guilty, or a plea of nolo contendere. The conviction by a court of competent jurisdiction of any permittee for a violation of this Article shall automatically have the effect of suspending the permit of that permittee until such time that the permit is reinstated by the Commissioner. As used in this subsection, "conviction" includes an adjudication of guilt, a plea of guilty, and a plea of nolo contendere."

SECTION 23. G.S. 58-70-40 is amended by adding a new subsection to read:

"(e) A collection agency shall report to the Commissioner any administrative action taken against the collection agency by another state or by another governmental agency in this State within 30 days after the final disposition of the matter. This report shall include a copy of the order or consent order and other information or documents filed in the proceeding necessary to describe the action."

SECTION 24. Article 35 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-69-60. Notification of criminal or administrative actions.**

(a) If an individual proprietor, officer, or partner of a motor club has been convicted in any court of competent jurisdiction for any crime involving dishonesty or breach of trust, the

motor club shall notify the Commissioner in writing of the conviction within 10 days after the date of the conviction. As used in this subsection, "conviction" includes an adjudication of guilt, a plea of guilty, or a plea of nolo contendere.

(b) A motor club shall report to the Commissioner any administrative action taken against the motor club by another state or by another governmental agency in this State within 30 days after the final disposition of the matter. This report shall include a copy of the order or consent order and other information or documents filed in the proceeding necessary to describe the action."

SECTION 25. G.S. 58-35-1(2) reads as rewritten:

"(2) "Insurance premium finance agreement" means a promissory note or other written agreement by which an insured promises or agrees to pay to, or to the order of, an insurance premium finance company the amount advanced or to be advanced under the agreement to an insurer ~~or to an insurance agent,~~ in payment of premiums on an insurance contract, together with a service charge as authorized and limited by this Article."

SECTION 26. G.S. 58-35-5(b) reads as rewritten:

"(b) ~~Application for license required under this Article shall be in writing, and in the form prescribed by the Commissioner.~~An application for a license under this Article shall be in writing, in a form prescribed by the Commissioner, and shall include a current GAAP financial statement of the applicant that has been prepared by a certified public accountant or by a qualified independent accountant who is engaged in the public practice of accounting. As used in this subsection, "GAAP financial statement" means a financial statement as defined by accounting principles generally accepted in the United States."

SECTION 27. Article 35 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-35-22. Notification of criminal or administrative actions.**

(a) If an individual proprietor, officer, or partner of a premium finance company has been convicted in any court of competent jurisdiction for any crime involving dishonesty or breach of trust, the premium finance company shall notify the Commissioner in writing of the conviction within 10 days after the date of the conviction. As used in this subsection, "conviction" includes an adjudication of guilt, a plea of guilty, or a plea of nolo contendere.

(b) A premium finance company shall report to the Commissioner any administrative action taken against the premium finance company, including any branch office, by another state or by another governmental agency in this State within 30 days after the final disposition of the matter. This report shall include a copy of the order or consent order and other information or documents filed in the proceeding necessary to describe the action."

SECTION 28. G.S. 58-33-46(a)(6) reads as rewritten:

"**§ 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:

...

(6) Having been convicted of a ~~felony,~~felony or a misdemeanor involving dishonesty, a breach of trust, or ~~a misdemeanor involving~~ moral turpitude."

SECTION 29. G.S. 58-2-69(b) reads as rewritten:

"(b) Every applicant for a license shall inform the Commissioner of the applicant's residential ~~address.~~address and provide the applicant's e-mail address to which the Commissioner can send electronic notifications and other messages. Every licensee shall give written notification to the Commissioner of any change of the licensee's residential or e-mail address within 10 business days after the licensee moves into the licensee's new ~~residence.~~residence or obtains a different e-mail address. This requirement applies if the change

of residential address is by governmental action and there has been no actual change of residence location; in which case the licensee shall notify the Commissioner within 10 business days after the effective date of the change. A violation of this subsection is not a ground for revocation, suspension, or nonrenewal of the license or for the imposition of any other penalty by the Commissioner, though a licensee who violates this subsection shall pay an administrative fee of fifty dollars ($50.00) to the Commissioner."

SECTION 30. Sections 22, 23, 24, and 27 of this act become effective October 1, 2009. Sections 19, 20, 21, 26, and 29 of this act become effective January 1, 2010. Section 5 of this act becomes effective October 1, 2010. The remainder of this act is effective when it becomes law.

HOUSE BILL 1166:
Insurance Law Changes.-AB

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Judiciary III	**Date:**	May 27, 2009
Introduced by:	Reps. Goforth, Wray	**Prepared by:**	Kory Goldsmith
Analysis of:	PCS to First Edition H1166-CSRCf-19		Committee Counsel

SUMMARY: House Bill 1166 is an agency bill that makes a number of changes to the laws related to licensing property, casualty or personal lines insurance agents, bail bondsmen, surplus lines carriers, collection agencies, and insurance premium finance companies.

In addition to the serial referral to House Judiciary II, this bill contains new fees and should be re-referred to House Finance.

BILL ANALYSIS:

Section 1 provides that the Financial Industry Regulatory Authority or any successor entity may be referred to as "FINRA" in Article 33 of Chapter 58

Sections 2, 5 and 10 substitute FINRA for the current term "National Association of Securities Dealers" in G.S. 58-33-26(e), G.S. 58-33-32(k), and G.S. 58-33-46(a) (2).

Section 3 clarifies existing law which provides that an individual may not simultaneously hold both a license as an adjuster and a license for property, casualty or personal lines insurance.

Section 4 requires individuals applying for a license as an agent, broker, limited representative, adjuster or motor vehicle damage appraiser to submit to a criminal background check as part of the licensure process. This requirement becomes effective October 1, 2010 and would apply to applications made on or after that date.

Section 6 repeals G.S. 58-33-35 which exempts certain applicants for an agent's license from taking an examination.

Sections 7 and 8 clarify the process by which an insurer may appoint an individual as an agent and requires the insurer to notify the Commissioner within 15 days of that appointment.

Section 9 repeals provisions that are made redundant because of the changes in Sections 7 and 8.

Section 10 allows the Commissioner to suspend, revoke, refuse to renew or put on probation an insurance license if the individual has been convicted a felony involving moral turpitude.

Section 11 requires that nonresident surplus lines licensees are to be licensed under the procedures applicable to agents, brokers, limited representatives, adjuster and motor vehicle damage appraisers.

Section 12 allows the Commissioner to specify the manner by which applicants for a bail bondsman or runner licenses must submit their fingerprints for a criminal background check.

Section 13 requires an applicant for a bail bondsman or runner license who is not able to complete the examination requirement within 30 days after notification of the commissioner to submit to another criminal background check.

Section 14 removes a provision that allowed a professional bondsman who ceases to employ a runner to cancel that runner's license.

Section 15 repeals a provision that required certain filings by licensed professional bondsmen, surety bondsmen, and runners with the clerk of court with jurisdiction over a principal.

Section 16. removes a provision that required a bail bondman who discontinues writing bail bonds to notify the clerk of court of that discontinuance.

Sections 17, 18, 19 and 21 require owners of collection agencies, motor clubs and insurance premium finance companies to notify the Commission of any criminal conviction involving dishonesty or breach of trust and of any administrative action by another state or another governmental agency. These requirements become effective October 1, 2009.

Section 20 removes from the definition of "insurance premium finance agreement" a reference to insurance agents so that insurance premium finance agreements may only be made between an insurance premium finance company and an insurer.

Section 22 requires applicants for a license to provide the Commissioner with an e-mail address as well as a residential address, and to notify the Commissioner of any change in the e-mail address.

EFFECTIVE DATE: Except as otherwise specifically noted, the act is effective when it becomes law.

H1166-SMRC-35(CSRCf-19) v2

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 957

Short Title:	Special Enrollment Period/Group Health Ins.	(Public)
Sponsors:	Senator Nesbitt.	
Referred to:	Commerce.	

March 26, 2009

A BILL TO BE ENTITLED

AN ACT TO CREATE A SPECIAL ENROLLMENT PERIOD IN THE NORTH CAROLINA GROUP HEALTH INSURANCE CONTINUATION LAW AND PROVIDE ELIGIBLE INDIVIDUALS WITH THE SAME CONTINUATION RIGHTS AS UNDER THE FEDERAL AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009.

The General Assembly of North Carolina enacts:

SECTION 1. Article 53 of Chapter 58 of the General Statutes of North Carolina is amended by adding a new section to read:

"**§ 58-53-41. Extension of election period and effect on coverage.**

(a) Definitions. – As used in this section, the following terms have the meanings specified:

(1) "Act" means the federal American Recovery and Reinvestment Act of 2009, P.L. 111-5, effective February 17, 2009.

(2) "Assistance eligible individual" has the same meaning as found in section 3001 of the Act.

(b) An employee or member who does not have an election of continuation coverage, as described in this Part, in effect on the effective date of this section, but who would be an assistance eligible individual under Title III of the Act if that election were in effect, may elect continuation coverage pursuant to the Part. The election shall be made no later than 60 days after the date the administrator of the group policy subject to this Part (or other entity involved) provides the notice required by section 3001(a)(7) of the Act. The administrator of the group policy subject to this Part (or other entity involved) shall provide such individuals with additional notice of the right to elect coverage pursuant to this section within 60 days after the effective date of this section.

(c) Continuation of coverage elected pursuant to subsection (b) of this section shall commence with the first period of coverage beginning on or after the effective date of this section and shall not extend beyond the period of continuation coverage that would have been required under G.S. 58-53-35 if the coverage had instead been elected pursuant to G.S. 58-53-10.

(d) With respect to any individual electing continuation coverage pursuant to this section, the period beginning on the date of the qualifying event and ending on the date of the first period of coverage on or after the effective date of this section shall be disregarded for purposes of determining the 63-day period referred to in G.S. 58-68-30(c)(2)a. and G.S. 58-51-17(a)(2)a."

SECTION 2. This act is effective when it becomes law.

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

CORRECTED NOTICE – Pulled SB 749

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

DAY & DATE: **Thursday, May 28, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

HB 1166 – INSURANCE LAW CHANGES – (AB) -Reps. Goforth, Wray and Lucas

SB 749 – REVISE UM/UIM LIABILITY COVERAGE REQUIREMENTS – Sen. Clodfelter

SB 957 – SPECIAL ENTROLLMENT PERIOD/GROUP HEALTH INSURANCE – Sen. Nesbitt

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at: **1:00** on **May 26, 2009.**

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

ATTACHMENT #1

VISITOR REGISTRATION SHEET

House Insurance — May 28, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Goodman	NC Chamber
Patrick Hannah	Liberty Mutual
Heather Barrett	Hunton & Williams
Ashley Bell	American Cancer Society
David Barnes	Poyner Spruill
[signature]	JD, AL, PA
[signature]	NC Collector
Barbara Caselli	BBGR
[signature]	PFFPNC
[signature]	PFFPNC
Butch Gunnells	NC Bev A

VISITOR REGISTRATION SHEET

House Insurance — May 28, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cam Civer	[illegible]
Penny Griffin	School of Gov.
Stephen Wohlers	DOI
TED HAMBY	NCDOI
Angela Ford	NCDOI
Ethan Maynard	NCDOI
[illegible]	BCS
Susan Valenti	NW
[illegible]	mwc
David Boag	mwc
Jennifer Cohen	IFNC

VISITOR REGISTRATION SHEET

House Insurance — May 28, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Betsy Vetter	American Heart Assn
Jon Allison	State Auto Insurance Columbus, OH
George Forlay	State Auto Ins Co Nashville, TN
Clyde Fitch	State Auto Insurance Co Columbus, OH
[illegible]	NMIPS
MIKE MANN	NCBAA
Jennifer Sasser	Williams Mullen
Bill Tibbens	Farmers Ins. Group.
Daniel Baum	K+L GATES
Elizabeth Dalton	NCDOI
Amy McCarley	Smith Anderson

VISITOR REGISTRATION SHEET

House Insurance — May 28, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jordan Schrader	prsp
Bill Eggen	ICC

House Pages

Name of Committee: Insurance Date: 5/28/09

1. Name: Lindsay Stutts
   County: Wayne
   Sponsor: Rep. Bell
2. Name: Netta Williams
   County: Johnston
   Sponsor: Daughtry
3. Name:
   County:
   Sponsor:
4. Name:
   County:
   Sponsor:
5. Name:
   County:
   Sponsor:

Sgt-At-Arms

1. Name: Earl Coker
2. Name: Martha Hudson
3. Name: Gerald Perry
   Red Finger

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 1166 A BILL TO BE ENTITLED AN ACT TO MAKE VARIOUS CHANGES IN THE LAWS GOVERNING INSURANCE PRODUCERS AND BROKERS, BAIL BONDSMEN, MOTOR CLUBS, PREMIUM FINANCE COMPANIES, AND COLLECTION AGENCIES.

☒ 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 JUDICIARY III.

(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.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

SB 957 A BILL TO BE ENTITLED AN ACT TO CREATE A SPECIAL ENROLLMENT PERIOD IN THE NORTH CAROLINA GROUP HEALTH INSURANCE CONTINUATION LAW AND PROVIDE ELIGIBLE INDIVIDUALS WITH THE SAME CONTINUATION RIGHTS AS UNDER THE FEDERAL AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009.

☒ 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 _____.

MINUTES

HOUSE COMMITTEE ON INSURANCE
June 2, 2009

The House Committee on Insurance met at 11:05 AM on Tuesday, June 2, 2009, in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael H. Wray; Vice Chair: M. Dickson, J. Dockham and M. Setzer. Members attending were Reps. Barnhart, Brubaker, Cole, Current, Faison, Howard, Hughes, and Pierce.

Chairman Goforth called the meeting to order and welcomed visitors. He recognized Sgt-At-Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachment #1)

Chairman Goforth recognized Rep. Laura Wiley to explain HB 589- Insurance/Cover Hearing Aids. Rep. Barnhart was recognized for a motion to have a PCS before the committee. Rep. Wiley explained the bill. It requires the state Health Plan for Teachers and State Employees and other health benefit plans subject to Chapter 58 of the General Statues, to provide hearing aid equipment coverage for hearing impaired plan members up to the age of 22. The limit on coverage is $2,500 per hearing aid per hearing impaired ear plus related services every 36 months. Application by the Plan of annual deductibles, co-insurance and other limitations for similar services would be allowed under the bill provided these same requirements are applied to other similar services. Rep. Wiley shared a list of organizations supporting the bill (Attachment #2) and introduced special guests, young children, to speak to the committee. She offered an amendment to allow "a physician or" an audiologist to clarify that the coverage shall include all medically necessary hearing aids and services needed. (Attachment #3) Chairman Wray moved to accept the amendment and it carried. Rep. Faison moved for a favorable report to the Committee Substitute 2 as amended, unfavorable as to committee substitute bill 1, and recommendation that committee substitute bill 2 be re-referred to the Appropriations Committee, and the motion carried.

Chairman Goforth called upon Sen. Doug Berger to present SB 780 – Struc. Settlement Annuities/Ins. Guar. Assn. Chairman Wray moved that the PCS be before the committee. Sen. Berger stated the House has already approved the House version of this bill. He asked Rep. Faison to explain the amendments added by the House. Rep. Faison moved that the committee substitute be given a favorable report, unfavorable as to the Senate substitute original bill, and recommendation that the House committee substitute bill be re-referred to the Judiciary III Committee. Motion carried.

The Chair called upon Sen. Fletcher Hartsell to present SB 893 – Workers' Comp Self-Insurance Security Ass'n. SB 893 would authorize the North Carolina Self-Insurance Guaranty Association to make assessments of group self-insurers, clarify exclusion of individual self-insurers that default on payments, exclude individual self-insurers failing to submit sufficient financial information to the Association, and raise the

amount to be deposited by certain self-insurers. Rep. Howard made a motion for a favorable report to the bill and recommendation that it be re-referred to the Committee on Commerce, Small Business, and Entrepreneurship, and the motion carried.

Chairman Goforth adjourned the meeting at 11:20 AM.

Representative Bruce Goforth, Chair

Mary Capps, Committee Assistant

HOUSE INSURANCE COMMITTEE

June 2, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

HB 589 – INSURANCE/COVER HEARING AIDS – Representatives England, M. Alexander, Wiley and Glazier

SB 780 – STRUC. SETTLEMENT ANNUNITIES/INS. GUAR. ASSN. – Senator Berger

SB 893 – WORKERS' COMP SELF-INSURANCE SECURITY ASS'N – Senator Hartsell

Adjourn

Mary Capps (Rep. Wray)

m: Ann Jordan (Rep. Goforth)
t: Monday, June 01, 2009 1:17 PM
To: Rep. Bob England; Rep. Martha Alexander; Rep. Laura Wiley; Rep. Rick Glazier
Subject: Insurance Meeting Notice for June 2 (2nd Notice).doc

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

CORRECTED NOTICE – Adds HB 589

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

DAY & DATE: **Tuesday, June 2, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

HB 589 – INSURANCE/COVER HEARING AIDS – Representatives England, M. Alexander, Wiley and Glazier

SB 780 – STRUC. SETTLEMENT ANNUNITIES/INS. GUAR. ASSN. – Senator Berger

SB 893 – WORKERS' COMP SELF-INSURANCE SECURITY ASS'N – Senator Hartsell

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at: **Noon on May 28, 2009.**

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

Mary Capps (Rep. Wray)

›m: Ann Jordan (Rep. Goforth)
nt: Thursday, May 28, 2009 11:46 AM
To: Sen. Doug Berger; Sen. Fletcher Hartsell, Jr.
Subject: Insurance Meeting Notice for June 2.doc

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

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

DAY & DATE: **Tuesday, June 2, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

SB 780 – STRUC. SETTLEMENT ANNUNITIES/INS. GUAR. ASSN. – Senator Berger

SB 893 – WORKERS' COMP SELF-INSURANCE SECURITY ASS'N – Senator Hartsell

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at: **Noon on May 28, 2009.**

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 589*
Committee Substitute Favorable 5/26/09
PROPOSED COMMITTEE SUBSTITUTE H589-CSTG-22 [v.1]

6/2/2009 7:22:39 AM

Short Title: Insurance/Cover Hearing Aids. (Public)

Sponsors:

Referred to:

March 16, 2009

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH BENEFIT PLANS AND THE STATE HEALTH PLAN TO COVER HEARING AIDS AND REPLACEMENT HEARING AIDS.

The General Assembly of North Carolina enacts:

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

"**§ 58-3-280. Coverage for hearing aids.**

(a) Every health benefit plan, including the State Health Plan for Teachers and State Employees, shall provide coverage for one hearing aid per hearing-impaired ear up to two thousand five hundred dollars ($2,500) per hearing aid every 36 months for covered individuals under the age of 22 years subject to subsection (b) of this section. The coverage shall include all medically necessary hearing aids and services that are ordered by an audiologist licensed in this State. Coverage shall be as follows: an amendment

(1) Initial hearing aids and replacement hearing aids not more frequently than every 36 months.

(2) A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the covered individual.

(3) Services, including the initial hearing aid evaluation, fitting, and adjustments, and supplies, including ear molds.

(b) The same deductibles, coinsurance, and other limitations as apply to similar services covered under the health benefit plan apply to hearing aids and related services and supplies required to be covered under this section.

(c) Nothing in this section prevents an insurer from applying utilization review criteria to determine medical necessity as defined by G.S. 58-50-61 as long as it does so in accordance with all requirements for utilization review programs and medical necessity determinations specified in that section, including the offering of an insurer appeal process and where applicable, health benefit plans external review as provided in Part 4 of Article 50 of Chapter 58 of the General Statutes."

SECTION 2. G.S. 135-45.8(13), as amended by Section 2(d) of Session Law 2009-16, reads as rewritten:

"**§ 135-45.8. General limitations and exclusions.**

The following shall in no event be considered covered expenses nor will benefits described in G.S. 135-45.6 through G.S. 135-45.11 be payable for:

...

(13) Charges for routine eye examinations, eyeglasses or other corrective lenses (except for cataract lenses certified as medically necessary for aphakia persons) ~~and~~and, except as authorized under G.S. 58-3-280, hearing aids or examinations for the prescription or fitting thereof.

...."

SECTION 3. This act becomes effective March 1, 2010, and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after that date.

HOUSE BILL 589:
Insurance/Cover Hearing Aids

2009-2010 General Assembly

Committee:	House Insurance	**Date:**	June 1, 2009
Introduced by:	Reps. England, M. Alexander, Wiley, Glazier	**Prepared by:**	Bill Patterson
Analysis of:	Second Edition		Committee Counsel

SUMMARY: ***House Bill 589 requires every health benefit plan, including the State Health Plan for Teachers and State Employees ("State Health Plan"), to provide coverage for one hearing aid per hearing-impaired ear up to $2,500 per hearing aid every 36 months. This coverage would apply to individuals under the age of 22. The bill also makes a conforming change to G.S. 135-45.8 "General limitations and exclusions." The PCS makes a technical change to Section 2 of the original bill.***

[As introduced, this bill was identical to S375, as introduced by Sen. Purcell, which is currently in Senate Ref to Commerce. If fav, re-ref to Appropriations/Base Budget.]

CURRENT LAW: G.S. 135-45.8(13), "General limitations and exclusions," excludes charges for hearing aids and for examinations for the prescription and fitting of hearing aids from coverage under the State Health Plan.

BILL ANALYSIS:

Section 1 of House Bill 589 creates a new section, G.S. 58-3-280, entitled "Coverage for hearing aids" requiring every health benefit plan, including the State Health Plan for Teachers and State Employees, to provide coverage for one hearing aid per hearing-impaired ear, up to $2,500 per hearing aid every 36 months. This coverage applies to individuals under the age of 22.

Coverage must include all medically necessary hearing aids and services ordered by an audiologist, including services and supplies, and an initial hearing aid evaluation, fitting and adjustments. New hearing aids must be provided when alterations to an existing hearing aid is inadequate.

The bill permits insurers to apply utilization review criteria in accordance with current law, including the required insurer appeal process. As defined in G.S. 58-50-61(a)(17), "utilization review" is a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, providers, or facilities.

Section 2 of the bill makes a conforming change to G.S. 135-45.8(13) to provide that the expenses authorized under new G.S. 58-3-280 are not excluded from coverage under the State Health Plan.

EFFECTIVE DATE: The act becomes effective March 1, 2010 and applies to health benefit plans delivered, issued or renewed on or after that date.

Ben Popkin, counsel to House Health, and Tim Hovis, counsel to Senate Commerce, substantially contributed to this summary.

H589-SMTG-66(e2) v3

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: House Bill 589 (First Edition)

SHORT TITLE: Insurance/Cover Hearing Aids.

SPONSOR(S): Representatives M. Alexander, Glazier, England, and Wiley

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY: The proposed bill requires the Plan, and other health benefit plans subject to Chapter 58 of the General Statutes, to provide hearing aid equipment coverage for hearing impaired plan members up to the age of 22. The limit on coverage is $2,500 per hearing aid per hearing impaired ear plus related services every 36 months per qualifying plan member. Application by the Plan of annual deductibles, co-insurance and other limitations for similar services would be allowed under the bill provided these same requirements are applied to other similar services.

EFFECTIVE DATE: January 1, 2010

ESTIMATED IMPACT ON STATE:

Aon Consulting, the consulting actuary for the State Health Plan for Teachers and State Employees, estimates that the bill's requirements will have a financial impact on the Plan's medical costs of approximately $270,000 per fiscal year of the biennium.

Hartman & Associates, the consulting actuary for the General Assembly's Fiscal Research Division, estimates that the bill's requirements will have a financial impact on the Plan's medical costs of approximately $255,000 per fiscal year of the biennium.

The additional cost impact, projected by either consulting actuary, would be expected to impact premium rates by less than one one-hundredth of one percent (0.01%) annually.

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2008, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.6 billion for FY 2008-09. The Plan's PPO benefit design includes three alternative benefit levels offered to plan members. The three alternative benefit levels include the following:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums;

2) The "Standard" 80/20 plan; and

3) The "Plus" 90/10 plan with enhanced benefits via lower out-of pocket requirements as compared to the other PPO plan alternatives offered.

Employees and retired employees electing coverage under the Plus alternative must make a partially contributory premium contribution for their own coverage. The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under all plans is offered on a fully contributory basis.

Financial Condition

Financial Projection (Revised) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year are projected to be $2.3 billion from premium collections, $53.9 million from Medicare Part D subsidies, and $2.7 million from investment earnings, for a total of slightly over $2.3 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.4 billion in claim-payment expenses and $168.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating loss is projected to be approximately $264.4 million for the fiscal year, assuming a 9% annual claims growth trend.

Projected operating losses are expected to deplete the Plan's cash balance of $139.8 million and leave it without sufficient operating resources to continue operations for the fiscal year. It is currently estimated by the Plan's Executive Administrator that the Plan will not be able to pay claims on a timely basis by March 31, 2009.

Consequently, the reforecast of Plan finances now indicates that the Plan will require up to $300 million in additional resources to operate for the balance of the 2008-09 fiscal year. This amount represents the

estimated funds necessary to pay claims and administrative expenses through June 30, 2009, plus funding a minimum stabilization reserve equal to 7.5% of projected claims, and assuming a future premium rate increase effective October 1, 2009.

Other Information

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment Data as of December 31, 2008

I. No. of Participants	Basic	Standard	Plus	Total	Percent of Total
Actives					
Employees	11,623	271,243	47,687	330,553	49.6%
Dependents	20,454	115,875	28,156	164,485	24.7%
Sub-total	32,077	387,118	75,843	495,038	74.2%
Retired					
Employees	1,726	127,081	17,967	146,774	22.0%
Dependents	1,117	14,935	3,476	19,528	2.9%
Sub-total	2,843	142,016	21,443	166,302	24.9%
Former Employees with Continuation Coverage					
Employees	60	1,349	344	1,753	0.3%
Dependents	61	501	182	744	0.1%
Sub-total	121	1,850	526	2,497	0.4%
Firefighters, Rescue Squad & National Guard					
Employees	-	3	2	5	0.0%
Dependents	-	3	-	3	0.0%
Sub-total	-	6	2	8	0.0%
Local Governments					
Employees	72	1,577	319	1,968	0.3%
Dependents	141	637	218	996	0.1%
Sub-total	213	2,214	537	2,964	0.4%
Total					
Employees	13,481	401,253	66,319	481,053	72.1%
Dependents	21,773	131,951	32,032	185,756	27.9%
Grand Total	**35,254**	**533,204**	**98,351**	**666,809**	**100%**
Percent of Total	**5.3%**	**80.0%**	**14.7%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	2,684	328,635	49,246	380,565
Employee Child(ren)	4,958	36,903	8,589	50,450
Employee Spouse	2,274	18,145	4,469	24,888
Employee Family	3,565	17,570	4,015	25,150
Total	**13,481**	**401,253**	**66,319**	**481,053**

Percent Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	19.9%	81.9%	74.3%	79.1%
Employee Child(ren)	36.8%	9.2%	13.0%	10.5%
Employee Spouse	16.9%	4.5%	6.7%	5.2%
Employee Family	26.4%	4.4%	6.1%	5.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Enrollment Data Continued

III. Enrollment by Sex	Basic	Standard	Plus	Total
Female	18,837	334,917	61,752	415,506
Male	16,417	198,287	36,599	251,303
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Sex	Basic	Standard	Plus	Total
Female	53.4%	62.8%	62.8%	62.3%
Male	46.6%	37.2%	37.2%	37.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	17,390	136,277	27,211	180,878
30 to 44	8,125	107,375	17,315	132,815
45 to 54	5,164	94,548	18,277	117,989
55 to 64	3,195	102,901	23,452	129,548
65 & Over	1,380	92,103	12,096	105,579
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	49.3%	25.6%	27.7%	27.1%
30 to 44	23.0%	20.1%	17.6%	19.9%
45 to 54	14.6%	17.7%	18.6%	17.7%
55 to 64	9.1%	19.3%	23.8%	19.4%
65 & Over	3.9%	17.3%	12.3%	15.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	49,534	12,080	61,614
Medicare Eligible	97,240	7,448	104,688
Total	**146,774**	**19,528**	**166,302**

Percent by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.7%	61.9%	37.0%
Medicare Eligible	66.3%	38.1%	63.0%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, "House Bill 589: An Act to Require Health Benefit Plans and the State Health Plan to Cover Hearing Aids and Replacement Hearing Aids", April 20, 2009, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "House Bill 589 Cover Hearing Aids", April 20, 2009, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Marilyn Chism, Director
Fiscal Research Division

DATE: April 21, 2009

Signed Copy Located in the NCGA Principal Clerk's Offices

NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

HOUSE BILL 589

COVER HEARING AIDS

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30305

April 2009

ACTUARIAL STATEMENT

The North Carolina State Health Plan for Teachers and State Employees has requested that Aon Consulting prepare an Actuarial Note in response to House Bill 589 entitled "An Act To Require Health Benefit Plans And The State Health Plan To Cover Hearing Aids And Replacement Hearing Aids."

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

April 20, 2009

Kenneth C. Vieira, F.S.A., M.A.A.A.
Senior Vice President

Date

April 20, 2009

Kirsten R. Schatten, A.S.A., M.A.A.A.
Assistant Vice President

Date

COVER HEARING AIDS

PLAN CHANGES

The proposed legislation requires all health benefit plans and the State Health Plan to cover hearing aids and replacement hearing aids. The full text of the bill is attached to this actuarial note.

PROJECTED COSTS

	Based on "Midpoint" Increase (in millions)		
Plan Design Change	2009-2010 Fiscal Year Cost	2010-2011 Fiscal Year Cost	Total Biennium Cost
Cover hearing aids and replacement hearing aids	$.27	$.27	$.54

* Based on total projected expenses of $2,687,502,073 and $2,919,507,795 for the 2010 and 2011 fiscal years respectively.

PRICING APPROACH AND COMMENTS

The following information was compiled and utilized in determining the projected costs or savings of each benefit component addressed in this actuarial note:

- Prevalence of children with moderate to profound hearing loss is estimated at .14% based on studies published by the Centers for Disease Control and Prevention (CDC).
- Total claimants are estimated at 173 based on Plan members under the age of 22 years.
- 33% of total claimants are expected to be covered for hearing aids each year based on coverage every 3 years. A spike in claims could occur in the first year for new coverage; however, this would be offset in the following year or two.
- 31% of claims are estimated to cover one hearing aid and 69% of claims are estimated to cover two hearing aids based on claims level data received from NC Health Choice.
- Projected costs incorporate a 10% risk factor.
- Based on an effective date of July 1, 2009, the projected cost to cover hearing aids is $267,736 per year.
- Survey information was also collected from other states covering this benefit. The information received confirmed reasonableness of the assumptions used in our calculations.

HOUSE BILL 589*

Short Title:	Insurance/Cover Hearing Aids.	(Public)
Sponsors:	Representatives England, M. Alexander, Wiley, Glazier (Primary Sponsors); Bell, Brisson, Carney, Crawford, Faison, Farmer-Butterfield, Harrison, Insko, Jackson, Jeffus, Jones, Lucas, Martin, McElraft, McLawhorn, Pierce, Randleman, Sutton, Tarleton, Wainwright, E. Warren, Whilden, and Williams.	
Referred to:	Health, if favorable, Insurance, if favorable, Appropriations.	

March 16, 2009

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH BENEFIT PLANS AND THE STATE HEALTH PLAN TO COVER HEARING AIDS AND REPLACEMENT HEARING AIDS.

The General Assembly of North Carolina enacts:

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

"**§ 58-3-280. Coverage for hearings aids.**

(a) Every health benefit plan, including the State Health Plan for Teachers and State Employees, shall provide coverage for the full cost of one hearing aid per hearing-impaired ear up to two thousand five hundred dollars ($2,500) per hearing aid every 36 months for covered individuals under the age of 22 years. The coverage shall include all related services that are prescribed by an audiologist licensed in this State. The prescribed hearing aids shall be medically appropriate to meet the needs of the individual according to accepted professional standards. Coverage shall be as follows:

(1) Initial hearing aids and replacement hearing aids not more frequently than every 36 months.

(2) A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child.

(3) Services and supplies including the initial hearing aid evaluation, fitting, and adjustments that are provided according to accepted standards.

(b) The same deductibles, coinsurance, and other limitations as apply to similar services covered under the health benefit plan apply to hearing aids and related services and supplies required to be covered under this section."

SECTION 2. G.S. 135-45.8(13) reads as rewritten:

"**§ 135-45.8. General limitations and exclusions.**

The following shall in no event be considered covered expenses nor will benefits described in G.S. 135-45.6 through G.S. 135-45.11 be payable for:

...

(13) Charges for eyeglasses or other corrective lenses (except for cataract lenses certified as medically necessary for aphakia ~~persons) and hearing aids or examinations for the prescription or fitting thereof.~~ persons).

...."

SECTION 3. This act becomes effective January 1, 2010, and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after that date.

HARTMAN & ASSOCIATES, LLC

ACTUARIAL CONSULTING

ARK V. HARTMAN, FSA, MAAA, MCA, EA

hartman@triad.rr.com

Phone: (336) 731-4038
Fax: (336) 731-2583

668 Link Road
Lexington, NC 27295

April 20, 2009

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: House Bill 589: An Act to Require Health Benefit Plans and the State Health Plan to Cover Hearing Aids and Replacement Hearing Aids

Dear Mr. Trogdon:

This bill amends G.S. 58-3-280 by adding a new section requiring every health benefit plan, including the North Carolina State Health Plan for Teachers and State Employees (the "Plan"), to provide coverage for the full cost of one hearing aid per hearing-impaired ear for covered individuals under the age of 22. Coverage is limited to a maximum of $2,500 per hearing aid. Coverage would include the initial hearing aid and replacement hearing aids not more frequently than every 36 months. The same deductibles, coinsurance, and other limitations as apply to similar services must apply to coverage for hearing aids.

The bill also amends G.S. 135-45.8 to remove hearing aids from the exclusions under the Plan. This act is effective January 1, 2010.

The estimated impact of this bill was determined by projecting the number of claims for hearing aids under the Plan. Data was obtained from research from the Centers for Disease Control, the Gallaudet Research Institute, and the Plan's survey of other state health plans. Based on this projection, the estimated annual cost of this bill is $255,000.

This cost assumes hearing aids are replaced every 3 years. I used an incidence rate of 1.4 hearing impaired individuals per 1000 members under the age of 22. 60% of all claims are projected to be for two hearing aids. Plan membership is assumed to remain constant at the December, 2008 level. Although the bill is effective for only six months in the initial fiscal year, no cost reduction was calculated to allow for higher initial utilization.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, FCA, EA
Consulting Actuary

MVH/mt

ATTACH MENT #2

ıizations (19) Supporting this Bill:

- **BEGINNINGS for Parents of Children Who Are Deaf or Hard of Hearing, Inc.**
- **NC Chapter of the Alexander Graham Bell Association for the Deaf and Hard of Hearing**
- **NC Hearing Loss Association**
- **The Arc of North Carolina**
- **NC Medical Society**
- **NC Speech Hearing Language Association**
- **NC Exceptional Children's Division, Department of Public Instruction**
- **NC Office of Education Services, Department of Health and Human Services**
- **NC Early Hearing Detection and Intervention Advisory Board**
- **NC Division of Services for the Deaf and Hard of Hearing, Department of Health and Human Services**
- **NC Family Support Network**
- **UNC Hospitals, Division of Otology/Neurotology and Skull Base Surgery**
- **Division of Speech & Hearing Sciences, UNC-CH School of Medicine**
- **Carolina Children's Communicative Disorders Program (CCCDP)**
- **Center for the Acquisition of Spoken Language Through Listening Enrichment (CASTLE)**
- **Triad Area HITCH-UP (Hearing Impaired Toddlers and Children Have Unlimited Potential—parent support group)**
- **Project EAR**
- **Department of Communication Sciences and Disorders, East Carolina University**
- **North Carolina Association of the Deaf**
- **Professionals across NC working with children with hearing loss and their families**
- **Parents across NC**

ATTACHMENT #3

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 589 DATE 6/2/09

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

COMMITTEE SUBSTITUTE ✓

(Rep.) Wiley Wray
Sen.)

1 moves to amend the bill on page 1, line 12
2 ( ) WHICH CHANGES THE TITLE
3 by inserting after the word "by" the words
4 "a physician or".
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SIGNED Laura Y. Wiley
Wray

ADOPTED ✓ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

SENATE BILL 780:
Struc. Settlement Annuities/Ins. Guar. Assn

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Judiciary III	**Date:**	June 1, 2009
Introduced by:	Sen. Berger of Franklin	**Prepared by:**	Bill Patterson
Analysis of:	Second Edition		Committee Counsel

SUMMARY: ***Senate Bill 780 expands the protection against defaulting insurers under the Life and Health Insurance Guaranty Association Act to include North Carolina residents who settle claims for personal injury or illness under an agreement funded at least in part by an annuity, regardless of whether the owner of the annuity contract is a State resident.***

The bill also extends protection to non-residents who settle their claims for personal injury or illness under agreements funded by annuities, if the following conditions are met:

> ***1) no coverage is offered by the insurance guaranty association of the state in which the payee or the contract owner reside, and***
>
> ***2) the contract owner is a resident of this State, or if not a resident of this State, the insurer issuing the annuity is domiciled in North Carolina and the contract owner's state of residence has an association similar to this State's association.***

[As introduced, this bill was identical to H889, as introduced by Reps. Haire, Love, Blue, Faison, which is currently in Senate Commerce.]

CURRENT LAW: The Life and Health Insurance Guaranty Association Act, codified as Article 62 of Chapter 58 of the General Statutes, provides protection to eligible persons against defaults by issuers of certain life and health insurance policies and annuity contracts, by creating an association of insurers responsible for fulfill the obligations of the defaulting insurer, subject to certain limitations.

Currently, the Act protects owners of annuity contracts issued to fund structured settlement agreements who reside in this State at the time when the issuing insurer is determined to be delinquent. If the contract owner is a non-resident, coverage is provided only if:

- the issuing insurer is domiciled in North Carolina and never held a license in the state where the contract owner resides, and
- the state where the contract owner resides has an association similar to North Carolina's Life and Health Insurance Guaranty Association but the contract owner is not eligible for coverage by that association.

G.S. 58-62-21(b)(2).

BILL ANALYSIS: Under a structured settlement, the funding annuity is issued to someone other than the person whose claim is being settled. Under current law, if a North Carolina resident settles a personal injury or workers compensation claim by means of a structured settlement, and if the entity to whom the funding annuity is issued is not a resident of North Carolina, the Act does not provide coverage in the event that the annuity issuer becomes unable to meet its contractual obligations.

The bill provides coverage to payees under annuities issued to fund structured settlements regardless of whether the owner of the annuity contract is a resident of this State, where the payee is a resident of North Carolina at the time the issuer of the annuity is determined to be unable to meet its contractual obligations.

If the payee under a structured settlement annuity is not a resident of this State at the time the annuity issuer is determined to be unable to meet its contractual obligations, the bill provides coverage only if both of the following conditions are met:

- the contract owner is a resident of this State, or if not a resident of this State, the insurer issuing the annuity is domiciled in North Carolina and the contract owner's state of residence has an association similar to this State's association; and
- no coverage is offered by the insurance guaranty association of the state(s) in which the payee or the contract owner reside

EFFECTIVE DATE: This act is effective when it becomes law and would apply to claims submitted to the Insurance Guaranty Association on or after that date.

S780-SMTG-65(e2) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 780
Commerce Committee Substitute Adopted 4/28/09
PROPOSED HOUSE COMMITTEE SUBSTITUTE S780-CSRD-60 [v.1]

6/2/2009 10:33:18 AM

Short Title: Struc. Settlement Annuities/Ins. Guar. Assn. (Public)

Sponsors:

Referred to:

March 25, 2009

A BILL TO BE ENTITLED

AN ACT TO EXPAND COVERAGE UNDER THE INSURANCE GUARANTY ASSOCIATION WITH RESPECT TO STRUCTURED SETTLEMENT ANNUITIES FOR MATTERS INVOLVING PERSONAL INJURY OR ILLNESS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-62-16 is amended by adding a new subdivision to read:

"(17a) 'Structured settlement annuities' means any contracts or certificates for annuities issued to fund, in whole or in part, a settlement agreement for a matter involving personal injury or illness, including any settlement agreement permitted under Chapter 97 of the General Statutes."

SECTION 2. G.S. 58-62-21(a) reads as rewritten:

"**§ 58-62-21. Coverage and limitations.**

(a) This Article provides coverage for the policies and contracts specified in subsection (b) of this section:

(1) To persons other than persons specified in subdivisions (3) and (4) of this subsection who, regardless of where they reside (except for nonresident certificate holders under group policies), are the beneficiaries, assignees, or payees of the persons covered under subdivision (2) of this ~~subsection, and~~ subsection;

(2) To persons other than persons specified in subdivisions (3) and (4) of this subsection who are owners or certificate holders under the policies, or in the case of unallocated annuity contracts to the persons who are the contract holders, and who are residents of this State, or who are not residents of this State, but only under all of the following conditions: (i) the insurers that issued the policies are domiciled in this State; (ii) the insurers never held a license in the states in which the persons reside; (iii) the states have associations similar to the association created by this Article; and (iv) the persons are not eligible for coverage by the ~~associations.~~associations;

(3) To persons who are payees (or beneficiaries of payees if the payees are deceased) under structured settlement annuities if the payees are residents of this State, regardless of where the contract owners of the structured settlement annuities reside; and

(4) To persons who are payees (or beneficiaries of payees if the payees are deceased) under structured settlement annuities if the payees are not residents of this State, but only if all of the following conditions are met:

a. The contract owners of the structured settlement annuities are residents of this State or, if not residents of this State, (i) the insurers that issued the structured settlement annuities are domiciled in this State and (ii) the state in which the contract owners reside has an association similar to the Association created by this Article; and

b. Neither the payees (or beneficiaries of payees if the payees are deceased) nor the contract owners of the structured settlement annuities are eligible for coverage by an association of the state in which the payees or contract owners reside."

SECTION 3. G.S. 58-62-21(d) reads as rewritten:

"(d) The benefits for which the Association is liable do not, in any event, exceed the lesser of:

...

(4) With respect to any one contract holder covered by any unallocated annuity contract not included in subdivision (3) of this subsection, five million dollars ($5,000,000) in benefits, regardless of the number of such contracts held by that contract ~~holder.~~ holder; or

(5) With respect to any one contract holder of a structured settlement annuity, one million dollars ($1,000,000) for all benefits, including cash values."

SECTION 4. G.S. 58-62-21(e) reads as rewritten:

"(e) In no event is the Association liable to expend more than ~~three hundred thousand dollars ($300,000)~~ five hundred thousand dollars ($500,000) in the aggregate with respect to any one individual under this section. This subsection does not apply to structured settlement annuities."

SECTION 5. This act is effective when it becomes law and applies to claims submitted to the Insurance Guaranty Association on or after that date.

SENATE BILL 893:
Workers' Comp Self-Insurance Security Ass'n

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Commerce, Small Business, and Entrepreneurship	**Date:**	June 1, 2009
Introduced by:	Sen. Hartsell	**Prepared by:**	Ben Popkin Committee Counsel
Analysis of:	Second Edition		

SUMMARY: ***Senate Bill 893 would authorize the North Carolina Self-Insurance Guaranty Association to make assessments of group self-insurers, clarify exclusion of individual self-insurers that default on payments, exclude individual self-insurers failing to submit sufficient financial information to the Association, and raise the amount to be deposited by certain self-insurers.***

BACKGROUND: The North Carolina Self-Insurance Guaranty Association is a "nonprofit, unincorporated legal entity which provides for the payment of covered claims [under the Workers' Compensation Act] against member, self-insurers...to avoid financial loss claimants because of the insolvency of member self-insurers." G.S. 97-131. The Association performs its duties under a Plan of Operation established by its Board and approved by the Commissioner of Insurance. The "Association Aggregate Security System" was "established by the Association whereby self-insurers collectively secure their aggregate self-insured workers' compensation liabilities through the {Association]." The Association may assess its members participating in the System based upon factors such as the total amount needed to provide aggregate security and an individual self-insurers' total workers' compensation liabilities and financial strength. The Association annually submits its plan for the System which must be approved by the Commissioner.

BILL ANALYSIS: **Section 1** of the bill would authorize the Association to annually assess **group** self-insurers participating in the System in an amount not to exceed 2% of gross premiums for the preceding calendar year. A group self-insurer is two or more employers who agree to pool their workers' compensation liabilities. Current law authorizes assessments against individual self-insurers.

Section 2 would make a technical amendment to clarify that an individual self-insurer that has defaulted on the payment of it workers' compensation liability is excluded from the System.

Section 3 would add a new subdivision to exclude individual self-insurers that fail to submit sufficient financial information from the System.

Section 4 Under current law, when no Association Aggregate Security System is in effect (this would occur when the Commissioner disapproves the System submitted by the Association), an individual self-insurer with a debt rating of BBB or better from Standard & Poor's must deposit with the Commissioner an amount not less than 25% of total undiscounted outstanding claims, but not less than $500,000. The Commissioner may **increase or decrease** this amount in his or her discretion. All other individual self-insurers must deposit a minimum amount not less than 100% of the self-insurer's outstanding claims, but not less than $500,000, or such **greater** amount as the Commissioner prescribes.

Section 4 would increase the minimum, deposit amount from 25% to 50% of total undiscounted, outstanding claims when no Association Aggregate Security System is in effect for individual self insurers who have a BBB debt rating or better.

EFFECTIVE DATE: Senate Bill 893 becomes effective July 1, 2009.

Tim Hovis, counsel to Senate Commerce, substantially contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 2

SENATE BILL 893
Commerce Committee Substitute Adopted 5/12/09

Short Title: Workers' Comp Self-Insurance Security Ass'n. (Public)

Sponsors:

Referred to:

March 26, 2009

A BILL TO BE ENTITLED

AN ACT TO ALLOW THE NORTH CAROLINA SELF-INSURANCE SECURITY ASSOCIATION TO COLLECT GROUP SELF-INSURER ASSESSMENTS; TO EXCLUDE FROM PARTICIPATION IN THE ASSOCIATION AGGREGATE SECURITY SYSTEM INDIVIDUAL SELF-INSURERS THAT FAIL TO SUBMIT CERTAIN FINANCIAL INFORMATION; AND TO ADJUST DEPOSIT REQUIREMENTS FOR ALL INDIVIDUAL SELF-INSURERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 97-133(a)(3a) is amended by adding a new sub-subdivision to read:

"f. Group assessments. – The Association may annually assess each member group self-insurer in an amount not to exceed two percent (2%) of the group self-insurer's annual gross premiums for the preceding calendar year, as determined under G.S. 105-228.5(b), (b1), and (c)."

SECTION 2. G.S. 97-185(a1)(3) reads as rewritten:

"(3) Individual self-insurers that have defaulted on the payment of ~~its~~ their self-insured workers' compensation liabilities. ~~liabilities from participation in the Association Aggregate Security System.~~"

SECTION 3. G.S. 97-185(a1) is amended by adding a new subdivision to read:

"(4) Individual self-insurers that fail to submit sufficient financial information to enable the Association to determine their total outstanding workers' compensation liabilities, or their creditworthiness, or both."

SECTION 4. G.S. 97-185(b3) reads as rewritten:

"(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 & 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%)~~ fifty percent (50%) 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."

SECTION 5. This act becomes effective July 1, 2009.

ATTACHMENT #1

VISITOR REGISTRATION SHEET

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Penny Burgess	School of Gov.
Cass Cassa	BPMHC
John McMillan	NFIS
Cathy Stahl	Stahl Law Firm
Meredith Henderson	Industrial Commission
Sam Sanders	WCSR
Todd Barlow	NCAJ
Paul Pulley	NCAJ
Chris McLean	Raleigh
Dick Taylor	NCAJ

VISITOR REGISTRATION SHEET

INS — 6-02-09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Wendy Ketaineyerian	Parent, NCAGBell President, & BEGINNINGS
James Mayerson	Beginnings
Jan Alley	BEGINNINGS
Tim DeMayer	Parent
David Skergan	Parent
Natalie Skergan	Parent
Collin Tastet	Child with Hearing Loss
Arthur Tastet	Parent of child with hearing loss
Jennifer Cohyn	IFNC
LOWELL MILLER	NCLHGA
William S. Patterson	Hunton & Williams
ANN LOPE	DUKE

VISITOR REGISTRATION SHEET

INS — 6-02-09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Carsley	BBCG
Daniel Blum	K+L GATES
MaryBe McMillan	NC AFL-CIO
Cory Taylor	Governor's Page
Mary Holcomb	Governor's Page
Josh Ramsey	Governor's Page
Greg Morris	Governors Page
Grant Means	Governor's Page
Josh Patterson	Governors Page
Drew Saunders	Electricities
Jim Skaggin	NCC
Preston Howard	MCIC

VISITOR REGISTRATION SHEET

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
JOE LANIER	520 WICKER
Rose Williams	NCDOI
Ray Martinez	NCDOI
Henry Patterson	Patterson Harkavy LLP
Heidi Chapman	Heidi G. Chapman PLLC
Ann Miller	Universal Finance
Clinton Rivers	Universal Finance PO Box 1087 Mocksville NC 27028
Terri DeMarcus	3226J Myra St Durham NC 27707

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☒Committee Substitute # 1 for

HB 589 A BILL TO BE ENTITLED AN ACT TO REQUIRE HEALTH BENEFIT PLANS AND THE STATE HEALTH PLAN TO COVER HEARING AIDS AND REPLACEMENT HEARING AIDS.

☒ With a favorable report as to the Committee Substitute Bill 2, unfavorable as to Committee Substitute Bill 1, and recommendation that Committee Substitute Bill 2 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/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.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☒Committee Substitute for
SB 780 A BILL TO BE ENTITLED AN ACT TO EXPAND COVERAGE UNDER THE INSURANCE GUARANTY ASSOCIATION WITH RESPECT TO STRUCTURED SETTLEMENT ANNUITIES FOR MATTERS INVOLVING PERSONAL INJURY OR ILLNESS.

☒ With a favorable report as to the House committee substitute bill, unfavorable as to the Senate Committee Sub original bill, and recommendation that the House committee substitute bill be re-referred to the Committee on JUDICIARY III.

(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.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☒Committee Substitute ... for
SB 893 A BILL TO BE ENTITLED AN ACT TO ALLOW THE NORTH CAROLINA SELF-INSURANCE SECURITY ASSOCIATION TO COLLECT GROUP SELF-INSURER ASSESSMENTS; TO EXCLUDE FROM PARTICIPATION IN THE ASSOCIATION AGGREGATE SECURITY SYSTEM INDIVIDUAL SELF-INSURERS THAT FAIL TO SUBMIT CERTAIN FINANCIAL INFORMATION; AND TO ADJUST DEPOSIT REQUIREMENTS FOR ALL INDIVIDUAL SELF-INSURERS.

☒ With a favorable report and recommendation that the bill be re-referred to the Committee on COMMERCE, SMALL BUSINESS, AND ENTREPRENEURSHIP.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ The bill/resolution is re-referred to the Committee on _____.

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 18, 2009

The House Committee on Insurance met at 11:00 AM on Thursday, June 18, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael Wray; Vice Chairs: M. Dickson, J. Dockham and M. Setzer. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Cole, Current, Faison, Gibson, Holliman, Howard, Hughes, Lewis, Pierce and Wainwright.

Chairman Wray called the meeting to order and welcomed visitors. He recognized Sgt-At Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachments)

Chairman Wray recognized Sen. McKissick to explain SB – Authorize Insurance for Former Employees. This bill would authorize certain counties to provide health insurance for former officers and employees of the county that are not receiving retirement benefits. Rep. Gibson made a motion for a favorable report. Motion carried.

Chairman Wray recognized Rep. Gibson to explain SB 981 – Mortgage Guaranty Insurance Revision that was sponsored by Senator Jenkins. Rep. Gibson asked Tim Hovis, Staff Counsel to explain the bill. Mr. Hovis said the bill gives the Commissioner of Insurance discretion to waive the minimum policyholder position financial requirements for mortgage guaranty insurers if the Commissioner finds that the insurer's policyholder's position is reasonable in relationship to the insurer's risk and is adequate to meet the insurer's financial needs, as determined by certain factors listed in the bill. Rep. Braxton moved for a favorable. But after a number of questions Rep. Gibson asked for the bill to the removed and replaced on Tuesday's calendar so it was not vote on in this meeting.

Chairman Wray recognized Rep. Goforth's motion for SB 1029 - PEO Amendment sponsored by Senator Bingham to be before the committee. Sen. Bingham asked Rose Williams with the Department of Insurance to speak on the bill. Ms. Williams said the Department supported the original bill but the PCS has some provision they oppose.

Chairman Wray announced that there will not be a vote on this bill today. He then recognized George Gersoma, CEO with Employer Resources. Mr. Gersoma spoke in support of self-funded PEO's. See comments in Attachment 1.

After more discussion on SB 1029, the committee adjourned at 11:45.

Representative Michael Wray, Chairman

Ann Jordan – Committee Assistant

HOUSE INSURANCE COMMITTEE

June 18, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

SB 468 – AUTHORIZE INSURANCE FOR FORMER EMPLOYEES – Sen. McKissick

SB 981 – MORTGAGE GUARANTY INSURANCE REVISIONS – Sen. Jenkins

SB 1029 – PEO AMENDMENTS – Sen. Bingham

Adjourn

SENATE BILL 468
Second Edition Engrossed 5/14/09
House Committee Substitute Favorable 6/3/09

Short Title: Authorize Insurance for Former Employees. (Public)

Sponsors:

Referred to:

March 9, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE COUNTIES TO PROVIDE HEALTH INSURANCE BENEFITS TO FORMER EMPLOYEES WHO ARE NOT RECEIVING RETIREMENT BENEFITS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 153A-93(d) reads as rewritten:

"(d) A county which is providing health insurance under G.S. 153A-92(d) may provide health insurance for all or any class of former officers and employees of the ~~county who are receiving benefits under subsection (a) of this section.~~county. Such health insurance may be paid entirely by the county, partly by the county and former officer or employee, or entirely by the former officer or employee, at the option of the county."

SECTION 2. G.S. 153A-93 is amended by adding a new subsection to read:

"(d1) Notwithstanding subsection (d) of this section, any county that has elected to and is covering its active employees only, or its active and retired employees under the State Health Plan or elects such coverage under the Plan, may not provide health insurance through the State Health Plan to all or any class of former officers and employees who are not receiving benefits under subsection (a) of this section. The county may, however, provide health insurance to such former officers and employees by any other means authorized by G.S. 153A-92(d). The health insurance premium may be paid entirely by the county, partly by the county and former officer or employee, or entirely by the former officer or employee, at the option of the county."

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

SENATE BILL 468:
Authorize Insurance for Former Employees

2009-2010 General Assembly

Committee:	House Insurance	**Date:**	June 17, 2009
Introduced by:	Sen. McKissick	**Prepared by:**	Ben Popkin
Analysis of:	Third Edition		Committee Counsel

SUMMARY: Senate Bill 468 would authorize certain counties to provide health insurance for former officers and employees of the county that are not receiving retirement benefits.

CURRENT LAW:

G.S. 153A-92(d) allows a county to purchase life insurance or health insurance or both for the benefit of all or any class of county officers and employees as a part of their compensation. A county may provide other fringe benefits for county officers and employees.

G.S. 153A-93(d) allows a county providing health insurance under G.S. 153A-92(d) to provide health insurance for all or any class of former officers and employees of the county who are receiving benefits under G.S. 153A-93(a). The subsection further provides that, at the option of the county, the health insurance may be: paid entirely by the county, partly by the county and former officer or employee, or entirely by the former officer or employee.

G.S. 153A-93(a) allows the board of commissioners to provide for enrolling county officers and employees in the Local Governmental Employees' Retirement System, the Law-Enforcement Officers' Benefit and Relief Fund, the Firemen's Pension Fund, or a retirement plan certified to be actuarially sound by a qualified actuary and may make payments into such a retirement system or plan on behalf of its employees.

BILL ANALYSIS:

Section 1 of Senate Bill 468 would amend G.S. 153A-93(d) to authorize counties to provide health insurance to former officers and employees that are not receiving retirement benefits. The existing language in G.S. 153A-93(d) specifies that at the option of the county, the insurance may be paid partly or entirely by the county or may be paid entirely by the former officer or employee.

Section 2 of the bill would prohibit a county that has elected or elects to participate in the State Health Plan from providing health insurance through the State Health Plan to former officers and employees who are not receiving retirement benefits. The county may provide any other form of health insurance to these officers and employees; however such officer or employee must pay the entire premium.

EFFECTIVE DATE:

Senate Bill 468 would become effective when it becomes law.

Theresa Matula, staff to Senate Pensions and Retirement, and Karen Cochrane-Brown, counsel to House Pensions and Retirement, substantially contributed to this summary.

S468-SMRD-160(e3) v1

SENATE BILL 981
Commerce Committee Substitute Adopted 5/5/09

Short Title: Mortgage Guaranty Insurance Revisions. (Public)

Sponsors:

Referred to:

March 26, 2009

A BILL TO BE ENTITLED

AN ACT TO GIVE THE COMMISSIONER OF INSURANCE DISCRETION TO WAIVE THE MINIMUM POLICYHOLDERS POSITION REQUIREMENT UNDER CERTAIN CIRCUMSTANCES FOR MORTGAGE GUARANTY INSURERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-10-125 reads as rewritten:

"**§ 58-10-125. Policyholders position and capital and surplus requirements.**

(a) For the purpose of complying with G.S. 58-7-75, a mortgage guaranty insurer shall maintain at all times a minimum policyholders position of not less than one twenty-fifth of the insurer's aggregate insured risk outstanding. The policyholders position shall be net of reinsurance ceded but shall include reinsurance assumed.

(b) ~~If~~ Subject to the provisions of subsections (i) through (l) of this section, if a mortgage guaranty insurer does not have the minimum amount of policyholders position required by this section it shall cease transacting new business until the time that its policyholders position is in compliance with this section.

(c) A mortgage guaranty insurer shall at all times maintain capital and surplus in the greater of the amount required by G.S. 58-7-75 or subsection (a) of this ~~section.~~section, unless a waiver is obtained by the mortgage guaranty insurer pursuant to subsection (i) of this section.

(d) through (h) Repealed by Session Laws 2007-127, s. 5, effective July 1, 2007.

(i) The Commissioner may waive the requirement found in subsection (a) of this section at the written request of a mortgage guaranty insurer upon a finding that the mortgage guaranty insurer's policyholders position is reasonable in relationship to the mortgage guaranty insurer's aggregate insured risk and adequate to its financial needs. The request must be made in writing at least 90 days in advance of the date that the mortgage guaranty insurer expects to exceed the requirement of subsection (a) of this section and shall, at a minimum, address the factors specified in subsection (j) of this section.

(j) In determining whether a mortgage guaranty insurer's policyholders position is reasonable in relation to the mortgage guaranty insurer's aggregate insured risk and adequate to its financial needs, all of the following factors, among others, may be considered:

(1) The size of the mortgage guaranty 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 mortgage guaranty insurer's business is diversified across time, geography, credit quality, origination, and distribution channels.

(3) The nature and extent of the mortgage guaranty insurer's reinsurance program.

(4) The quality, diversification, and liquidity of the mortgage guaranty insurer's assets and its investment portfolio.

(5) The historical and forecasted trend in the size of the mortgage guaranty insurer's policyholders position.

(6) The policyholders position maintained by other comparable mortgage guaranty insurers in relation to the nature of their respective insured risks.

(7) The adequacy of the mortgage guaranty insurer's reserves.

(8) The quality and liquidity of investments in affiliates. The Commissioner may treat any such investment as a nonadmitted asset for purposes of determining the adequacy of surplus as regards policyholders.

(9) The quality of the mortgage guaranty insurer's earnings and the extent to which the reported earnings of the mortgage guaranty insurer include extraordinary items.

(10) An independent actuary's opinion as to the reasonableness and adequacy of the mortgage guaranty insurer's historical and projected policyholders position.

(11) The capital contributions which have been infused or are available for future infusion into the mortgage guaranty insurer.

(12) The historical and projected trends in the components of the mortgage guaranty insurer's aggregate insured risk, including, but not limited to, the quality and type of the risks included in the aggregate insured risk.

(k) The Commissioner may retain accountants, actuaries, or other experts to assist the Commissioner in the review of the mortgage guaranty insurer's request submitted pursuant to subsection (i) of this section. The mortgage guaranty insurer shall bear the Commissioner's cost of retaining those persons.

(l) Any waiver shall be (i) for a specified period of time, not to exceed two years unless the Commissioner determines that a longer period is reasonable and justified under the circumstances, and (ii) subject to any terms and conditions that the Commissioner shall deem best suited to restoring the mortgage guaranty insurer's minimum policyholders position required by subsection (a) of this section."

SECTION 2. This act becomes effective July 1, 2009.

SENATE BILL 981:
Mortgage Guaranty Insurance Revisions

2009-2010 General Assembly

Committee:	House Insurance	**Date:**	June 17, 2009
Introduced by:	Sen. Jenkins	**Prepared by:**	Tim Hovis
Analysis of:	Third Edition		Committee Counsel

SUMMARY: ***Senate Bill 981 authorizes the Commissioner of Insurance to waive the minimum policyholders position financial requirements for mortgage guaranty insurers if the Commissioner finds that the insurer's policyholders position is reasonable in relationship to the insurer's risk and is adequate to meet the insurer's financial needs, as determined by certain factors listed in the bill.***

[As introduced, this bill was identical to H1150, as introduced by Rep. Holliman, which is currently in House Financial Institutions, if favorable, Insurance.]

BACKGROUND: Mortgage guaranty insurance, also known as private mortgage insurance provides coverage for losses incurred by a mortgage lender resulting from a borrower's failure or inability to make mortgage payments. Typically, mortgage guaranty insurance is purchased by the borrower for the protection of the lender.

According to the Department of Insurance, more guaranty insurers are domiciled in NC than any other state in the country.

CURRENT LAW: G.S. 58-10-125 requires guaranty insurers to maintain at all times a minimum policyholders position of not less than 1/25th of the insurers outstanding risk. The policyholders position is the sum of the contingency reserve of the insurer and the policyholders' equity (the insurer's net worth). If the insurer fails to maintain the minimum policyholders position, it must cease transacting new business until it reaches the required minimum position.

BILL ANALYSIS: Senate Bill 981 authorizes the Commissioner to waive the minimum policyholders position financial requirements if the Commissioner finds that the insurer's policyholders position is reasonable in relationship to the insurer's risk and is adequate to meet the insurer's financial needs. An insurer must request a waiver in writing at least 90 days in advance of the date the insurer expects to exceed the required minimum policyholders position.

In determining whether insurer's policyholders position is reasonable and adequate, the Commissioner shall consider the following factors (among others):

- The size of the mortgage guaranty insurer as measured by assets, capital, surplus reserves, premiums, and other criteria.
- The extent to which its business is diversified across time, geography, credit quality, etc.
- The nature and extent of its reinsurance.
- The quality, diversification, and liquidity of its assets and investments.
- The historical and forecasted trend in its policyholders position.
- The policyholders position of comparable companies.
- The adequacy of its reserves.
- The quality and liquidity of investment in affiliates.
- The quality of its earnings.

- An independent actuary's opinion of its policyholders position.
- Actual and potential capital contributions.
- Historical and forecasted trends in its aggregate risk.

The Commissioner may retain experts to assist in the review of the request. The mortgage guaranty insurer bears the Commissioner's costs in retaining those persons.

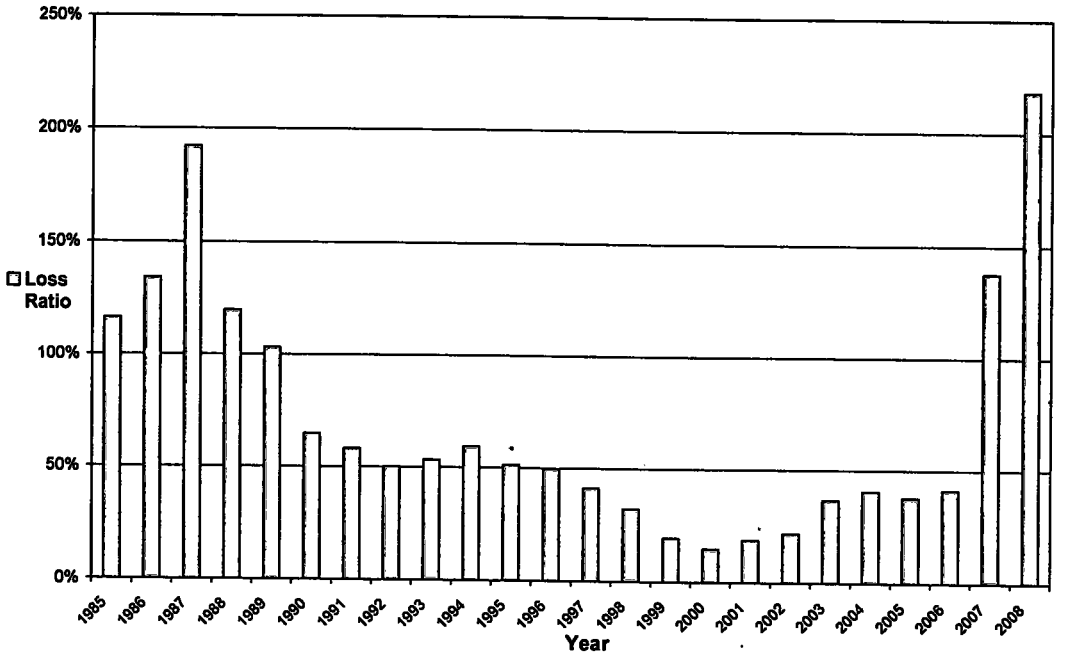
The waiver must be:

- For a specified period of time, not to exceed two years, unless the Commissioner determines that a longer period is justified under the circumstances.
- Subject to any terms and conditions that the Commissioner deems best suited to restoring the insurer's minimum policyholders position.

EFFECTIVE DATE: This act becomes effective July 1, 2009.

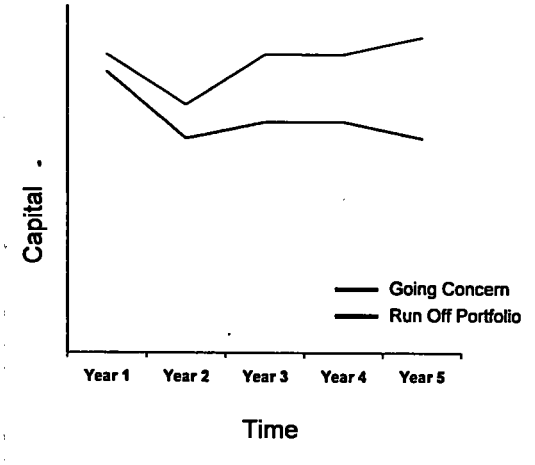
S981-SMRG-74(e3) v1

MI Industry Loss Ratios, 1985 to 2008



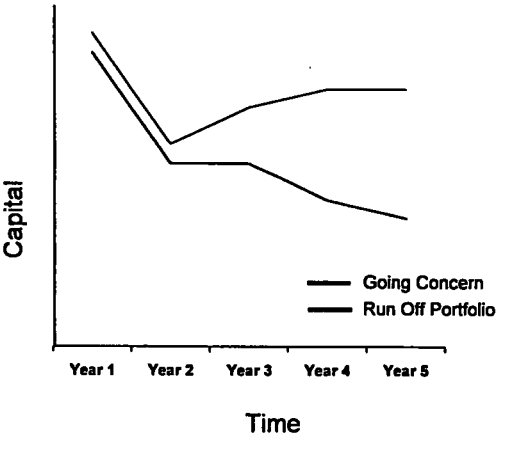
Importance of New Business To MIs

Moderate Environment



Illustrative Example

Stress Environment



Illustrative Example

25:1 is Arbitrary and Breach Consequences Automatic. Flexibility Allows Otherwise Solvent and Solid Company to Write New Business and Continue to Support Economy Through Downturn

Talking Points for S. 981
Mortgage Guaranty Insurance Revision

- This is a challenging time for the private mortgage insurance industry and for the housing finance industry generally.

- The legislation assures the continued availability of private mortgage insurance, which plays a crucial role in the residential housing market.

- The health of mortgage insurers is an important component in any economic recovery effort and is particularly important for low/moderate income homebuyers and first-time homebuyers.

- Current economic conditions, characterized by rising unemployment, falling home values, increasing delinquencies, and tighter credit standards have driven higher claims rates for insurers.

- Current law requires private mortgage insurers to cease writing mortgage insurance policies if the company exceeds the required 25-to-1 risk/capital ratio.

- Under this inflexible standard, some companies are at risk of being forced to stop writing new business, even though these companies are sufficiently capitalized to meet all of their obligations.

- Such an outcome would only serve to further delay recovery of the housing market, making loans harder to come by at the worst possible time.

- This legislation would give the Commissioner of Insurance discretion to temporarily waive the risk-to-capital ratio requirement for private mortgage insurers for up to 2 years.

- The Department of Insurance has worked with industry to develop a set of objective criteria for the Commissioner to consider in granting such a waiver. **The Department of Insurance and the private mortgage industry both strongly support this bill.**

- Granting the Commissioner this flexibility will allow the Commissioner to protect policyholders, while simultaneously working to ensure the health of the private mortgage industry during a period of extraordinary economic circumstances.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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SENATE BILL 1029
Commerce Committee Substitute Adopted 5/4/09
House Committee Substitute Favorable 6/10/09
PROPOSED HOUSE COMMITTEE SUBSTITUTE S1029-CSRD-67 [v.1]

6/18/2009 9:57:46 AM

Short Title: PEO Amendments. (Public)

Sponsors:

Referred to:

March 31, 2009

A BILL TO BE ENTITLED

AN ACT TO AMEND THE NORTH CAROLINA PROFESSIONAL EMPLOYER ORGANIZATION ACT CONCERNING BONDING PROVISIONS AND MAINTENANCE OF EMPLOYEE BENEFITS, AND TO CLARIFY THE APPLICATION OF TAX CREDITS AND OTHER INCENTIVES TO PROFESSIONAL EMPLOYER ORGANIZATIONS.

The General Assembly of North Carolina enacts:

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

"(a) An applicant for licensure shall file with the Commissioner a surety bond for the benefit of the Commissioner as follows:

(1) If the applicant was initially licensed prior to October 1, 2008, the bond, or other items as provided for in subsection (f) of this section, shall be in the amount of one hundred thousand dollars ($100,000).

(2) If the applicant was not initially licensed prior to October 1, 2008, the bond, or other items as provided for in subsection (f) of this section, shall be in an amount equal to five percent (5%) of the applicant's prior year's total North Carolina wages, benefits, workers compensation premiums, and unemployment compensation contributions, but not greater than five hundred thousand dollars ($500,000), or such greater amount as the Commissioner may require."

SECTION 2. G.S. 58-89A-105 reads as rewritten:

"**§ 58-89A-105. Employee benefit plans; required disclosure; other reports.**

(a) A licensee may sponsor and maintain employee benefit plans for the benefit of assigned employees. Any health insurance plan sponsored and maintained by a licensee licensed on or after October 1, 2009, shall only be fully insured by one of the following:

(1) A licensed insurance company that is authorized to write accident and health insurance, as defined in G.S. 58-7-15(3).

(2) A service corporation organized and licensed under Article 65 of this Chapter.

(3) A health maintenance organization organized and licensed under Article 67 of this Chapter.

(a1) A client company may sponsor and maintain employee benefit plans for the benefit of assigned employees.

(b), (c) Repealed by Session Laws 2008-124, s. 7.4, effective October 1, 2008.

(d) For the purposes of this section, a health insurance plan is fully insured only if all of the benefits provided under the plan are covered by an approved policy issued by one or more of the entities specified in subsection (a) of this section. A health insurance plan is not fully insured if the plan is any form of stop-loss insurance or any other form of reinsurance.

(e) ~~Existing licensees shall comply with subsection (a) of this section by October 1, 2009. Before October 1, 2009, if an~~ An existing licensee ~~sponsors and maintains~~ that sponsored and maintained any health insurance plan that is not fully insured by one or more of the entities specified in subsection (a) of this ~~section, the licensee~~ section before October 1, 2009, shall do all of the following:

(1) Use a third-party administrator licensed or registered under Article 56 of this Chapter.

(2) Hold all plan assets, including participant contributions, in a trust account.

(3) Provide sound reserves for the plan as determined by generally accepted actuarial standards.

(4) "

SECTION 3. G.S. 58-89A-31 reads as rewritten:

"**§ 58-89A-31. Tax credits and other incentives.**

For purposes of determination of tax credits and other economic incentives provided by the State or a political subdivision and based on employment, covered employees are considered employees solely of the client. A client shall be entitled to the benefit of any tax credit, economic incentive, or other benefit arising as the result of the employment of covered employees of the client. Each professional employer organization must provide, upon request by a client, employment information that is required by any agency or department of the State or a political subdivision responsible for administration of any tax credit or economic incentive and that is necessary to support a request, claim, application, or other action by a client seeking the tax credit or economic incentive. For purposes of this section, the term "political subdivision" has the same meaning as in G.S. 162A-65(a)(8)."

SECTION 4. This act becomes effective October 1, 2009.

Doug Dersema
CCO - PEO Employers Resources

Senate Bill 1029

ATTACHMENT #1

Protect Health Insurance Options for North Carolina Small Businesses

The PCS to S. 1029, a bill that makes changes to North Carolina's Professional Employer Organization (PEO) law, contains an important provision that will protect affordable health coverage for hundreds of employees and the small businesses for which they work.

In 2008, the General Assembly made significant changes to the state's PEO law, notably prohibiting PEO self-funded health plans effective October 1, 2009. The changes were prompted by the highly publicized failure of an *unlicensed* PEO that allegedly committed fraud against its clients. That law will unnecessarily deprive North Carolinians of a cost-effective health benefit option. This is especially burdensome in an environment where one in five businesses nationwide is no longer able to offer health insurance.

The PCS will protect small business health coverage for hundreds of North Carolinians.

The PCS will allow licensed PEOs that operate self-funded health plans prior to October 1, 2009 to continue to offer self-funded health benefit plans if they comply with the following requirements:

(1) Use a third-party administrator licensed or registered under Article 56 of this Chapter.
(2) Hold all plan assets, including participant contributions, in a trust account.
(3) Provide sound reserves for the plan as determined by generally accepted actuarial standards.

Licensed PEOs operating self-funded health benefit plans have a track record of successful operation in North Carolina. There are a limited number of these PEOs and all are subject to regulatory oversight by the Department of Insurance.

Talking points for PEO self-funded health plan provision

- This PCS contains an important provision that will protect affordable health coverage for hundreds of employees and the small businesses for which they work.

- The reason this provision is needed is that late last session, the General Assembly made changes to the state's PEO law, notably passing an outright prohibition on PEO self-funded health plans effective October 1, 2009.

- The changes were prompted by the highly publicized failure of an *unlicensed* PEO, The Castleton Group, that allegedly committed fraud against its clients.

- The law we passed will unnecessarily deprive North Carolinians of a cost-effective health benefit option. This is especially burdensome in an environment where one in five businesses nationwide is no longer able to offer health insurance to their employees.

- These health plans represent an affordable insurance option for small businesses that want to provide coverage for their employees, but cannot afford other more expensive insurance products. Without this alternative, these employees will likely stop providing insurance coverage as of October 1st of this year.

- To ensure that we don't take health care options away from small businesses, the provision will allow licensed PEOs that operate self-funded health plans prior to October 1, 2009 to continue to offer self-funded health benefit plans if they comply with the following requirements:

(1) Use a third-party administrator licensed or registered in the state.
(2) Hold all plan assets, including participant contributions, in a trust account.
(3) Provide sound reserves for the plan as determined by generally accepted actuarial standards.

- Licensed PEOs operating self-funded health benefit plans have a track record of successful operation in North Carolina.

- There are a limited number of these PEOs and all are subject to regulatory oversight by the Department of Insurance.

ATTACHMENT #1

VISITOR REGISTRATION SHEET

Insurance — **Name of Committee**

6/18/09 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tammy Moran	Lane + Associates
Paul Mahoney	CAPSTRAT
Leslie Belanger Coman	Capstrat
George Gersema	Employers Resource
Doug Miskiew	Capstrat
John Taggart	Genworth
Joe Lanier	520 Wicker
Cindie Louve	RMIC Corp.
Crystal Martin	RMIC
David Green	Genworth Financial
Joanne Hree	Genworth Financial

VISITOR REGISTRATION SHEET

House Committee on Insurance — 6/18/09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Daniel Baum	K+L Gates
Wendy Kelly	SZD Lobbyists
Tony Riddick	NCDOI
Kristin Milam	NCDOI
Sonny Watts	NC DOI
Ron Ennis	NC DOI
J.C. Teller	Dearborn Co.
Patricia C. Ramer	NCACC
Ed Turlington	Brooks Pierce
Adam Pearson	NAPEO
Jeff Butts	Lobbyist & Associates, PPS PA

VISITOR REGISTRATION SHEET

Way & Mean — 6/17/09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mark Deason	AT&T
Sherry Pelkington	NC DOC
Mildred Spearman	NCDOC
Lemuel Hinton	NCUC
Daniel Long	NCUC
Amanda Garrett	NCARD
Kim Hargrove	NCARD
Andrew Meehan	NCAEC
Gene Ainsworth	A & A
Jim Blackburn	Association of County Commissioners
Stan Pace	Verizon

VISITOR REGISTRATION SHEET

House Committee on Insurance — 6/18/09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lindsay Clifton	Gov's Office
Judy Chrucie	Sen. Bingham
John Hoomani	NCDOL
Christopher Lizak	NCM Capital Mgmt. Group Durham, NC
Ashley J. Bell	American Cancer Society
Penny Burgin	School of Gov.
Allan Beckmann	NC DST
Ron Sanyal	Non-Profit Org.
Steven Waters	
Alicia Dotts	MWC
Stephen Wohlers	NCDOI
Rose Williams	NCDOT

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ted Hamby	NC DOI

HOUSE PAGES

NAME OF COMMITTEE Insurance DATE 6/18/09

1. Name: Brantley Craft
   County: Guilford
   Sponsor: Harrison
2. Name: Jake Evans
   County: Caldwell
   Sponsor: Edgar Starnes
3. Name: Jim Stirling
   County: Wake
   Sponsor: Speaker Hackney
4. Name: Berkeley Bennett
   County: Wake
   Sponsor: Speaker of the House
5. Name:
   County:
   Sponsor:

SGT-AT-ARM

1. Name: Young Bae
2. Name: Judy Turner
3. Name:
4. Name:

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

House By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☒Committee Substitute for

SB 468 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE COUNTIES TO PROVIDE HEALTH INSURANCE BENEFITS TO FORMER EMPLOYEES WHO ARE NOT RECEIVING RETIREMENT BENEFITS.

☒ 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 _____.

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 23, 2009

The House Committee on Insurance met at 11:00 AM on Tuesday, June 23, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael H. Wray; Vice Chairs: M. Dickson, J. Dockham and M. Setzer. Members attending were Reps. Barnhart, Braxton, Brubaker, Cole, Current, Faison, Gibson, Holliman, Howard, Hughes, Lewis, Pierce and Wainwright.

Chairman Goforth called the meeting to order and welcomed visitors. He recognized Sgt-At-Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachment #1)

Chairman Goforth recognized Rep. Dale Folwell to explain HB 1483 - UNC Infirmaries/State Health Plan Network. HB 1483 would direct the Executive Director of the State Health Plan to negotiate with the Plan's claims processing contractor to include the UNC infirmaries in the network of providers under the Plan. Rep. Folwell shared coverage and price summary for the UNC campuses. (Attachment #2) He has to do more work on how to get the infirmaries in the network and will not ask for a vote on the bill today.

Chairman Goforth recognized Rep. Gibson to explain SB 981-Mortgage Guaranty Insurance Revisions. At a previous meeting, a motion for a favorable report was made by Rep. Braxton. After much discussion, Rep. Braxton moved for a favorable report, and the motion carried.

The meeting adjourned at 11:47 AM.

Bruce Goforth

Representative Bruce Goforth, Chairman

Mary Capps

Mary Capps – Committee Assistant

HOUSE INSURANCE COMMITTEE

June 23, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

HB 1483 – UNC INFIRMARIES/STATE HEALTH PLAN NETWORK – Reps. Folwell, Samuelson, Neumann and Whilden

SB 981 – MORTGAGE GUARANTY INSURANCE REVISIONS – Sen. Jenkins

Adjourn

HOUSE BILL 1483

Short Title:	UNC Infirmaries/State Health Plan Network.	(Public)
Sponsors:	Representatives Folwell, Samuelson, Neumann, Whilden (Primary Sponsors); Hurley and Jackson.	
Referred to:	Insurance, if favorable, Appropriations.	

April 13, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE STATE HEALTH PLAN TO NEGOTIATE WITH ITS CLAIMS PROCESSING CONTRACTOR TO INCLUDE UNC INFIRMARIES IN THE CLAIMS PROCESSING CONTRACTOR'S PROVIDER NETWORK.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-45(d) reads as rewritten:

"(d) The Plan benefits shall be provided under contracts between the Plan and the claims processors selected by the Plan. The Executive Administrator may contract with a pharmacy benefits manager to administer pharmacy benefits under the Plan. Such contracts shall include the applicable provisions of G.S. 135-45.1 through G.S. 135-45.15 and the description of the Plan in the request for proposal, and shall be administered by the respective claims processor or Pharmacy Benefits Manager, which will determine benefits and other questions arising thereunder. The contracts necessarily will conform to applicable State law. If any of the provisions of G.S. 135-45.1 through G.S. 135-45.15 and the request for proposals must be modified for inclusion in the contract because of State law, such modification shall be made. If the Plan uses a network of providers that is under contract with the Plan's claims processing contractor, the Executive Administrator may negotiate with the claims processing contractor to include certain providers in the claims processing contractor's network."

SECTION 2. The Executive Administrator of the State Health Plan for Teachers and State Employees shall negotiate with its claims processing contractor to include UNC infirmaries in the claims processing contractor's provider network.

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

HOUSE BILL 1483:
UNC Infirmaries/State Health Plan Network

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Appropriations	**Date:**	June 17, 2009
Introduced by:	Reps. Folwell, Samuelson, Neumann, Whilden	**Prepared by:**	Bill Patterson Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***House Bill 1483 directs the Executive Director of the State Health Plan to negotiate with the Plan's claims processing contractor to include the UNC infirmaries in the network of providers under the Plan.***

CURRENT LAW: G.S. 145-135(d) requires that benefits under the State Health Plan be provided under contracts with claim processors selected by the Plan.

BILL ANALYSIS: Section 1 of the bill authorizes the State Health Plan's Executive Director to negotiate with the claims processing contractor to include certain providers in the Plan's provider network. Section 2 of the bill directs the Executive Director to negotiate with the claims processing contractor to include UNC infirmaries in the Plan's provider network.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: Blue Cross Blue Shield of North Carolina is the current State Health Plan claims processor responsible for negotiating contracts with the Plan's network providers.

UNC infirmaries provide outpatient health services to students enrolled at the constituent institutions of the University of North Carolina. Non-students are not eligible for treatment at UNC infirmaries. Specific benefits and eligibility requirements vary from campus to campus. Most professional charges, excluding specialty care, are covered by the student health services fee paid by each student. Non-covered charges are generally paid at the time of service or charged to the student's university account. UNC infirmaries are not currently State Health Plan network providers.

H1483-SMTG-70(e1) v8

ATTACHMENT #2

Question #9: How does the coverage and price from the responses to the fall 2008 RFP compare to current student health insurance plans?

Campus	Current 2008 - 2009			Results From Fall 2008 RFP		
	Participation	Maximum Basic Benefit	Annual Student Premium	Participation	Maximum Basic Benefit	Annual Student Premium
ASU	voluntary purchase	$10,000	$1,008	hard waiver	$100,000	$549-$679
	did not purchase	$0	$0	hard waiver	$100,000	$549-$679
ECU	voluntary purchase	$50,000	$1,294	hard waiver	$100,000	$549-$679
	did not purchase	$0	$0	hard waiver	$100,000	$549-$679
ECSU	hard waiver	$6,000	$456	hard waiver	$100,000	$549-$679
FSU	hard waiver	$6,000	$396	hard waiver	$100,000	$549-$679
NCA&T	hard waiver	$10,000	$458	hard waiver	$100,000	$549-$679
NCCU	hard waiver	$5,000	$516	hard waiver	$100,000	$549-$679
NCSU	voluntary purchase	$100,000	$1,161	hard waiver	$100,000	$549-$679
	did not purchase	$0	$0	hard waiver	$100,000	$549-$679
UNC-A	hard waiver	$30,000	$611	hard waiver	$100,000	$549-$679
UNC-C	hard waiver	$50,000	$688	hard waiver	$100,000	$549-$679
UNC-CH	voluntary purchase	$250,000	$1,565	hard waiver	$100,000	$549-$679
	did not purchase	$0	$0	hard waiver	$100,000	$549-$679
UNC-G	hard waiver	$100,000	$780	hard waiver	$100,000	$549-$679
UNC-P	hard waiver	$6,000	$486	hard waiver	$100,000	$549-$679
UNCSA	hard waiver	$5,000	$380	hard waiver	$100,000	$549-$679
UNC-W	voluntary purchase	$30,000	$1,452	hard waiver	$100,000	$549-$679
	did not purchase	$0	$0	hard waiver	$100,000	$549-$679
WCU	hard waiver	$30,000	$596	hard waiver	$100,000	$549-$679
WSSU	hard waiver	$10,000	$448	hard waiver	$100,000	$549-$679

Question #10: How many uninsured students are on the five campuses with voluntary plans?

Answer: The estimate by each Student Health Center Director for his/her campus is: 9-10%, 10%, 10-15%, 15-20%, and 18-33%. This does not factor in that the RFP excludes students enrolled for less than 6 credit hours or only taking distance education classes (see Question #2).

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: House Bill 1483 (First Edition)

SHORT TITLE: UNC Infirmaries/State Health Plan Network.

SPONSOR(S): Representatives Folwell, Neumann, Samuelson, and Whilden

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY: HB 1483 requires the Plan to negotiate with its Claims Processing Contractor (CPC) to include campus medical infirmaries operated by UNC system schools' in the provider network operated by the CPC.

EFFECTIVE DATE: When it becomes law.

ESTIMATED IMPACT ON STATE:

Aon Consulting, the consulting actuary for the State Health Plan for Teachers and State Employees, comments that the proposed legislation would have an impact to the Plan's costs, but notes that these costs are not quantifiable based on available information.

Hartman and Associates, the consulting actuary for the General Assembly's Fiscal Research Division, comments that implementation costs are reported to be in a range of $180,000 to $260,000 based on information provided by the Plan's Claims Processing Contractor. Hartman also notes that potential impact on the Plan's annual medical claims costs is not quantifiable based on available information from the Plan's Claims Processing Contractor.

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Given that the bill affects a potential legal and administrative relationship between the Claims Processing Contractor (CPC) and a UNC campus-based medical provider focused on student care, no independent actuarial analysis of data was possible. All assumptions and cost estimates reported by each consulting actuary were provided by the Plan and its Claims Processing Contractor and were not independently evaluated.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2008, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.6 billion for FY 2008-09. The Plan's PPO benefit design includes three alternative benefit levels offered to plan members. The three alternative benefit levels include the following:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums;

2) The "Standard" 80/20 plan; and

3) The "Plus" 90/10 plan with enhanced benefits via lower out-of pocket requirements as compared to the other PPO plan alternatives offered.

As of July 1, 2009, the State will continue to finance the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts will be derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage will be paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.5 billion for FY 2009-10 and $2.7 billion for FY 2010-11. The Plan's PPO benefit design will include two alternative benefit levels listed below:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums; and

2) The "Standard" 80/20 plan.

The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under both plans is offered on a fully contributory basis.

Financial Condition

Financial Projection (Revised Summer 2008) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year were projected to be $2.3 billion from premium collections, $53.9 million from Medicare Part D subsidies, and $2.7 million from investment earnings, for a total of slightly over $2.3 billion in receipt

income for the year. Projected disbursements from the Plan were expected to be $2.4 billion in claim-payment expenses and $168.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating loss was projected to be approximately $264.4 million for the fiscal year, assuming a 9% annual claims growth trend.

Projected operating losses were expected to deplete the Plan's cash balance of $139.8 million and leave it without sufficient operating resources to continue operations for the fiscal year.

Financial Projection (Revised April 2009) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year are projected to be $2.3 billion from premium collections, $49.0 million from Medicare Part D subsidies, $3.3 million from investment earnings, and $250.0 million from a direct General Fund appropriation from the Rainy Day Fund (Savings Reserve Account) for a total of approximately $2.6 billion in receipt income for the year. The $250 million from a direct General Fund appropriation was provided by Session Law 2009-16 (Senate Bill 287) to finance a shortfall in funds available to pay health care benefits, administrative costs, and adequately fund the Plan's beginning cash balance on July 1, 2009. Projected disbursements from the Plan are expected to be $2.4 billion in claim-payment expenses and $180.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating income is projected to be approximately $7.1 million for the fiscal year, assuming a 9% annual claims growth trend.

Financial Projection 2009-11 Biennium (April 2009) – Session Law 2009-16 (Senate Bill 287) appropriates funds from various sources, authorizes annual premium rate increases, makes various benefit and provider related changes to achieve financial savings, and directs other various changes to the Plan. The enacted law also appropriates the sum of $250 million from the Savings Reserve Account ("Rainy Day Fund") of the General Fund for the 2008-09 fiscal year. The following summarized financial projections by fiscal year for the 2009-11 biennium assume the changes enacted in Session Law 2009-16 (Senate Bill 287).

For the fiscal year beginning July 1, 2009, the Plan is projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year are projected to be $2.4 billion from premium collections, $56.3 million from Medicare Part D subsidies, and $8.0 million from investment earnings for a total of approximately $2.5 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.3 billion in claim-payment expenses and $185.6 million in administration and claims-processing expenses for projected total expenses of nearly $2.5 billion for FY 2008-09.. The Plan's net operating income is projected to be approximately $14.8 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan is projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year are projected to be $2.7 billion from premium collections, $50.4 million from Medicare Part D subsidies, and $8.8 million from investment earnings for a total of approximately $2.7 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.5 billion in claim-payment expenses and $191.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.7 billion for FY 2010-11. The Plan's operating income is projected to be approximately $30.6 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Other Information

Historically, the Plan has applied a premium increase in October of the first fiscal year of a biennium. However, the annual premium increases authorized in Session Law 2009-16 (Senate Bill 287) changes that methodology to an annual increase at the beginning of each fiscal year of the 2009-11 biennium.

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment Data as of December 31, 2008

I. No. of Participants	Basic	Standard	Plus	Total	Percent of Total
Actives					
Employees	11,623	271,243	47,687	330,553	49.6%
Dependents	20,454	115,875	28,156	164,485	24.7%
Sub-total	32,077	387,118	75,843	495,038	74.2%
Retired					
Employees	1,726	127,081	17,967	146,774	22.0%
Dependents	1,117	14,935	3,476	19,528	2.9%
Sub-total	2,843	142,016	21,443	166,302	24.9%
Former Employees with Continuation Coverage					
Employees	60	1,349	344	1,753	0.3%
Dependents	61	501	182	744	0.1%
Sub-total	121	1,850	526	2,497	0.4%
Firefighters, Rescue Squad & National Guard					
Employees	-	3	2	5	0.0%
Dependents	-	3	-	3	0.0%
Sub-total	-	6	2	8	0.0%
Local Governments					
Employees	72	1,577	319	1,968	0.3%
Dependents	141	637	218	996	0.1%
Sub-total	213	2,214	537	2,964	0.4%
Total					
Employees	13,481	401,253	66,319	481,053	72.1%
Dependents	21,773	131,951	32,032	185,756	27.9%
Grand Total	**35,254**	**533,204**	**98,351**	**666,809**	**100%**
Percent of Total	**5.3%**	**80.0%**	**14.7%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	2,684	328,635	49,246	380,565
Employee Child(ren)	4,958	36,903	8,589	50,450
Employee Spouse	2,274	18,145	4,469	24,888
Employee Family	3,565	17,570	4,015	25,150
Total	**13,481**	**401,253**	**66,319**	**481,053**

Percent Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	19.9%	81.9%	74.3%	79.1%
Employee Child(ren)	36.8%	9.2%	13.0%	10.5%
Employee Spouse	16.9%	4.5%	6.7%	5.2%
Employee Family	26.4%	4.4%	6.1%	5.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Enrollment Data Continued

III. Enrollment by Sex	Basic	Standard	Plus	Total
Female	18,837	334,917	61,752	415,506
Male	16,417	198,287	36,599	251,303
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Sex	Basic	Standard	Plus	Total
Female	53.4%	62.8%	62.8%	62.3%
Male	46.6%	37.2%	37.2%	37.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	17,390	136,277	27,211	180,878
30 to 44	8,125	107,375	17,315	132,815
45 to 54	5,164	94,548	18,277	117,989
55 to 64	3,195	102,901	23,452	129,548
65 & Over	1,380	92,103	12,096	105,579
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	49.3%	25.6%	27.7%	27.1%
30 to 44	23.0%	20.1%	17.6%	19.9%
45 to 54	14.6%	17.7%	18.6%	17.7%
55 to 64	9.1%	19.3%	23.8%	19.4%
65 & Over	3.9%	17.3%	12.3%	15.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	49,534	12,080	61,614
Medicare Eligible	97,240	7,448	104,688
Total	**146,774**	**19,528**	**166,302**

Percent by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.7%	61.9%	37.0%
Medicare Eligible	66.3%	38.1%	63.0%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, "House Bill 1483 An Act to Direct the State Health Plan to Negotiate With Its Claims Processing Contractor to Include UNC Infirmaries in the Claims Processing Contractor's Provider Network", June 20, 2009, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "House Bill 1483 UNC Infirmaries/State Health Plan Network", June 22, 2009, original of which is on file with the Comprehensive Major Medical Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

"HB 1483, UNC Infirmaries/State Health Plan Network", State Health Plan for Teachers and State Employees, June 21, 2009.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Marilyn Chism, Director
Fiscal Research Division

DATE: June 22, 2009

Signed Copy Located in the NCGA Principal Clerk's Offices

HARTMAN & ASSOCIATES, LLC

ACTUARIAL CONSULTING

.RK V. HARTMAN, FSA, MAAA, MCA, EA

hartman@triad.rr.co

Phone: (336) 731-4038
Fax: (336) 731-2583

668 Link Road
Lexington, NC 27295

June 20, 2009

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: House Bill 1483: An Act to Direct the State Health Plan to Negotiate With Its Claims Processing Contractor to Include UNC Infirmaries in the Claims Processing Contractor's Provider Network

Dear Mr. Trogdon:

This bill amends G.S. 135-45(d) to specifically authorize the Executive Administrator of the North Carolina State Health Plan for Teachers and State Employees (the "Plan") to negotiate with the Plan's claims processing contractor to include certain providers in the claims processing contractor's network. The bill then directs the Executive Administrator to negotiate with the claims processing contractor to include UNC infirmaries in the claims processing contractor's provider network.

This act is effective when it becomes law.

Information provided by the Plan and its claims processing contractor indicates implementation costs of $214,000 to $306,000 to include the UNC infirmaries and coordinate benefits under the State Health Plan. This analysis also indicates that the impact on the Plan's claim costs is not quantifiable.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, FCA, EA
Consulting Actuary

MVH/mt

NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

HOUSE BILL 1483

UNC INFIRMARIES / STATE HEALTH PLAN NETWORK

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30305

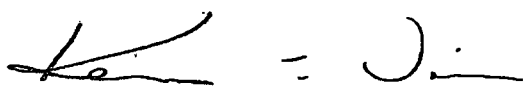
June 2009

ACTUARIAL STATEMENT

The North Carolina State Health Plan for Teachers and State Employees has requested that Aon Consulting prepare an Actuarial Note in response to House Bill 1483 entitled "An Act To Direct The State Health Plan To Negotiate With Its Claims Processing Contractor To Include UNC Infirmaries In The Claims Processing Contractor's Provider Network."

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.



June 22, 2009

Kenneth C. Vieira, F.S.A., M.A.A.A.
Senior Vice President

Date

June 22, 2009

Kirsten R. Schatten, A.S.A., M.A.A.A.
Assistant Vice President

Date

UNC INFIRMARIES / STATE HEALTH PLAN NETWORK

PLAN CHANGES

The proposed legislation requires the Plan to negotiate with its Claims Processing Contractor (CPC) to include UNC infirmaries in the CPC's provider network. The full text of the bill is attached to this actuarial note.

PROJECTED COSTS

	Based on "Midpoint" Increase (in millions)		
Plan Design Change	2009-2010 Fiscal Year Cost	2010-2011 Fiscal Year Cost	Total Biennium Cost
Require Plan to negotiate with CPC to include UNC infirmaries in CPC network	Fiscal impact cannot be quantified		

PRICING APPROACH AND COMMENTS

The following information was compiled and utilized in determining the projected costs or savings of each benefit component addressed in this actuarial note:

- Fiscal impact considerations related to the proposed changes outlined in this bill were provided to Aon by State Health Plan based on information received from the Plan's Claims Processing Contractor. This Analysis is attached to this actuarial note.

- Aon expects the bill will have a fiscal impact on the Plan's cost; however, we do not believe the impacts can be quantified for purposes of an actuarial note.

Analysis
House Bill 1483
UNC Infirmaries / State Health Plan Network

H1483 Synopsis

This Bill mandates in Section 1 that the "Executive Administrator may negotiate with the claims processing contractor to include certain providers in the claims processing contractor's network." Section 2 states: "The Executive Administrator of the State Health Plan for Teachers and State Employees shall negotiate with its claims processing contractor to include UNC infirmaries in the claims processing contractor's provider network." The act is effective when it becomes law.

Current Situation—How Infirmaries are Structured

- There are sixteen UNC campuses statewide.
- Each campus charges a Student Health Fee as a part of the tuition and fees.
    - Part –time students may have access depending upon how many hours they are enrolled in at the university, and the campus.
- That Student Health Fee covers certain services in full; however, it is not an insurance plan.
- Services covered at 100% under the Student Health Fee may vary from campus-to-campus.
- The Infirmaries also offer certain services that may vary from campus to campus on a fee-for-service basis.
- **It is the fee –for- service health care expenses that H1483 is trying to address; currently, UNC infirmaries do not participate in the BCBSBNC network.**
- University infirmaries typically are not set up to negotiate with insurance carriers or administrators, collect copays, and file claims for services on behalf of members.

Cost Impact Analysis

An implementation cost impact was prepared by the Claims Processing Contractor, and is included with this analysis. Upon further review of this estimate with the Claims Processing Contractor, several components for implementation and ongoing administration were not considered in the initial analysis. In addition, there is no incentive or mandate in the Bill for UNC to contract with the Claims Processing Contractor, so SHP could pay charges for services at these providers.

This is not a simple addition of a group of providers to a network. Each infirmary has a unique grouping of services that it covers under the umbrella of the Student Health Fee in full through the university. Some student health centers offer different services and a broader range of services on a fee-for-service basis to their students than other campuses.

Also, in all other cases with provider networks, benefits are paid based on a benefit plan connected with an employer group. In this case, the benefit plan would somehow have to be attached to the provider group to 'recognize' and carve out those services that are covered under the Student Health

Services fee. The claims processing system would need to recognize whether a service that was billed was included in the Student Health Fee or not.

It is also not a simple coordination of benefits (COB) because school infirmary services are not health benefit plans. Therefore, students have to either be placed in unique benefit plans that are connected somehow to their parents plan for the calculation of family deductible and coinsurance, or a business process will need to be set up to manually determine benefits and which services are included or excluded from the Student Health Fee each time a claim is submitted.

The range of costs estimated by the Claims Processing Contractor to implement the program would be **$214,000 to $306,000.** That includes setting up 32 unique plans, 16 for Basic and 16 for the Standard Plan to recognize the benefits that would need to be carved out at each of the campuses. **It did not include:**

- Enrollment Impacts
- Business Process Changes in Enrollment
- Ongoing staffing support
- Paying these providers a higher fee to get them into the network

Due to the complexity of potential program structure, the full costs of the program cannot be determined at this time and cannot be quantified for the purposes of an actuarial note. Additional administrative, implementation and FTE costs would be expected. In addition, it may increase medical costs if UNC will not negotiate discounts.

Membership Assumptions

- The number of dependent children over age 18 is approximately 32,647.
- Dependent children would be using the infirmary—any adult spouses or employees would typically commute and use network providers closer to home.
- Only full-time students are eligible for coverage beyond age 19.
- Although there are dependents over age 19 that are not full-time students, disabled dependents are not taken out of the 32,647 for the purposes of this estimate. It is assumed that all 32,647 dependents are full-time students.
- Based on current statistics, about 66% of North Carolinians seek post-secondary education in North Carolina. The percentage of students seeking college education varies by economic status and income level. It is assumed for this exercise that 32,647 dependents represent the 66% of students that seek some post-secondary education.
- As of a 2004 study tracking North Carolina's high school graduates attending postsecondary institutions, 30.1% of North Carolina high school graduates attended a UNC campus post-secondary school. The years reviewed in this study were even years from 1986-2002. The 30.1% is 2002 data. The percentage of students attending North Carolina campuses fluctuated up or down during each two-year time period measured; the net increase from 1986-2002 was 6.2%.
- Estimate that about 33% of high school students matriculate to UNC Campuses or approximately half of the 32,647 dependents covered under the State Health Plan go to a UNC campus.

- Given the above information, assume 45% to 50% of the 32,647 or 14,500—16,400 students who are also members of the State Health Plan go to one of the sixteen UNC Campuses. Again, this estimate is on the high side because information regarding disabled students age 19 and over, and the number of 18 year old dependents were not readily available.

Implementation Assumptions and Issues

- All UNC Campuses would be able to establish a billing infrastructure that could negotiate with claims processing contractors for services on a fee-for –service basis, collect and track copays only for those services not covered under the fee, and bill the claims processing contractor for the services rendered.
    - **UNC is currently not set up to do so**
- Services covered under the Student Health Fee may vary across the 16 UNC Campuses.
- Services covered under the Student Health Fee would not be covered or paid by the State Health Plan.
- Any claims processing systems would need to recognize and exclude those services normally covered under the health benefit plan that would not be covered because students have already paid for them under the Student Health Fee.
- However, those services would only be excluded if billed by Student Health at UNC. If the student went to any other Network Provider, the provider would continue to collect the appropriate copay and bill for services.
- Some system infrastructure will need to be set up if this Bill is passed, regardless of the number of State Health Plan members accessing the system.
- In Section 2, the Bill requires the Claims Processing Contractor to include UNC infirmaries in the claims processing contractor's provider network. It does not specify that each UNC campus has to accept contract terms. Therefore, there is likelihood that based on the mandate, SHP would be expected to pay charges for services at some campuses.
- The PPO Network is the sole responsibility of the Claims Processing Contractor, and currently, this Bill is in conflict with the agreement between the Claims Processing Contractor and the State Health Plan.

	TOTAL EFFORT (HRS)	
	Low	High
(Review Func & Tech Specs, Load infirmaries, etc.)	26	33
figuration	40	485
pment (Claims adjudication and payment)	200	300
	180	270
	180	270
gement (5 - 6 months)	800	960
Total (Hours)	1,426	2,318
Estimated Cost	**$214,000**	**$306,000**

mptions and additional concerns which could adversely impact the implementation costs

efit packages will be assigned at the new benefit year .
nual claims administration may be required.
s may not have robust claims filing systems.
s that all services will not be eligible.
s are not contracting with BCBSNC. We currently offer a student health policy through UNC and NC State where the student can enroll and benefits are paid based on the group plan.
State Health Plan moved to PPO, the provider networks were setup to mirror that of the commercial membership. As a result in order to reduce the administrative costs, a company co
was created in PowerMHS, which copies the provider network supporting commercial membership to a company within PowerMHS designed to support the SHP. This program would n
o significant revisions to change how Company 04 (SHP Company) would be created. Due to this change it would be necessary to do extensive testing and regression testing between
/ 01 and 04, to ensure the change does not impact other members.
ementation would be complicated because we would need to map out along with Benefits Configuration how to identify these providers. This might be accomplished with a provider capa
e, etc., in order to apply the benefits correctly.
ract exists with the provider; and the member is directed to seek services at the infirmary, it would result in BCBSNC paying 100% of billed charges; otherwise the member is put in the

PowerMHS, we are limited in our benefits area to map benefits based on provider, par codes, capacity and provider specialty code. It appears there may be benefit variables by locatic
l development may be required to map the benefits to the providers.
naries could not be published in the provider directories because it would direct other members to their location. The SHP would need to work with the infirmaries to advertise this benef
lirect the members to the infirmaries.

HOUSE BILL 1483

Short Title:	UNC Infirmaries/State Health Plan Network.	(Public)
Sponsors:	Representatives Folwell, Samuelson, Neumann, Whilden (Primary Sponsors); Hurley and Jackson.	
Referred to:	Insurance, if favorable, Appropriations.	

April 13, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE STATE HEALTH PLAN TO NEGOTIATE WITH ITS CLAIMS PROCESSING CONTRACTOR TO INCLUDE UNC INFIRMARIES IN THE CLAIMS PROCESSING CONTRACTOR'S PROVIDER NETWORK.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-45(d) reads as rewritten:

"(d) The Plan benefits shall be provided under contracts between the Plan and the claims processors selected by the Plan. The Executive Administrator may contract with a pharmacy benefits manager to administer pharmacy benefits under the Plan. Such contracts shall include the applicable provisions of G.S. 135-45.1 through G.S. 135-45.15 and the description of the Plan in the request for proposal, and shall be administered by the respective claims processor or Pharmacy Benefits Manager, which will determine benefits and other questions arising thereunder. The contracts necessarily will conform to applicable State law. If any of the provisions of G.S. 135-45.1 through G.S. 135-45.15 and the request for proposals must be modified for inclusion in the contract because of State law, such modification shall be made. If the Plan uses a network of providers that is under contract with the Plan's claims processing contractor, the Executive Administrator may negotiate with the claims processing contractor to include certain providers in the claims processing contractor's network."

SECTION 2. The Executive Administrator of the State Health Plan for Teachers and State Employees shall negotiate with its claims processing contractor to include UNC infirmaries in the claims processing contractor's provider network.

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

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

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

DAY & DATE: **Tuesday - June 23, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

HB 1483 – UNC INFIRMARIES/STATE HEALTH PLAN NETWORK – Reps. Folwell, Samuelson, Neumann and Whilden

SB 981 – MORTGAGE GUARANTY INSURANCE REVISIONS – Sen. Jenkins

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at: **2:30 pm on June 22, 2009.**

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

ATTACHMENT #1

VISITOR REGISTRATION SHEET

House Insurance — June 23, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Green	Genworth Financial
Jeanne Shea	Genworth Financial
Tom Kleissler	Genworth Financial
JOE LANIER	520 WICKER
Wendy Kelly	520 Wicker
Roz Swift	NCCCO
Mark Fleming	BCBSNC
Barbara Canada	BB&C
Anita Watkins	UNC GA
Carol Burrell	SHBNC
Dr McConnaughey	SAS
Chris Byrd	SAS

VISITOR REGISTRATION SHEET

House Insurance — June 23, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Cohen	IFNC
Tony Riddick	NCOOI
Rod Martinez	✓
Daniel Blum	K&L GATES
Patrick Hannah	Liberty Mutual
John Goodman	NC Chamber
Joel Rutherford	RMIC
Cindie Lowe	RMIC
Crystal Martin	RMIC
Ashley Bell	American Cancer Society
Chris Fitzsimon	NC Policy Watch
Bruce Mallette	UNC General Administration

VISITOR REGISTRATION SHEET

House Insurance — June 23, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Seth Pelser	Rep. Hollina
Frank Sutherland	Sands Anderson
FRANK FOLGER	NATIONWIDE
[illegible]	NMRS
CLEONARD	A.C.L.I.
Michelle Frazier	MF+S
John McMillan	MF+S
Chris McLaurin	Raleigh
John McMillan	MF+S
Rev. MARK H. CREECH	CAL
Kelly Graham	NCAJ

VISITOR REGISTRATION SHEET

House Insurance — June 23, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Paul Pulley	NCAJ

HOUSE PAGES

NAME OF COMMITTEE Insurance DATE 6/23/09

1. Name: Madison Pleasant
   County: Wake
   Sponsor: Ross
2. Name: Dena Turnage
   County: Greene
   Sponsor: Braxton
3. Name: Mary George Harper
   County: Greene
   Sponsor: Braxton
4. Name: Haley Beaman
   County: GREENE
   Sponsor: BRAXTON.
5. Name: James Stephens
   County: Wake
   Sponsor: Starn

SGT-AT-ARM

1. Name: Charles Williams
2. Name: Martha Gadison
3. Name: Bob Rossi
4. Name:

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

House By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☒Committee Substitute for

SB 981 A BILL TO BE ENTITLED AN ACT TO GIVE THE COMMISSIONER OF INSURANCE DISCRETION TO WAIVE THE MINIMUM POLICYHOLDERS POSITION REQUIREMENT UNDER CERTAIN CIRCUMSTANCES FOR MORTGAGE GUARANTY INSURERS.

☒ 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 _____.

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 25, 2009

The House Committee on Insurance met at 11:00 AM on Thursday, June 25, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael Wray; Vice Chairs: M. Dickson, and J. Dockham. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Cole, Current, Faison, Gibson, Holliman, Howard, Hughes, and Pierce.

Chairman Wray called the meeting to order and welcomed visitors. He recognized Sgt-At Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachments)

Chairman Wray recognized Rep. Dockham to explain HB 1294 – NC Risk Pool Premiums/Notice Requirements which was sponsored by Reps. Dockham, England and Insko. Rep. Dockham said the bill was back before the committee for concurrence. He said that any subsidies would be federal and not state and moved that the committee concur. Motion carried.

Chairman Wray recognized Rep. Holliman to explain HB 1305 – Beach Plan Changes. Rep. Goforth moved for the PCS to be before the Committee. Rep. Holliman said this plan had been in the works for months with people and groups from all across the state helping to draft the legislation. Rep. Holliman said that with this legislation they were trying to help people in the East as much as possible.

Rose Williams from the NC Department of Insurance was recognized to discuss the bill. She said this insurance is not meant to compete in the private market. It is to be used as a last resort to cover 18 eastern counties. The result of a recent study shows that the Beach Plan does not have enough surpluses to cover catastrophic occurrences. (Attachment 1)

Chairman Wray recognized Commission of Insurance Wayne Goodwin to speak. Commissioner Goodwin explained the State Statute that requires the Insurance Commissioner to regulate the Beach Plan. (Attachment 2)

Chairman Wray recognized Staff Counsel Tim Hovis to explain the bill. See Bill Summary for details.

Chairman Wray recognized Rep. Holliman for additional remarks. He said this is a consensus bill intended to protect our insurance market and to help the working and middle-class people who live along our coast. If insurance carriers leave the state, as has happened in Florida, taxpayers will ultimately bear a larger share of the burden.

Chairman Wray recognized John McMillan, a lobbyist with Manning Fulton, for his comments. (Attachment 3)

Lisa Martin, with the NC Homebuilders Association was recognized for comment. She said one of the main problems is the coverage being limited to $750,000.

In compliance with legislative rules, Chairman Wray said the meeting had to adjourn. He asked Ms. Martin to come to the next meeting to continue her comments.

The meeting adjourned at 11:45.

Representative Michael Wray, Chairman

Ann Jordan – Committee Assistant

HOUSE INSURANCE COMMITTEE

June 25 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

HB 1294 – NC RISK POOL PREMIUMS/NOTICE REQUIREMENTS – Reps. Dockham, England and Insko

HB 1305 – BEACH PLAN CHANGES – Reps. Holliman

Adjourn

HOUSE BILL 1294:
NC Risk Pool Premiums/Notice Requirements

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Judiciary II	**Date:**	June 24, 2009
Introduced by:	Rep. Dockham	**Prepared by:**	Ben Popkin
Analysis of:	Fifth Edition	.	Committee Counsel

SUMMARY: House Bill 1294 would allow the Board of Directors of the High Risk Insurance Pool to provide premium subsidies to individuals with income levels up to 300% of the federal poverty guidelines, if federal funds are available. The bill would also require insurers to notify applicants for health insurance coverage about the existence of the High Risk Insurance Pool in certain circumstances, and would increase the time from 6 to 12 months following the Pool's first enrollment during which applicants are eligible for the shorter preexisting condition waiting period of 6 months.

BILL SUMMARY: **Section 1** of the bill would add language granting the Board the authority to provide premium subsidies to individuals with income levels up to 300% of the federal poverty guidelines, if federal grant funds are available. **Section 2** would require an insurer to provide written notice to an individual about the High Risk Insurance Pool upon a determination by the insurer that the applicant is eligible because the person has been rejected coverage or offered coverage that limits coverage for the person's high-risk medical conditions. *There is no current requirement that insurers notify applicants for health insurance coverage of the existence of the High Risk Insurance Pool.* **Section 3** would increase the time period from 6 months to 12 months from the Pool's first enrollment during which an individual may enroll in the Pool and be subject to a 6 (rather than 12) month preexisting condition waiting period. After that time, the preexisting condition waiting period will be 12 months from enrollment.

EFFECTIVE DATE: The notice requirement in Section 2 of the bill would apply to applications received on or after October 1, 2009. The remainder of the bill is effective when it becomes law.

The 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family	Poverty guideline
1	$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010
For families with more than 8 persons, add $3,740 for each additional person.	

**This summary was substantially contributed to by Ms. Kory Goldsmith, Attorney, Research Division.*

H1294-SMRD-165(e5) v1

HOUSE BILL 1294

Committee Substitute Favorable 5/5/09
Third Edition Engrossed 5/13/09
Senate Commerce Committee Substitute Adopted 6/2/09
Fifth Edition Engrossed 6/3/09

Short Title: NC Risk Pool Premiums/Notice Requirements. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE NORTH CAROLINA HEALTH INSURANCE RISK POOL TO PROVIDE PREMIUM SUBSIDIES IF FUNDS ARE AVAILABLE AND TO REQUIRE INSURERS TO NOTIFY APPLICANTS FOR HEALTH INSURANCE COVERAGE ABOUT THE EXISTENCE OF THE POOL.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-180(e) reads as rewritten:

"(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 acting upon the approval or authorization of 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.

(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.

(4a) Provide premium subsidies if federal grant funds are available for individuals with incomes up to three hundred percent (300%) of the federal poverty guidelines and the Board deems it is fiscally prudent to do so.

(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) Establish policies, conditions, and procedures for reinsuring risks of participating health insurers, as defined in G.S. 58-68-25(a), 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.

(8) Employ and fix the compensation of employees.

(9) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public.

(10) Provide for reinsurance for the Pool.

(11) Issue additional types of health insurance policies to provide optional coverage, including Medicare supplemental insurance coverage.

(12) Provide for and employ cost containment measures and requirements including preadmission screening, second surgical opinion, concurrent utilization review, disease management, individual case management, health and wellness programs including a smoking cessation initiative, and other commonly used benefit plan design features for the purpose of making health insurance coverage offered by the Pool more cost-effective.

(13) 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.

(14) Adopt bylaws, policies, and procedures as may be necessary or convenient for the implementation of this Part and the operation of the Pool."

SECTION 2. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-276. Notice relating to the North Carolina Health Insurance Risk Pool.**

(a) An insurer shall provide a written notice of the existence of the North Carolina Health Insurance Risk Pool to an applicant for individual health insurance coverage upon the insurer making a determination that the applicant is eligible for coverage by the Pool as provided in G.S. 58-50-195(a)(1) or (2).

(b) The notice required in subsection (a) of this section shall be provided to an applicant no later than 10 business days after the insurer reaches a determination under subsection (a) of this section. An insurer may provide a single notice relating to multiple applicants located at a single address provided the notice lists the name of each individual affected separately.

(c) The Commissioner may adopt rules to implement this section, including rules establishing the language, content, format, and methods of distribution of the notice required by this section.

(d) For purposes of this section:

(1) "Applicant" means any person who seeks to contract for individual health insurance coverage, including any dependent for which application is made and about whom an independent underwriting decision is made by an insurer.

(2) "Health insurance coverage" is as defined in G.S. 58-50-175(10).

(3) "Insurer" is as defined in G.S. 58-50-175(13)."

SECTION 3. Section 1.4 of S.L. 2007-532 reads as rewritten:

"**SECTION 1.4.** Notwithstanding G.S. 58-50-210(a), individuals enrolling in the Pool within ~~six months~~12 months of the date that enrollment into the Pool first begins shall be subject to a six-month preexisting condition waiting period."

SECTION 4. Section 2 of this act applies to applications for health insurance coverage made on or after October 1, 2009. The remainder of this act is effective when it becomes law.

HOUSE BILL 1305:
Beach Plan Changes

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Finance	**Date:**	June 24, 2009
Introduced by:	Rep. Holliman	**Prepared by:**	Tim Hovis
Analysis of:	PCS to First Edition H1305-CSTH-2		Committee Counsel

OVERVIEW: The North Carolina Insurance Underwriting Asssociation (NCIUA), also known as the Beach Plan was created to serve as a market of last resort to make property insurance available to people who are unable to buy insurance through the standard or voluntary market. The Association is not a public body, but is a private entity comprised of all property and casualty insurers in the State. By statute, the Plan covers two areas: (1) the barrier islands, referred to under the Plan as the Beach area; and (2) 18 coastal counties, referred to as the Coastal area. The Plan offers commercial, homeowners, dwelling, and wind only coverage.

All member companies share in the expenses, profits, and losses of the Plan. Each year that the Plan generates revenues in excess of claims paid, the Plan may elect to return the excess funds to the member companies or hold those funds as "surplus." The surplus is used to cover Plan losses where claims filed are greater than the premium received. Should claims exceed the revenues from premiums, the amount of surplus, and any applicable reinsurance, member companies are assessed by the Plan to pay the claims.

The Plan also files with the Commissioner for his or her approval rates for separate policies of windstorm and hail, policy deductible plans to be paid by property owners, and the percentage differential or surcharge for coverage offered by the Plan. The surcharge is a percentage amount above the voluntary market rate approved by the Commissioner which all beach and coastal property owners must pay to purchase homeowners coverage through the Plan. The surcharge applies to homeowner's coverage and homeowner's wind and hail coverage only.

Since 1995, exposure to losses for all properties covered by the Plan has grown exponentially. The NCIUA estimates that in 1995 total exposure under the Plan was $3.6B. By 2008, exposure had grown to $72B, leading to concern that assessments on insurers for losses resulting from a hurricane may cause financial difficulties for many insurers.

SUMMARY: Proposed Committee Substitute for House Bill 1305 makes various changes to Article 45 of Chapter 58 of the General Statutes. These changes include the following:

- Renames the Beach Plan the "Coastal Property Insurance Pool."
- Requires that the surplus of the Association be retained to pay losses, purchase reinsurance, and pay operating expenses and provides that the surplus may not be distributed to member companies.
- Sets maximum coverage limits by statute and decrease those limits to $750,000 for homeowners and dwelling policies (currently $1.5M) and limits contents coverage to 40% of building value (currently 70%).

- Increases homeowners coverage surcharges to 10% above approved voluntary market rates for separate wind and hail coverage (currently 5%) and 20% for wind and hail as a part of a homeowner's policy (currently 15%).
- Provides that surcharges may be applied to dwelling and commercial policies, not just homeowners policies.
- Requires the Association to file a schedule of credits for policyholders based on mitigation and construction features.
- Requires the Association to submit to the Commissioner an installment plan for premium payments.
- Provides that when losses incurred by the Association result in an assessment against insurers of $1B, the Association may, subject to the approval and order of the Commissioner, institute a catastrophic assessment recoupment on residential and commercial property holders statewide to recover any assessment exceeding $1B. Recoupment or recoupments shall not exceed an aggregate amount of 10% of the annual policy premium on any one policy of insurance.
- Requires insurers to report by February 1 of each year the amount of homeowner's insurance written in the Beach and Coastal areas.
- Requires the N.C. Rate Bureau to revise, monitor, and review territories in the Beach and Coastal areas.
- Requires public notice in at least two newspapers with statewide distribution of filings for increases in residential property insurance rates.

EFFECTIVE DATE: The Proposed Committee Substitute for House Bill 1305 is effective when it becomes law and applies to policies filed, issued, or renewed on or after that date.

H1305-SMRG-76(CSTH-2) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1305
PROPOSED COMMITTEE SUBSTITUTE H1305-CSRG-43 [v.12]

6/24/2009 9:06:31 PM

Short Title: Beach Plan Changes. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE COASTAL PROPERTY INSURANCE POOL, PRESENTLY KNOWN AS THE BEACH PLAN, AS RECOMMENDED BY THE JOINT SELECT STUDY COMMITTEE ON THE POTENTIAL IMPACT OF MAJOR HURRICANES ON THE NORTH CAROLINA INSURANCE INDUSTRY; REQUIRE THAT THE NORTH CAROLINA RATE BUREAU PROVIDE PUBLIC NOTICE OF CERTAIN FILINGS IN NEWSPAPER PUBLICATIONS AND VIA INTERNET; RE-AFFIRM THAT THE NORTH CAROLINA INSURANCE UNDERWRITING ASSOCIATION IS INTENDED TO BE EXEMPT FROM STATE AND FEDERAL TAXATION, EXCEPT FOR PREMIUM TAXES; CLARIFY THE POWERS AND DUTIES OF THE ASSOCIATION; CLARIFY AND PROVIDE CERTAINTY REGARDING ASSESSMENTS AGAINST MEMBER INSURANCE COMPANIES BY THE ASSOCIATION; ADJUST THE COASTAL INSURANCE COVERAGE LIMITS OF THE ASSOCIATION IN ORDER TO ENSURE THAT THE COASTAL PROPERTY INSURANCE POOL IS THE MARKET OF LAST RESORT; MANDATE THAT THE ASSOCIATION SHALL RETAIN ALL SURPLUS FOR USE IN PURCHASING REINSURANCE, PAYING CLAIMS TO POLICYHOLDERS, AND FOR ASSOCIATION OBLIGATIONS; PROHIBIT DISTRIBUTION OF SURPLUS TO MEMBER INSURANCE COMPANIES; REQUIRE THE ASSOCIATION TO FILE A SCHEDULE OF PREMIUM CREDITS FOR COASTAL INSURANCE POLICYHOLDERS WHO HAVE VOLUNTARILY MITIGATED THEIR RISK OF DAMAGE FROM HURRICANES AND OTHER WIND DAMAGE; REQUIRE THE ASSOCIATION TO ESTABLISH AND MAINTAIN AN INSTALLMENT PLAN FOR PREMIUM PAYMENTS FOR THE EASE OF POLICYHOLDERS; DEFINE AND ESTABLISH WHAT ACTIONS ARE ALLOWED UPON THE OCCURRENCE OF A DEFICIT EVENT, INCLUDING CAPPING ANY CATASTROPHIC ASSESSMENT RECOUPMENT FROM HOMEOWNERS STATEWIDE; IMPOSE AN ADDITIONAL REGULATORY CHARGE ON THE ASSOCIATION TO BE PAID TO THE DEPARTMENT; REQUIRE THAT ASSOCIATION ACTIVITIES BE MADE TRANSPARENT AND AVAILABLE TO ANY MEMBER COMPANY OR BOARD MEMBER; PROVIDE FOR SUCCESSION AND DISSOLUTION OF THE ASSOCIATION; PROVIDE FOR SURCHARGES OF TEN PERCENT FOR SEPARATE WIND AND HAIL COVERAGE, TWENTY PERCENT FOR WIND AND HAIL HOMEOWNERS COVERAGE, AND A MINIMUM WIND AND HAIL DEDUCTIBLE

OF ONE PERCENT FOR COVERAGE WRITTEN BY THE ASSOCIATION; PROVIDE FOR SURCHARGES ON COMMERCIAL AND DWELLING COVERAGE IN ADDITION TO SURCHARGES CURRENTLY IMPOSED ON HOMEOWNERS POLICIES; DELETE THE TIME LIMIT FOR THE COMMISSIONER TO DISAPPROVE A RATE BUREAU FILING AND TO MAKE OTHER CHANGES CONSISTENT WITH THE FINDINGS OF THE JOINT SELECT STUDY COMMITTEE ON THE POTENTIAL IMPACT OF MAJOR HURRICANES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 45 of Chapter 58 of the General Statutes reads as rewritten:

"Article 45.

"Essential Property Insurance for Beach Area Property.

"§ 58-45-1. Declarations and purpose of Article.

(a) It is hereby declared by the General Assembly of North Carolina that an adequate market for essential property insurance is necessary to the economic welfare of the beach and coastal areas of the State of North Carolina and that without such insurance the orderly growth and development of those areas would be severely impeded; that furthermore, adequate insurance upon property in the beach and coastal areas is necessary to enable homeowners and commercial owners to obtain financing for the purchase and improvement of their property; and that while the need for such insurance is increasing, the market for such insurance is not adequate and is likely to become less adequate in the future; and that the present plans to provide adequate insurance on property in the beach and coastal areas, while deserving praise, have not been sufficient to meet the needs of this area. It is further declared that the State has an obligation to provide an equitable method whereby every licensed insurer writing essential property insurance in North Carolina is required to meet its public responsibility instead of shifting the burden to a few willing and public-spirited insurers. It is the purpose of this Article to accept this obligation and to provide a mandatory program to assure an adequate market for essential property insurance in the beach and coastal areas of North Carolina.

(b) The General Assembly further declares that it is its intent in creating and, from time to time, amending this Article that the market provided by this Article not be the first market of choice, but the market of last resort.

(c) It is the intent of the General Assembly that except for North Carolina gross premium taxes and the fire and lightning tax, the activities of the Association be exempt from State and federal taxation to the fullest extent permitted by law.

"§ 58-45-5. Definition of terms.

As used in this Article, unless the context clearly otherwise requires:

(1) ~~"Association" means~~Association. – ~~the~~ The North Carolina Insurance Underwriting Association established under this Article;

(2) ~~"Beach area" means~~ Beach area. – ~~all~~ All of that area of the State of North Carolina south and east of the inland waterway from the South Carolina line to Fort Macon (Beaufort Inlet); thence south and east of Core, Pamlico, Roanoke and Currituck sounds to the Virginia line, being those portions of land generally known as the Outer Banks;

(2a) ~~"Coastal area" means~~Coastal area. – ~~all~~ All of that area of the State of North Carolina comprising the following counties: Beaufort, Brunswick, Camden, Carteret, Chowan, Craven, Currituck, Dare, Hyde, Jones, New Hanover, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Tyrrell, and Washington. "Coastal area" does not include the portions of these counties that lie within the beach area.

(2b) Coastal Property Insurance Pool. – The name of that which was formerly known as "the Beach Plan", and which is governed by the North Carolina Insurance Underwriting Association. All references to the "Beach Plan" shall

mean the Coastal Property Insurance Pool, which is the market of last resort provided by the Association to the Beach area and the Coastal area.

(3) Repealed by Session Laws 1991, c. 720, s. 6.

(3a) ~~"Crime insurance" means~~Crime insurance. – ~~insurance~~ Insurance against losses resulting from robbery, burglary, larceny, and similar crimes, as more specifically defined and limited in the various crime insurance policies, or their successor forms of coverage, approved by the Commissioner and issued by the Association. Such policies shall not be more restrictive than those issued under the Federal Crime Insurance Program authorized by Public Law 91-609.

(3b) ~~"Directors" means~~Directors. – ~~the~~ The Board of Directors of the Association.

(4) ~~"Essential property insurance" means~~Essential property insurance. – ~~insurance~~ Insurance against direct loss to property as defined in the standard statutory fire policy and extended coverage, vandalism and malicious mischief endorsements thereon, or their successor forms of coverage, as approved by the Commissioner;

(5) ~~"Insurable property" means~~ Insurable property. – ~~real~~ Real property at fixed locations in the beach and coastal area, including travel trailers when tied down at a fixed location, or the tangible personal property located therein, but shall not include insurance on motor vehicles; which property is determined by the Association, after inspection and under the criteria specified in the plan of operation, to be in an insurable condition. However, any one and two family dwellings built in substantial accordance with the Federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards promulgated by the association and approved by the Commissioner, or the North Carolina Uniform Residential Building Code and any structure or building built in substantial compliance with the North Carolina State Building Code, including the design-wind requirements, which is not otherwise rendered uninsurable by reason of use or occupancy, shall be an insurable risk within the meaning of this Article. However, none of the following factors shall be considered in determining insurable condition: neighborhood, area, location, environmental hazards beyond the control of the applicant or owner of the property. Also, any structure begun on or after January 1, 1970, not built in substantial compliance with the Federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards promulgated by the association and approved by the Commissioner, or the North Carolina Uniform Residential Building Code or the North Carolina State Building Code, including the design-wind requirements therein, shall not be an insurable risk. The owner or applicant shall furnish with the application proof in the form of a certificate from a local building inspector, contractor, engineer or architect that the structure is built in substantial accordance with the Federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards promulgated by the association and approved by the Commissioner, or the North Carolina Uniform Residential Building Code or the North Carolina State Building Code; however, an individual certificate shall not be necessary where the structure is located within a political

subdivision which has certified to the Association on an annual basis that it is enforcing the North Carolina Uniform Residential Building Code or the North Carolina State Building Code and has no plans to discontinue enforcing these codes during that year.

(6) Repealed by Session Laws 1995 (Regular Session, 1996), c. 592, s. 2.

(6a) ~~"Net direct premiums" means~~Net direct premiums. – ~~gross~~ Gross direct premiums (excluding reinsurance assumed and ceded) written on property in this State for essential property insurance, farmowners insurance, homeowners insurance, and the property portion of commercial multiple peril insurance policies as computed by the Commissioner, less:

a. Return premiums on uncancelled contracts;

b. Dividends paid or credited to policyholders; and

c. The unused or unabsorbed portion of premium deposits.

(6b) Nonrecoupable assessment. – Any assessment levied on and payable by members of the Association that is not directly recoverable from policyholders, but which shall be considered as an appropriate factor in the making of rates by the North Carolina Rate Bureau.

(7) ~~"Plan of operation" or "plan" means~~Plan of operation. – ~~the~~ The plan of operation of the Association approved or promulgated by the Commissioner under this Article.

(8) Catastrophic assessment recoupment. – Any recoupment of assessments on member insurers collected by member insurers from policyholders statewide, including Association and Fair Plan policyholders, upon issuance or renewal of residential and commercial property insurance policies, other than National Flood Insurance policies, after a deficit event has occurred as provided in G.S. 58-45-47. The amount of the catastrophic assessment recoupment or recoupments collected in a particular year shall not exceed an aggregate amount of ten percent (10%) of policy premium. A catastrophic assessment recoupment shall be limited to the recovery of losses resulting from claims for property damage and allocated loss expenses.

(9) Voluntary market. – Insurance written voluntarily by companies other than through this Article or Article 46 of this Chapter.

(10) Voluntary market rates. – Property insurance rates determined or permitted under Articles 36, 40, or 41 of this Chapter.

"§ 58-45-6. Persons who can be insured by the Association.

As used in this Article, "person" includes the State of North Carolina and any county, city, or other political subdivision of the State of North Carolina.

"§ 58-45-10. North Carolina Insurance Underwriting Association created.

There is hereby created the North Carolina Insurance Underwriting Association, consisting of all insurers authorized to write and engage in writing within this State, on a direct basis, essential property insurance, except town and county mutual insurance associations and assessable mutual companies as authorized by G.S. 58-7-75(5)b, 58-7-75(5)d, and 58-7-75(7)b and except an insurer who only writes insurance in this State on property exempted from taxation by the provisions of G.S. 105-278.1 through G.S. 105-278.8. Every such insurer shall be a member of the Association and shall remain a member of the Association so long as the Association is in existence as a condition of its authority to continue to transact the business of insurance in this State.

"§ 58-45-15. Powers and duties of Association.

The Association shall, pursuant to the provisions of this Article and the plan of operation, and with respect to the insurance coverages authorized in this Article, have the power on behalf of its members:

(1) To cause to be issued policies of insurance to applicants;.
(2) To assume reinsurance from its members;
(3) To cede reinsurance to its members and to purchase reinsurance in behalf of its ~~members.~~members; and
(4) To require insureds of the Association to purchase federal flood insurance where applicable and available in order to obtain replacement cost, to the extent possible, or other preferential forms, endorsements, or coverages.
(5) To pledge the proceeds of assessments, projected reinsurance recoveries, other recoverables, and any other funds available to the Association as the source of revenue for and to secure lines of credit or other borrowings or financing arrangements necessary to fund any actual, projected, or future deficits of the Association.
(6) To publish in the North Carolina Register all homeowners' rate filings with the Department of Insurance.

"§ 58-45-20. Temporary directors of Association.

Within 10 days after April 17, 1969, the Commissioner shall appoint a temporary board of directors of this Association, which shall consist of 11 representatives of members of the Association. Such temporary board of directors shall prepare and submit a plan of operation in accordance with G.S. 58-45-30 and shall serve until the permanent board of directors shall take office in accordance with said plan of operation.

"§ 58-45-25. Each member of Association to participate in nonrecoupable assessments. ~~its expenses, profits, and losses.~~

(a) Subject to the limitations contained in G.S. 58-45-47, ~~Each~~ each member of the Association shall participate in the ~~expenses, profits, and losses of~~nonrecoupable assessments levied by the Association in the proportion that its net direct premium written in this State during the preceding calendar year for residential and commercial properties outside of the beach and coastal areas bears to the aggregate net direct premiums written in this State during the preceding calendar year for residential and commercial properties outside of the beach and coastal areas by all members of the Association, as certified to the Association by the Commissioner. The Commissioner shall certify each member's participation after review of annual statements and any other reports and data necessary to determine participation and may obtain any necessary information or data from any member of the Association for this purpose. Any insurer that is authorized to write and that is engaged in writing any insurance, the writing of which requires the insurer to be a member of the Association under G.S. 58-45-10, shall become a member of the Association on the first day of January after authorization. The determination of the insurer's participation in the Association shall be made as of the date of membership of the insurer in the same manner as for all other members of the Association.

(b) All member companies shall receive credit each year for essential property insurance, farmowners insurance, homeowners insurance, and the property portion of commercial multiple peril policies voluntarily written in the beach and coastal areas in accordance with guidelines and procedures to be submitted by the Directors to the Commissioner for approval. Such credits shall also apply to any nonrecoupable assessments levied pursuant to G.S. 58-45-47. The participation of each member company in the ~~expenses, profits, and losses of~~ nonrecoupable assessments levied by the Association shall be reduced accordingly; provided, no credit shall be given where coverage for the peril of wind has been excluded. The guidelines and procedures for granting credit shall encourage and assist each member company to voluntarily write these coverages in the beach and coastal areas for commercial and residential properties.

(b1) The accumulated surplus of the Association shall be retained from year to year and used to pay losses, reinsurance costs, and other operating expenses as necessary. No member

company shall be entitled to the distribution of any portion of the Association's surplus, except pursuant to contractual obligations incurred prior to the effective date of this law.

(b2) The premiums, surplus, assessments, investment income, and other revenue of the Association are funds received for the sole purpose of providing insurance coverage, paying claims for Association policyholders, purchasing reinsurance, securing and repaying debt obligations issued by the Association, and conducting all other activities of the Association, as required or permitted by this Article. Accumulated surplus shall not be removed from the Association or used for other purposes except pursuant to contractual obligations incurred by the Association prior to the effective date of this law.

(c) The North Carolina Insurance Underwriting Association shall use the "take out" program, as filed with and approved by the Commissioner, in the coastal area.

"**§ 58-45-30. Directors to submit plan of operation to Commissioner; review and approval; ~~amendments.~~amendments; appeal from Commissioner to superior court.**

(a) The Directors shall submit to the Commissioner for his review and approval, a proposed plan of operation. The plan shall set forth the number, qualifications, terms of office, and manner of election of the members of the board of directors, and shall grant proper credit annually to each member of the Association for essential property insurance, farmowners, homeowners insurance, and the property portion of commercial multiple peril policies voluntarily written in the beach and coastal areas and shall provide for the efficient, economical, fair and nondiscriminatory administration of the Association and for the prompt and efficient provision of essential property insurance in the beach and coastal areas of North Carolina to promote orderly community development in those areas and to provide means for the adequate maintenance and improvement of the property in those areas. The plan may include the establishment of necessary facilities; management of the Association; the assessment of members to defray losses and expenses; underwriting standards; procedures for the acceptance and cession of reinsurance; procedures for determining the amounts of insurance to be provided to specific risks; time limits and procedures for processing applications for insurance; and any other provisions that are considered necessary by the Commissioner to carry out the purposes of this Article.

(b) The proposed plan and any amendments thereto shall be filed with ~~reviewed by~~ the Commissioner and approved by him if he finds that such plan fulfills the purposes provided by G.S. 58-45-1. In the review of the proposed plan the Commissioner may, in his discretion, consult with the directors of the Association and may seek any further information which he deems necessary to his decision. If the Commissioner approves the proposed plan, he shall certify such approval to the directors and the plan shall become effective 10 days after such certification. If the Commissioner disapproves all or any part of the proposed plan of operation he shall return the same to the directors with his written statement for the reasons for disapproval and any recommendations he may wish to make. The directors may alter the plan in accordance with the Commissioner's recommendation or may within 30 days from the date of disapproval return a new plan to the Commissioner. Should the directors fail to submit a plan that meets the requirements of this Article ~~a proposed plan of operation within 90 days of April 17, 1969, or a new plan which is acceptable to the Commissioner~~, or accept the recommendations of the Commissioner within 30 days after his disapproval of the plan, the Commissioner shall promulgate and place into effect a plan of operation that meets the requirements of this Article certifying the same to the directors of the Association. Any such plan promulgated by the Commissioner shall take effect 10 days after certification to the directors: ~~Provided, however, that until a plan of operation is in effect, pursuant to the provisions of this Article, any existing temporary placement facility may be continued in effect on a mandatory basis on such terms as the Commissioner may determine.~~

(c) The directors of the Association may, subject to the approval of the Commissioner, amend the plan of operation at any time. The Commissioner may review the plan of operation at any time the Commissioner deems expedient or prudent, but not less than once in each calendar year. After review of the plan the Commissioner may amend the plan after consultation with the directors and upon certification to the directors of the amendment. Any order of the Commissioner with respect to the proposed plan of operation or any amendments thereto shall be subject to review upon petition by the Association as provided by G.S. 58-2-75.

(d) As used in this subsection, "homeowners' insurance policy" means a multiperil policy providing full coverage of residential property similar to the coverage provided under an HO-2, HO-3, HO-4, or HO-6 policy under Article 36 of this Chapter. The Association shall issue, for principal residences, homeowners' insurance policies approved by the Commissioner. Homeowners' insurance policies shall be available to persons who reside in the beach and coastal areas who meet the Association's underwriting standards and who are unable to obtain homeowners' insurance policies from insurers that are authorized to transact and are actually writing homeowners' insurance policies in this State. The Association shall file for approval by the Commissioner underwriting standards to determine whether property is insurable. The standards shall reflect underwriting standards commonly used in the voluntary homeowners' insurance business. The terms and conditions of the homeowners' insurance policies available under this subsection shall not be more favorable than those of homeowners' insurance policies available in the voluntary market in beach and coastal counties.

(e) The Association shall, subject to the Commissioner's approval or modification, provide in the plan of operation for coverage for appropriate classes of manufacturing risks.

(f) As used in this section, "plan of operation" includes all written rules, practices, and procedures of the Association, except for staffing and personnel matters.

"**§ 58-45-35. Persons eligible to apply to Association for coverage; contents of application.**

(a) Any person having an insurable interest in insurable property, may, on or after the effective date of the plan of operation, be entitled to apply to the Association for such coverage and for an inspection of the property. A broker or agent authorized by the applicant may apply on the applicant's behalf. Each application shall contain a statement as to whether or not there are any unpaid premiums due from the applicant for essential property insurance on the property.

The term "insurable interest" as used in this subsection shall include any lawful and substantial economic interest in the safety or preservation of property from loss, destruction or pecuniary damage.

(b) If the Association determines that the property is insurable and that there is no unpaid premium due from the applicant for prior insurance on the property, the Association, upon receipt of the premium, or part of the premium, as is prescribed in the plan of operation, shall cause to be issued a policy of essential property insurance and shall offer additional extended coverage, optional perils endorsements, business income and extra expense coverage, crime insurance, separate policies of windstorm and hail insurance, or their successor forms of coverage, for a term of one year or three years. Short term policies may also be issued. Any policy issued under this section shall be renewed, upon application, as long as the property is insurable property.

(b1) If the Association determines that the property, for which application for a homeowners' policy is made, is insurable, that there is no unpaid premium due from the applicant for prior insurance on the property, and that the underwriting guidelines established by the Association and approved by the Commissioner are met, the Association, upon receipt of the premium, or part of the premium, as is prescribed in the plan of operation, shall cause to be issued a homeowners' insurance policy.

(c) If the Association, for any reason, denies an application and refuses to cause to be issued an insurance policy on insurable property to any applicant or takes no action on an

application within the time prescribed in the plan of operation, the applicant may appeal to the Commissioner and the Commissioner, or the Commissioner's designee from the Commissioner's staff, after reviewing the facts, may direct the Association to issue or cause to be issued an insurance policy to the applicant. In carrying out the Commissioner's duties under this section, the Commissioner may request, and the Association shall provide, any information the Commissioner deems necessary to a determination concerning the reason for the denial or delay of the application.

(d) An agent who is licensed under Article 33 of this Chapter as an agent of a company which is a member of the Association established under this Article shall not be deemed an agent of the Association. The foregoing notwithstanding, an agent of a company which is a member of the Association shall have the authority, subject to the underwriting guidelines established by the Association, to temporarily bind coverage with the Association. The Association shall establish rules and procedures, including any limitations for binding authority, in the plan of operation.

Any unearned premium on the temporary binder shall be returned to the policyholder if the Association refuses to issue a policy. Nothing in this section shall prevent the Association from suspending binding authority in accordance with its plan of operation.

(e) Policies of windstorm and hail insurance provided for in subsection (b) of this section are available only for risks in the beach and coastal areas for which essential property insurance has been written by licensed insurers. Whenever such other essential property insurance written by licensed insurers includes replacement cost coverage, the Association shall also offer replacement cost coverage. In order to be eligible for a policy of windstorm and hail insurance, the applicant shall provide the Association, along with the premium payment for the windstorm and hail insurance, a certificate that the essential property insurance is in force. The policy forms for windstorm and hail insurance shall be filed by the Association with the Commissioner for the Commissioner's approval before they may be used. Catastrophic losses, as determined by the Association and approved by the Commissioner, that are covered under the windstorm and hail coverage in the beach and coastal areas shall be adjusted by the licensed insurer that issued the essential property insurance and not by the Association. The Association shall reimburse the insurer for reasonable expenses incurred by the insurer in adjusting windstorm and hail losses.

"**§ 58-45-36. Temporary contracts of insurance.**

Consistent with G.S. 58-45-35(d), the Association shall be temporarily bound by a written temporary binder of insurance issued by any duly licensed insurance agent or broker. Coverage shall be effective upon payment to the agent or broker of the entire premium or part of the premium, as prescribed by the Association's plan of operation. Nothing in this section shall impair or restrict the rights of the Association under G.S. 58-45-35(b) to decline to issue a policy based upon a lack of insurability as determined by the Association or the existence of an unpaid premium due from the applicant.

"**§ 58-45-40. Association members may cede insurance to Association.**

Any member of the Association may cede to the Association essential property insurance written on insurable property, to the extent, if any, and on the terms and conditions set forth in the plan of operation.

"**§ 58-45-41. Coverage limits.**

(a) The Association shall cause to be issued insurance up to the reasonable value of the insurable property, subject to a maximum of seven hundred fifty thousand dollars ($750,000) on habitational property. The above limits on habitational property shall apply to the value of the building only. Insurance issued by the Association for commercial property shall not exceed three million dollars ($3,000,000) on any freestanding structure or any building unit within multiple firewall divisions, provided the aggregate insurance on structures with multiple firewall divisions shall not exceed six million dollars ($6,000,000) on all interest at one risk.

(b) Contents of habitational property can be insured up to forty percent (40%) of the building value.

(c) If the value of the property exceeds the maximum coverage limits as described in this section, the Association shall not issue coverage without the insured's purchase of excess coverage to the full value of the property insured.

"§ 58-45-45. Rates, rating plans, rating rules, and forms applicable.

(a) Rates shall not be excessive, inadequate, or unfairly discriminatory. Except as provided in ~~subsection (b)~~ subsections (a1), (a2) and (b) of this section, ~~the~~ rates, rating plans, rating rules, and forms applicable to the insurance written by the Association shall be in accordance with the most recent manual rates or adjusted loss costs and forms that are legally in effect in the State. Except as provided in subsection (c) of this section, no special surcharge, other than those presently in effect, may be applied to the property insurance rates of properties located in the beach and coastal areas.

(a1) Effective January 1, 2010, the Association's rates shall be the North Carolina Rate Bureau Manual Rates plus a surcharge of ten percent (10%) of the applicable North Carolina Rate Bureau Manual Rate for wind and hail coverage and a surcharge of twenty percent (20%) of the applicable North Carolina Rate Bureau Manual Rate for homeowner's insurance including wind and hail coverage. It is the intent of the General Assembly that these surcharges ensure that the Coastal Property Insurance Pool is the market of last resort over and above the manual rate.

(a2) The Association shall offer a deductible for wind and hail coverage of one percent (1%) of the insured value of the property for all policies and may offer any other deductible options provided by the North Carolina Rate Bureau, so long as the deductible is not lower than one percent (1%) of the insured value of the property applicable to wind and hail losses.

(b) The rates, rating plans, and rating rules for the separate policies of windstorm and hail insurance described in G.S. 58-45-35(b) shall be filed by the Association with the Commissioner for the Commissioner's approval, disapproval, or modification. The provisions of Articles 40 and 41 of this Chapter shall govern the filings. Policy deductible plans, consistent with G.S. 58-45-1(b), may be filed by the Association with the Commissioner for the Commissioner's approval, disapproval, or modification.

(c) Notwithstanding subsection (a) of this section, the Association may, subject to the prior approval of the Commissioner, adopt a schedule of special surcharges above corresponding manual rates and the rates set out in subsection (a1) of this section relating to ~~homeowners' insurance~~ homeowner's, dwelling, and commercial policies issued by the ~~Association pursuant to G.S. 58-45-30(d).~~ Association, including coverage for separate policies of windstorm and hail written by the Association pursuant to G.S. 58-45-35(b) and (e) in conjunction with policies written pursuant to Article 36 of this Chapter. Such schedule may reflect any differences in risk that can be demonstrated to have a probable effect on losses or expenses. Notwithstanding subsections (a) and (b) of this section, the provisions of G.S. 58-36-10(1), 36-15(a), 58-36-20, and 58-36-25 shall apply to such filings.

(d) When the Association files rates, classification plans, rating plans, rating systems, or surcharges, the procedures of G.S. 58-40-25 through G.S. 58-40-45 shall apply, and the appeal procedures of G.S. 58-2-80 and G.S. 58-2-85 shall apply to filings under this section, except as otherwise provided.

(e) The Association shall file no later than May 1, 2010, a schedule of credits for policyholders based on the presence of mitigation and construction features and on the condition of buildings that it insures. The Association shall develop rules applicable to the operation of the schedule and mitigation program, with approval by the Commissioner. The schedule shall not be unfairly discriminatory and shall be reviewed by the Association annually, with the results included as part of the Association's annual report to the Commissioner.

(f) The Association shall file not later than May 1, 2010 with the Commissioner an installment plan for premium payments and shall accept other methods of payment which are the same as those filed by the Rate Bureau. The Association shall collect an installment fee if premiums are paid other than on an annual basis.

"**§ 58-45-46. Unearned premium, loss, and loss expense reserves.**

The Association shall make provisions for reserving unearned premiums and reserving for losses, including incurred but not reported losses, and loss expenses, in accordance with G.S. 58-3-71, 58-3-75, and 58-3-81.

"**§ 58-45-47. Deficit event.**

(a) When the Association knows that it has incurred losses and allocated loss expenses in a particular calendar year that result in an assessment of its member companies exceeding one billion dollars ($1,000,000,000), then the Association shall immediately give notice to the Commissioner that a deficit event has occurred.

(b) Upon a determination by the Association that a deficit event has occurred, the Association shall determine, in its discretion, the appropriate means of financing the deficit, which may include, but is not limited to, the purchase of reinsurance, arranging lines of credit or other forms of borrowing or financing. If the Association determines that the member companies have paid one billion dollars ($1,000,000,000) in assessments in any given year pursuant to subsection (a) of this section, the Association may, subject to the approval and order of the Commissioner, authorize member companies to charge a catastrophic assessment recoupment on their residential and commercial property insurance policyholders statewide to recover any assessment paid by member companies exceeding one billion dollars ($1,000,000,000). Catastrophic assessment recoupment or recoupments under this section shall not exceed an aggregate amount of ten percent (10%) of the annual policy premium on any one policy of insurance. The catastrophic assessment recoupment collected under this section shall be transferred directly to the Association on a periodic basis as determined by the Association and ordered by the Commissioner. The Association and the FAIR Plan shall also charge their policyholders the assessment recoupment as provided in this section.

(c) The catastrophic assessment recoupment shall be clearly identified to policyholders on the premium statement, declarations page, or by other appropriate electronic or written method. The identification shall refer to the post-catastrophe loss for which the assessment was imposed. Any such catastrophic assessment recoupment shall not be considered premium for any purpose including premium taxes or commissions, except that failure to pay the catastrophic assessment recoupment shall be treated as failure to pay premium and shall be grounds for termination of insurance. The identified catastrophic assessment recoupment shall be accompanied by an explanation of the assessment recoupment and shall appear on the medium by which the assessment recoupment is conveyed to the policyholder. The explanatory language shall be prescribed by the Commissioner.

(d) The Association shall report quarterly to the Commissioner providing all financial information for each catastrophic assessment recoupment authorized by this section, including total assessment recoupment funds recovered to date and any information reasonably requested by the Commissioner.

(e) Nothing contained in this section prohibits the Association from entering into any financing arrangements for the purpose of financing a deficit, provided that the pledge of catastrophic assessment recoupment amounts under such financing agreements shall not result in the actual levying of any assessment recoupment until after the Association has incurred a deficit and until after the Commissioner has approved implementation of the Association's assessment recoupment plan.

"**§ 58-45-50. Appeal from acts of Association to Commissioner; appeal from Commissioner to superior court.**

(a) Any person or any insurer who may be aggrieved by an act, ruling, or decision of the Association other than an act, ruling, or decision relating to (i) the cause or amount of a claimed loss or (ii) the reasonableness of expenses incurred by an insurer in adjusting windstorm and hail losses, may, within 30 days after the ruling, appeal to the Commissioner. Any hearings held by the Commissioner under the appeal shall be in accordance with rules adopted by the Commissioner: Provided, however, the Commissioner is authorized to appoint a member of the Commissioner's staff as deputy commissioner for the purpose of hearing those appeals and a ruling based upon the hearing shall have the same effect as if heard by the Commissioner. All persons or insureds aggrieved by any order or decision of the Commissioner may appeal as is provided in G.S. 58-2-75.

(b) No later than 10 days before each hearing, the appellant shall file with the Commissioner or the Commissioner's designated hearing officer and shall serve on the appellee a written statement of the appellant's case and any evidence that the appellant intends to offer at the hearing. No later than five days before the hearing, the appellee shall file with the Commissioner or the designated hearing officer and shall serve on the appellant a written statement of the appellee's case and any evidence that the appellee intends to offer at the hearing. Each hearing shall be recorded and may be transcribed. If the matter is between an insurer and the Association, the cost of the recording and transcribing shall be borne equally by the appellant and appellee; provided that upon any final adjudication the prevailing party shall be reimbursed for his share of such costs by the other party. If the matter is between an insured and the Association, the cost of transcribing shall be borne equally by the appellant and appellee; provided that the Commissioner may order the Association to pay recording or transcribing costs for which the insured is financially unable to pay. Each party shall, on a date determined by the Commissioner or the designated hearing officer, but not sooner than 15 days after delivery of the completed transcript to the party, submit to the Commissioner or the designated hearing officer and serve on the other party, a proposed order. The Commissioner or the designated hearing officer shall then issue an order.

"§ 58-45-55. Reports of inspection made available.

All reports of inspection performed by or on behalf of the Association shall be made available to the members of the Association, applicants, agent or broker, and the Commissioner.

"§ 58-45-60. Association and Commissioner immune from liability.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, the Association or its agents or employees, the board of directors, 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.

"§ 58-45-65. Association to file annual report with Commissioner.

The Association shall file in the office of the Commissioner on an annual basis on or before January 1 a statement which shall summarize the transactions, conditions, operations and affairs of the Association during the preceding year. Such statement shall contain such matters and information as are prescribed by the Commissioner and shall be in such form as is approved by him. The Commissioner may at any time require the Association to furnish to him any additional information with respect to its transactions or any other matter which the Commissioner deems to be material to assist him in evaluating the operation and experience of the Association.

"§ 58-45-70. Commissioner may examine affairs of Association.

The Commissioner may from time to time make an examination into the affairs of the Association when he deems it to be prudent and in undertaking such examination he may hold a public hearing pursuant to the provisions of G.S. 58-2-50. The expenses of such examination shall be borne and paid by the Association.

"§ 58-45-71. Report of member companies to Commissioner.

Each member company of the Association shall report by February 1 of each year to the Commissioner the amount of homeowner's coverage, including separate coverage for homeowner's wind and hail, written in the preceding calendar year by that member company in the Beach area and the Coastal area. The report shall include the number and type of homeowner's policies written by the member company in each area, the total amount of homeowner's coverage for each area, any increases and decreases in homeowner's coverage written in each area from the prior year, and other information as prescribed by the Commissioner and in such form as approved by him.

"**§ 58-45-75. Commissioner authorized to promulgate reasonable rules and regulations.**

The Commissioner shall have authority to make reasonable rules and regulations, not inconsistent with law, to enforce, carry out and make effective the provisions of this Article. The Commissioner shall not be liable for any act or omission in connection with the administration of the duties imposed upon him by the provisions of this Article.

"**§ 58-45-80. Premium taxes to be paid through Association.**

All premium taxes due on insurance written under this Article shall be remitted by each insurer to the Association; and the Association, as collecting agent for its member companies, shall forward all such taxes to the Secretary of Revenue as provided in Article 8B of Chapter 105 of the General Statutes.

"**§ 58-45-85. Assessment; inability to pay.**

(a) If any insurer fails, by reason of insolvency, to pay any assessment as provided in this Article, the amount assessed each insurer shall be immediately recalculated, excluding the insolvent insurer, so that its assessment is assumed and redistributed among the remaining insurers. Any assessment against an insolvent insurer shall not be a charge against any special deposit fund held under the provisions of Article 5 of this Chapter for the benefit of policyholders.

(b) The nonrecoupable assessment of a member insurer may be ordered deferred in whole or in part upon application by the insurer if, in the opinion of the Commissioner or his designee, payment of the assessment would render the insurer insolvent or in danger of insolvency or would otherwise leave the insurer in a condition so that further transaction of the insurer's business would be hazardous to its policyholders. If payment of an assessment against a member insurer is deferred by order of the Commissioner or his designee in whole or in part, the amount by which the assessment is deferred must be assessed against other member insurers in the same manner as provided in this Article. In its order of deferral, or in necessary subsequent orders, the Commissioner or his designee shall prescribe a plan by which the assessment so deferred must be repaid to the Association by the impaired insurer with interest at the six-month treasury bill rate adjusted semi-annually. The plan shall also provide for the reimbursement of excess assessments paid by member companies as a result of a deferral of assessments for an impaired insurer.

"**§ 58-45-90. Open meetings.**

The Association is subject to the Open Meetings Act, Article 33C of Chapter 143 of the General Statutes, as amended.

"**§ 58-45-95. Information availability.**

Information concerning the Association's activities shall be made fully available upon request by any company or Board member of the Association; provided, that no competitive information concerning an individual company's business plans, data, or operations may be disclosed by the Association if such company has properly designated such information as being a trade secret pursuant to G.S. 66-152(3) upon submitting such information to the Association. No confidential information may be disclosed by the Association identifying individual policyholders without such policyholder's consent unless such information is provided pursuant to reasonable rules adopted by the Association permitting such information

to be disclosed for the purpose of enhancing the availability of insurance that is written in the voluntary market.

"**§ 58-45-96. Succession and dissolution.**

In the event that a successor organization is created to perform the Association's general functions, the surplus, assets, and liabilities then held by the Association shall be transferred to such successor organization. The pledge or sale of, the lien upon, and the security interest in any rights, revenues, or other assets of the Association created pursuant to any financing arrangements entered into by the Association shall be and remain valid and enforceable on the successor organization, notwithstanding the commencement of any rehabilitation, insolvency, liquidation, bankruptcy, conservatorship, reorganization, or similar proceeding against the Association. No such proceeding shall relieve the Association of its obligation to continue to collect assessments or other revenues pledged pursuant to any financing arrangements. In the event of dissolution, surplus then held shall not be distributed to member insurers."

SECTION 2. Article 6 of Chapter 58 of the General Statues is amended by adding a new section to read:

"**§ 58-6-26. Additional insurance regulatory charge for the North Carolina Underwriting Association.**

There is levied an annual charge on the North Carolina Underwriting Association, created under G.S. 58-45-10, for the purpose of reimbursing the General Fund for the appropriations to the Department of Insurance to pay its expenses incurred in regulating the Association. The percentage rate shall be set by the Department each year. The minimum rate the Department may impose is one and one-half percent (1.5%). The percentage rate may not exceed the rate necessary to defray the costs incurred by the Department for the additional responsibilities of the Department imposed under G.S. 58-45-30. The percentage rate is applied to the premium taxes remitted to the Association by its members in G.S. 58-45-80. The charge levied on the Association is payable at the time the Association forwards the taxes remitted by its members to the Department of Revenue. The proceeds of the charge levied under this section shall be credited to the Insurance Regulatory Fund created under G.S. 58-6-25 and used in the manner set forth in that section. This charge is in addition to the charge imposed under G.S. 25-6-25."

SECTION 3. G.S. 58-36-10 reads as rewritten:

"**§ 58-36-10. Method of rate making; factors considered.**

The following standards shall apply to the making and use of rates:

(1) Rates or loss costs shall not be excessive, inadequate or unfairly discriminatory.

(2) Due consideration shall be given to actual loss and expense experience within this State for the most recent three-year period for which that information is available; to prospective loss and expense experience within this State; to the hazards of conflagration and catastrophe; to a reasonable margin for underwriting profit and to contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers; to investment income earned or realized by insurers from their unearned premium, loss, and loss expense reserve funds generated from business within this State; to past and prospective expenses specially applicable to this State; and to all other relevant factors within this State: Provided, however, that countrywide expense and loss experience and other countrywide data may be considered only where credible North Carolina experience or data is not available.

(3) In the case of property insurance rates under this Article, consideration may be given to the experience of property insurance business during the most recent five-year period for which that experience is available. In the case of property insurance rates under this Article, consideration shall be given to

the insurance public protection classifications of fire districts established by the Commissioner. The Commissioner shall establish and modify from time to time insurance public protection districts for all rural areas of the State and for cities with populations of 100,000 or fewer, according to the most recent annual population estimates certified by the State Budget Officer. In establishing and modifying these districts, the Commissioner shall use standards at least equivalent to those used by the Insurance Services Office, Inc., or any successor organization. The standards developed by the Commissioner are subject to Article 2A of Chapter 150B of the General Statutes. The insurance public protection classifications established by the Commissioner issued pursuant to the provisions of this Article shall be subject to appeal as provided in G.S. 58-2-75, et seq. The exceptions stated in G.S. 58-2-75(a) do not apply.

(4) Risks may be grouped by classifications and lines of insurance for establishment of rates, loss costs, and base premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in hazards or expense provisions or both. Those standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. The Bureau shall establish and implement a comprehensive classification rating plan for motor vehicle insurance under its jurisdiction. No such classification plans shall base any standard or rating plan for private passenger (nonfleet) motor vehicles, in whole or in part, directly or indirectly, upon the age or gender of the persons insured. The Bureau shall at least once every three years make a complete review of the filed classification rates to determine whether they are proper and supported by statistical evidence, and shall at least once every 10 years make a complete review of the territories for nonfleet private passenger motor vehicle insurance to determine whether they are proper and reasonable.

(5) In the case of workers' compensation insurance and employers' liability insurance written in connection therewith, due consideration shall be given to the past and prospective effects of changes in compensation benefits and in legal and medical fees that are provided for in General Statutes Chapter 97.

(6) To ensure that policyholders in the Beach and Coastal areas of the North Carolina Insurance Underwriting Association whose risks are of the same class and essentially the same hazard are charged premiums that are commensurate with the risk of loss and premiums that are actuarially correct, the North Carolina Rate Bureau shall revise, monitor and review the existing territorial boundaries used by the Bureau when appropriate to establish geographic territories in the Beach and Coastal areas of the Association for rating purposes. In revising these territories, the Bureau shall use statistical data sources available to define such territories to represent relative risk factors that are actuarially sound and not unfairly discriminatory. The new territories and any subsequent amendments proposed by the Bureau or Association shall be subject to the Commissioner's approval and shall appear on the Bureau Web site, the Association's Web site, and the Department's Web site once approved."

SECTION 4. G.S. 58-36-20(a) reads as rewritten:

"(a) At any time within 50 days after the date of any filing, the Commissioner may give written notice to the Bureau specifying in what respect and to what extent the Commissioner

contends the filing fails to comply with the requirements of this Article and fixing a date for hearing not less than 30 days from the date of mailing of such notice. At the hearing the factors specified in G.S. 58-36-10 shall be considered. If the Commissioner after hearing finds that the filing does not comply with the provisions of this Article, he may issue his order determining wherein and to what extent such filing is deemed to be improper and fixing a date thereafter, within a reasonable time, after which the filing shall no longer be effective. ~~Any order of disapproval under this section must be entered within 210 days after the date the filing is received by the Commissioner.~~"

SECTION 5. Article 36 of Chapter 58 is amended by adding a new section to read:

"**§ 58-36-120. Public notice of certain filings.**

Whenever the Rate Bureau files for an increase in insurance rates for residential property insurance, the Bureau shall give public notice in at least two newspapers with statewide distribution and in the North Carolina Register, within 10 business days after the filing, which notice shall state that the Commissioner may or may not schedule and conduct a hearing with respect to the filing. The same information shall be posted on the web site for the North Carolina Rate Bureau and the North Carolina Department of Insurance website within three days after the filing."

SECTION 6. G.S. 58-46-55 reads as rewritten:

"**§ 58-46-55. Rates, rating plans, rating rules, and forms applicable.**

(a) The rates, rating plans, rating rules, and forms applicable to the insurance written by the association shall be in accordance with the most recent manual rates or adjusted loss costs and forms that are legally in effect in this State. No special surcharge, other than those presently in effect, may be applied to the property insurance rates of properties located in the geographic areas to which this Article applies.

(b) The surcharges set out in G.S. 58-45-45 shall not apply to policies written in the FAIR plan."

SECTION 7. This act is effective when it becomes law and applies to policies filed, issued, and renewed on or after that date.

ATTACHMENT #1

Rep. Holliman, Goforth, Rep. Wray:

I am Rose Vaughn Williams and I am legislative counsel to the North Carolina Department of Insurance.

I have been asked to speak today to give you a broad and general outline of the Beach Plan. The bill will be spoken to later.

First point is, as you know, the Beach Plan is not a state agency; it is not run by the state, not run by DOI. The money in the Beach Plan belongs to the private insurance companies of NC, not the state. Fortunately, too, any liabilities and shortfalls of the Beach Plan are not a liability of the state.

The BP affects the HO insurance market of the entire state, however, and that is why it is important to discuss it as you are doing today.

The Beach Plan was created by the legislature after a legislative study in the late 60's to encourage economic development on the barrier island and to be sure folks on the beach could get insurance even if a company was not willing to sell them insurance there.

The Beach Plan is required by statue to be a market of last resort. It is meant to sell insurance to those who cannot get a private insurance company to sell to them.

From 1968 to 1988 the BP wrote "Dwelling and fire" only policies for the BEACH area. A Dwelling only policy is a "bare minimums". (Not a package policy).

In 1988 the General Assembly authorized insurance companies to send the wind portion of the risk of their policies to the Beach Plan (58-45-35(e) in what is called the Beach area. This is called "exing" the wind.

The Insurance Company keeps other risks like fire and theft, but sends the wind risk, the bigger risk, to the Beach Plan.

In 1997 the General Assembly extended the BP so it would also serve the 18 counties west of the inlet waterway: Beaufort, Brunswick, Camden, Carteret, Chowan', Craven, Currituck, Dare, Hyde, Jones, New Hanover, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Tyrell and Washington.

...the Beach Plan is not just houses on the beach...

In 1997 the General Assembly passed a law to allow the companies to begin exing the wind portion of their policies in the COAST areas, also (18 counties west of the inlet waterway)

This led to a big increase in the size of the Beach Plan and the exposure to loss that it had.

In 2003, the General Assembly authorized the BP to write full Homeowner's coverage (comprehensive coverage, not just the wind) for people on the beach and coast whose primary residence in on the beach or coastal area (not a vacation home). This was done via 58-45-35(d).

How the Beach Plan Operates

Pursuant to statute, the members of the Beach Plan are an "association" called the North Carolina Insurance Underwriting Association which was established by statute. Members of the Association consist of all insurers authorized to write essential property insurance (with a few exceptions I won't concern you with today).

By statute each member of the Association (each insurance company) participates in the expenses and losses of the Association by way of a

proportional formula that is based on the amount of Homeowner's Insurance business the company does in NC OUTSIDE the beach and coast area and the amount of Homeowner's insurance business ALL companies doing business in NC do outside the beach and coast area.

Each member company receives a credit each year for essential property insurance written in the beach and coastal areas. Their share of the expenses and losses of the Association are reduced accordingly, however, no credit is given if the peril of wind has been excluded. In other words, the more wind coverage an insurance company writes on the coast, the less that company will have to pay in any future assessments for shortfalls from the Beach Plan.

This is a very important feature of the Beach Plan created by the General Assembly because it acts as an incentive for companies to provide wind coverage on the coast. The more wind coverage a company writes, the less it will have to pay in any future assessments.

The Beach Plan operates as a private insurance company. The Beach Plan Board of Directors sets the minimum deductibles paid on policies in the Beach Plan, how much reinsurance is purchased, and how much surplus is held by the Beach Plan.

Rate.

By statute the rate the Beach Plan charges is the most recent rate filed by the Rate Bureau and approved by the Commissioner for property for use in the whole state.

Because the Beach Plan is supposed to be the market of last resort, statute 58-45-45(b) allows the "Wind Pool" (that part of the BP that covers only wind) to charge an amount above the manual rates on wind policies only. Right now that amount above the rate amount set

by the BP is 15%. So, when the BP has taken on a wind-only policy from a private insurer the Beach Plan charges the consumer 5% above the Rate Bureau set rate (which is the rate cap set by the Commissioner).

Statute 58-45-45(c) allows the BP to charge more than the Rate Bureau rate for Homeowner's policies issued by the Beach Plan. Homeowner's policies are policies that provide more than just wind coverage. Right now the BP has chosen to charge 15% above the Rate Bureau rate on full homeowner's policies in the BP.

The Beach Plan is supposed to be more expensive than the private market. It was not meant to compete with the private market and that is what the case has been. Private companies couldn't compete with the Beach Plan rate.

DOI's role in the Beach Plan

The role of the Department of Insurance in the Beach Plan is limited.

The Department of Insurance reviews and approves changes to the Beach Plan's Plan of Operation. 58-45-30(c)

The Commissioner of Insurance hears appeals from acts of the Beach Plan.

The Department of Insurance reviews and approves the rates of the separate polices of windstorm and hail insurance (that 15% and 25%).

The COI appoints those 4 members of the BP Board of Directors who are insurance agents and he appoints the 3 public members to the BP Board of Directors. The remaining 7 members are appointed by the insurance companies.

Surplus

Right now it has close to $800 million in equity, or surplus. Four years ago they had only just over 100 million in surplus.

Retaining surplus is new and wasn't always done by the Beach Plan. It is the companies' money, so the companies returned it to their members. The BP has recently begun to retain surplus instead of returning it to the companies.

Reinsurance

This is "insurance on the insurance". The BP has purchased over a billion dollars worth of reinsurance since 2007. They held no reinsurance before that. They plan to buy more reinsurance with the surplus that has been retained.

The total value of property covered by the Beach Plan excluding commercial property is about 60 billion in PRIVATE property, about 70 billion if you include commercial property. This number changes of course, as values change.

The issue is complex. A study was held by a legislative panel after the end of the last session and that group met numerous times up to January 21st of this year to learn about the issue. The conclusions of that study were condensed in a report by legislative staff, including a proposed bill, which became the impetus for this bill, HB 1305.

The big issue is that the Beach Plan does not have enough surplus and reinsurance to pay claims for a large catastrophic storm or series of storms that may occur in a year. A shortfall in the BP means the BP will assess all HO insurance companies doing business in NC to make up for the shortfall. The companies are calculating that their assessments will be huge and believe that for some of them the assessments will exceed

their total amount of premium in the state. They are becoming increasingly concerned.

Some smaller companies have left the state, some have reduced the number of homeowner's policies they are selling in the state, and some have made other underwriting changes, such as only selling homeowner's policies if the customer also buys their auto policy from that company. When companies reduce their writings it affects the whole state, not just the beach and coastal areas, because the amount of their Beach Plan assessments is based on the amount of Homeowner's insurance the company sells OUTSIDE the beach and coastal area.

Even homeowners' insurance companies who only write in the central or western part of our state must participate in the Beach Plan assessments.

COMMISSIONER

Remarks by Insurance Commissioner Wayne Goodwin
House[WG1] Insurance Committee Meeting
Legislative Building
June 25, 2009 • 11:00 a.m.

- **Good morning, Mr. Chairman and Members of the Committee.**

- **This is my first time speaking in-person before the House Insurance Committee since my election.**

- **Today I appear because of before you about a bill that was prompted by your Joint Legislative Study Committee on the Impact of Hurricanes on the North Carolina Insurance Market.**

- **Before you do your duty deliberating the subject of this bill and the issue of coastal insurance, I will take just a few**

brief minutes to reflect on what duty our State statutes require of me.

- **As our state's Insurance Commissioner, I have a *dual* duty:**

- **<u>First</u>, our law requires that the Insurance Commissioner protect consumers from excessive, inadequate and unfairly discriminatory insurance rates.**

- **<u>Second</u>, our law requires that the Insurance Commissioner do all he or she can to ensure a solvent, accessible (which means "available"), well-regulated insurance market in North Carolina.**

- ***Some* may say that those two duties are mutually exclusive. They are not. As**

Insurance Commissioner I spend <u>every</u> day protecting consumers by working for fair rates based on actual risk, and working to ensure that insurance companies that do business here in NC follow State law and are solvent in order to pay claims so that consumers may repair their homes or replace their damaged property, and otherwise resume their lives after a particular incident.

- **To perform this job I have the benefit of a terrific team of independent experts with many years of experience performing actuarial and statistical analyses at the Department, and with many years working with my Department and now with me to meet**

those dual duties of the office of Insurance Commissioner.

- **These are the same experts whose recommendations to the office of Insurance Commissioner have saved consumers many Billions of dollars over the years.**

- **Despite the short title of the bill, what has led us to this point is <u>not</u> an eastern NC versus western NC issue. What's led us to this point is <u>not</u> just a NC issue. Coastal insurance and the availability of insurance have quickly become a legislative issue in <u>every</u> State with a coastline between Maine and Texas. *A significant part of the problem has been the lack of certainty for insurers and consumers as to what happens from***

a homeowners' insurance perspective when the next series of seriously catastrophic storms strike the Tar Heel state.

- **And, unlike some states that have handled it poorly, it is my duty to make sure our legislators have the benefit of our independent experts at the Department of Insurance so that NC can work *before* a storm or series of storms hits so that our state is as prepared as possible to deal with the potential outcomes and protect our people and property.**

- **To that end, preventing a homeowners' insurance availability crisis across the State is an imperative … We must do our level best to avoid and prevent a**

homeowners' insurance crisis that has already stricken other Southern states, states that have been *reactive* instead of *proactive* on their own coastal insurance crises.

- **By being *proactive*, NC will help ensure all North Carolinians continue to have access to homeowners' insurance from solvent companies and have a choice among insurance companies.**

- **In meeting with Insurance Commissioners around the nation on the subject of post-catastrophe coastal insurance, and particularly in the South, I can tell you this: NC must handle this issue in a way that's *right and best* for NC, that protects**

consumers *and* preserves a choice among solvent companies.

- ***If we do not act*, then many NC consumers will <u>not</u> have insurance to rebuild after a Hurricane Hazel-like catastrophe.**

- ***If we do not act* in an appropriate way for NC, then we will see even more insurance companies either reduce their coverage and lines of insurance here <u>or</u> leave the State altogether, and not just the beach or coast.**

- ***If we do not act*, then as those insurance companies leave … our citizens and small businesses all over NC will have *fewer and fewer* companies from which to get not only their homeowners'**

insurance but also their auto, commercial liability, and other types of insurance.

- **Do know that throughout the process of analyzing the issue before your joint legislative study committee and thereafter, my Department of Insurance staff and I have fought long and hard to protect consumers. In fact, this one issue alone has consumed much of every workday since my term began in January.**

- **And, as you will see during your deliberations on this bill, this is a *most complex issue* -- In addition to my dual duties as Insurance Commissioner, addressing our coastal insurance crisis necessarily involves an understanding**

of: (1) the business of insurance, including availability of re-insurance on the international scale; (2) State and federal law; (3) mathematical science; (4) actuarial science; (5) political science; and, (6) meteorological science. The first four of those rely upon certainties and data; the remaining two – as we all know - are obviously much less certain but are nonetheless important.

- **Whatever the solution is will involve <u>both</u> science and policy.**

- **As Insurance Commissioner, I take my charge very seriously to ensure that we protect consumers protect consumers by ensuring a solvent, accessible, well-**

regulated insurance market across our State.

- **And, as you all know, no one piece of legislation is perfect and this bill certainly is not perfect. But legislation, particularly involving complex subjects, is often the result of compromise.**

- **Accordingly, I believe that this is the best compromise bill *possible at this time* for consumers because it only applies IF AND WHEN there is a future huge, Hurricane Hazel-like storm. I also know that this bill is a work in progress.**

- **As I've stated since last year, with an complex subject involving *so many moving parts*, there necessarily needs to**

be <u>one</u> comprehensive bill and not multiple separate bills.

- **One simple but significant thing to know about this bill is this: By requiring the coastal insurance wind pool to retain its present surplus *and* by requiring the insurance industry to take other measures in the bill, we all will be forcing the insurance industry to give up $800 Million in surplus *plus* another $1 Billion to help North Carolina recover from a future Hazel-like hurricane.**

- **That protects consumers.**

- **The more money that the Beach Plan has in the bank, the larger the storm or series of storms it can handle *without***

turning to its member companies, and subsequently, policyholders.

- **That also protects consumers.**
- **In this bill we also have mitigation credits. That means if an affected homeowner has taken steps to protect one's home – such as by installation of shutters or other storm prevention measures – then there will be a discount on their insurance premium.**
- **That protects consumers.**
- **In this bill we also have a voluntary installment payment plan for those homeowners affected by coastal rate increases.**
- **That's good for consumers.**

- **Additionally, there is more oversight of the Beach Plan and coastal insurance program by the Department of Insurance.**

- **That also protects consumers.**

- **And, as to the Department's statutory duty to maintain a solvent and accessible marketplace, I am obligated to report to you that we've heard and continue to hear the threats from industry saying that they will leave the state if North Carolina does not address the crisis now.**

- **Because of what we have witnessed in other Southern states and have continued to see here in NC, and based on my independent technical experts at**

the Department, I have no choice but to believe *some* of what the insurance companies are saying.

- **Fewer insurance companies doing business here means less choice for consumers and ultimately higher rates for… all… of North Carolina.**

- **This is unacceptable.**

- **Everyone – consumers and the industry - need certainty in the event of a catastrophic wind event.**

- **We, of course, at the Department of Insurance want to see consumers across the state have a *lessened* chance of having to pay for a catastrophe.**

- **I assure you that my focus is and will always be on the dual duties that ultimately protect consumers.**

- **And, that is why I've been meeting with and listening to consumers and businesses and local officials all across North Carolina on this subject.**

- **Thank you, Mr. Chairman and members of the committee.**

This bill changes part of this, but not much. In a nutshell, it does the following:

- The $750 million in retained earnings of the Beach Plan is taken forever to be used to pay losses and expenses.
- The insurance companies still don't get any premiums on policies issued by the Beach Plan, and they still have to pay excess losses.
- But under the bill, what they have to pay is capped at $1 billion per year.
- In the event of a catastrophic hurricane- more severe than any North Carolina has ever experienced- losses in excess of Beach Plan resources would be spread across the state but with a number of safeguards.
  1) No statewide surcharge would take place until the Beach Plan has used its assets to pay toward those losses;
  2) No surcharge would take place until the insurance companies have paid an additional $1 billion toward those losses- each year;
  3) No statewide surcharge would take place until the reinsurance was exhausted;
  4) In fact, under conditions as they exist in 2009, no surcharge could be imposed until the Beach Plan has paid out $2.4 billion in losses to its policyholders.
  5) Surcharges would be capped at 10% of the policyholder's premium per year. (the average annual policy premium in N.C. is $600- so the average policyholder would receive a $60 surcharge.)
  6) Put in perspective, the most losses the Beach Plan has ever paid in one year on policies the Beach Plan issued was $149.7 million when Hurricane Fran hit N.C. in 1996;
- Attached is a copy of the chart that was explained in committee last Thursday.

What do other southeastern coastal states do? Most have no company assessments- all excess losses are passed on to policyholders.

What is the alternative?

1) Do what other states do.
2) Charge higher premiums so companies will be encouraged to write policies in coastal areas.
3) Do nothing. The Commissioner and the companies say that is not an option.

The industry still has a number of objections to this bill. Yet, without this legislation, according to the Commissioner, the insurance market in North Carolina is a ticking time bomb. I won't speculate on what will happen to the insurance market in North Carolina if this problem is not addressed. The Commissioner has expressed his opinion. The Insurance Federation of North Carolina joins with the Commissioner and urges you to pass HB 1305.

Sincerely yours,

John B. McMillan

Attachment

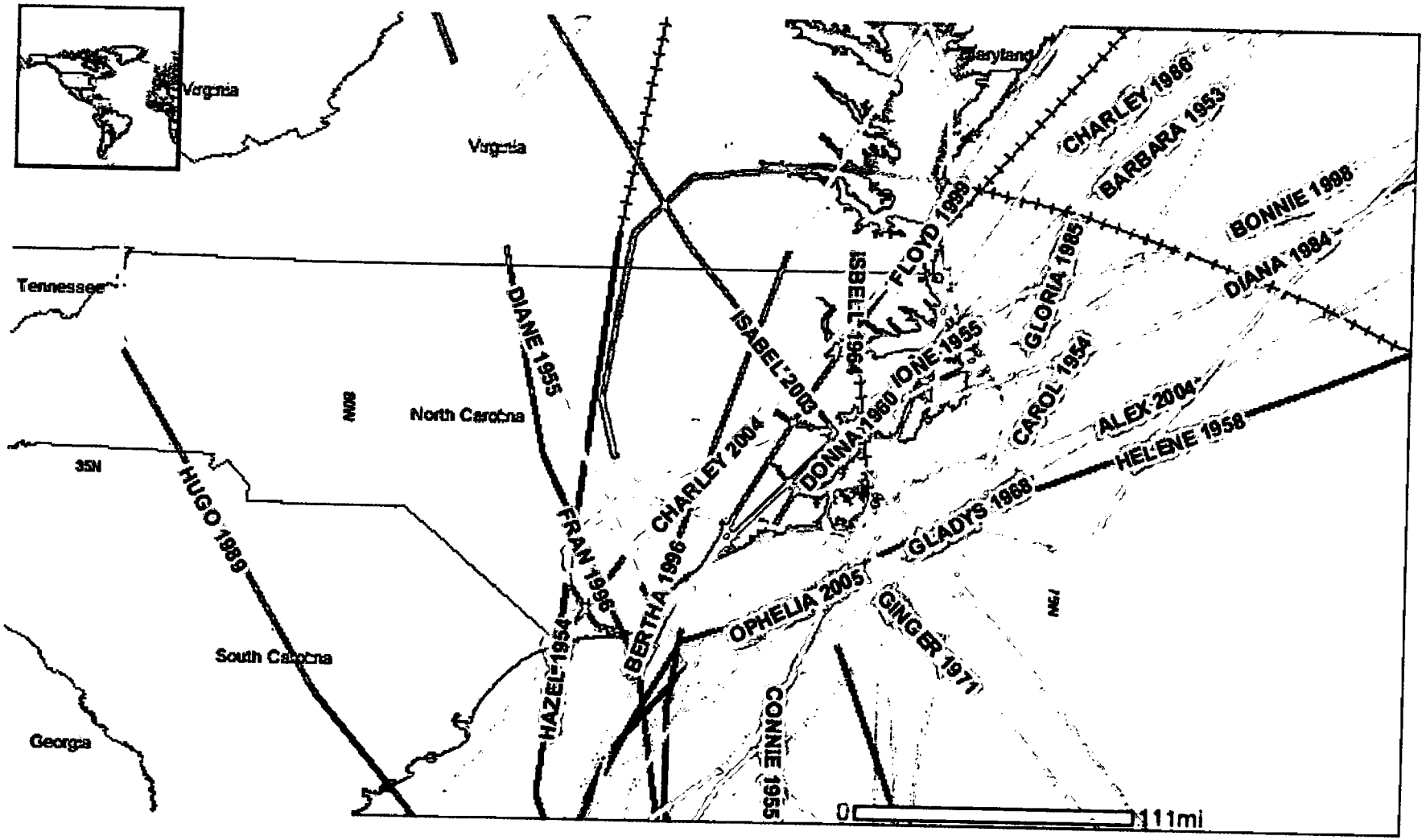
NORTH CAROLINA BEACH PLAN 2009

<table>
<tr><th>RETAINED EARNINGS</th><th>NON RECOUPABLE ASSESSMENTS</th><th colspan="3">REINSURANCE WITH 25% CO-PAY</th></tr>
<tr><td>$250 Million</td><td rowspan="2">$700 Million</td><td>$250 Million Co-Pay</td><td>$50 Million Co-Pay</td><td>$200 Million Catastrophic Surcharges</td></tr>
<tr><td>$500 Million</td><td>$750 Million Reinsurance</td><td>$150 Million Reinsurance</td><td>$600 Million Reinsurance</td></tr>
</table>

$2.4 Billion in Losses Before Catastrophic Surcharges

Since 1950, 24 named hurricanes (Category 1-5) have hit North Carolina. While a handful of storms have ventured inland and caused damage far from the coast, the majority of storms' paths follow the coastline.

The below map shows the storms affecting North Carolina since 1950.



Source: NOAA Coastal Services Center

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

Senate ☒ Committee Substitute for
HB 1294 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE NORTH CAROLINA HEALTH INSURANCE RISK POOL TO PROVIDE PREMIUM SUBSIDIES IF FUNDS ARE AVAILABLE AND TO REQUIRE INSURERS TO NOTIFY APPLICANTS FOR HEALTH INSURANCE COVERAGE ABOUT THE EXISTENCE OF THE POOL.

☒ With recommendation that the House concur, and be referred to J 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 bill/resolution is placed on the Calendar of _____.

HOUSE PAGES

NAME OF COMMITTEE Insurance DATE June 25, 2009

1. Name: Catherine Hedgepeth
   County: Nash
   Sponsor: Stewart
2. Name: Robert Barnes
   County: Nash
   Sponsor: Stewart
3. Name: Lexi Hegeth
   County: Wake
   Sponsor: Paul Stam
4. Name: Hillary Davis
   County: Wake
   Sponsor: Ross
5. Name:
   County:
   Sponsor:

SGT-AT-ARM

1. Name: John Brandon
2. Name: Martha Gaddison
3. Name: Trey Raby
4. Name:

HOUSE INSURANCE COMMITTEE

June 29 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

HB 1305 – BEACH PLAN CHANGES – Reps. Holliman

Adjourn

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 30, 2009

The House Committee on Insurance met at 11:00 AM on Tuesday, June 30, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael H. Wray; Vice Chairs: M. Dickson and J. Dockham. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Cole, Current, Faison, Gibson, Holliman, Howard, Hughes and Pierce.

Chairman Goforth called the meeting to order and welcomed visitors. He recognized Sgt-At-Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachment #1)

Chairman Goforth recognized Rep. Holliman to continue discussion on HB 1305 – Beach Plan Changes. The objective is to make changes to the Beach Plan that will position the Beach Plan to be what it was intended to be – the insurer of last resort and not the insurer of first resort. We have worked diligently with the industry and the Department of Insurance to come up with a bill everyone can support.

Chairman Goforth recognized Ms. Lisa Martin, with the North Carolina Homebuilders, and asked her to continue her remarks from last week. Her Association feels flood insurance should not be required by the Beach Plan, and it does not support lowering the maximum value of coverage from the current $1.5 million to $750,000.

The Chair called upon Mr. Mac Montgomery, Mayor of Kure Beach. He is concerned about insurance provided under the North Carolina Beach Plan and the future of fair and equitable insurance coverage on the coast. He represents a small coastal community that is fairly typical. He and his Council are committed to working together with all parties to come up with a solution that will benefit all parts of our state. (Attachment #2)

The Chair recognized Mr. Rick Zechini, North Carolina Association of Realtors, and he stated the legislation is a great step in the right direction. His Association has similar interests as the Homebuilders Association.

Next, Mr. John Miletti, Vice President Governmental Affairs, Travelers Insurance, echoed the previous speakers. It appears the committee is close to having a piece of legislation ready. It is important to take into account what other states have done to try and maintain and improve their market place. He is looking forward to working with everyone to get to a final finished product.

Mr. John Bode, lobbyist for Independent Insurance Agents, is pleased with the bill. He has been working with the Department of Insurance, companies and people on the beach for the last three years to get something that will helps North Carolina and the coastal community to prepare itself for what inevitably will be coming some day-a Hurricane Hazel type storm.

Mr. John McMillan, Insurance Federation of North Carolina, stated the Federation joins with the Commissioner of Insurance and urges passage of HB 1305. The Federation has concerns about the bill as noted in his June 29th, 2009, letter. (Attachment #3)

Rep. Faison was recognized and moved that the PCS for HB 1305 be given a favorable report, unfavorable as to original bill, and re-referred to the Finance Committee, and the motion passed.

Chairman Goforth adjourned the meeting at 11:40 AM.

Bruce Goforth

Representative Bruce Goforth, Chairman

Mary Capps

Mary Capps – Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1305
PROPOSED COMMITTEE SUBSTITUTE H1305-CSRG-43 [v.12]

6/24/2009 9:06:31 PM

Short Title: Beach Plan Changes. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE COASTAL PROPERTY INSURANCE POOL, PRESENTLY KNOWN AS THE BEACH PLAN, AS RECOMMENDED BY THE JOINT SELECT STUDY COMMITTEE ON THE POTENTIAL IMPACT OF MAJOR HURRICANES ON THE NORTH CAROLINA INSURANCE INDUSTRY; REQUIRE THAT THE NORTH CAROLINA RATE BUREAU PROVIDE PUBLIC NOTICE OF CERTAIN FILINGS IN NEWSPAPER PUBLICATIONS AND VIA INTERNET; RE-AFFIRM THAT THE NORTH CAROLINA INSURANCE UNDERWRITING ASSOCIATION IS INTENDED TO BE EXEMPT FROM STATE AND FEDERAL TAXATION, EXCEPT FOR PREMIUM TAXES; CLARIFY THE POWERS AND DUTIES OF THE ASSOCIATION; CLARIFY AND PROVIDE CERTAINTY REGARDING ASSESSMENTS AGAINST MEMBER INSURANCE COMPANIES BY THE ASSOCIATION; ADJUST THE COASTAL INSURANCE COVERAGE LIMITS OF THE ASSOCIATION IN ORDER TO ENSURE THAT THE COASTAL PROPERTY INSURANCE POOL IS THE MARKET OF LAST RESORT; MANDATE THAT THE ASSOCIATION SHALL RETAIN ALL SURPLUS FOR USE IN PURCHASING REINSURANCE, PAYING CLAIMS TO POLICYHOLDERS, AND FOR ASSOCIATION OBLIGATIONS; PROHIBIT DISTRIBUTION OF SURPLUS TO MEMBER INSURANCE COMPANIES; REQUIRE THE ASSOCIATION TO FILE A SCHEDULE OF PREMIUM CREDITS FOR COASTAL INSURANCE POLICYHOLDERS WHO HAVE VOLUNTARILY MITIGATED THEIR RISK OF DAMAGE FROM HURRICANES AND OTHER WIND DAMAGE; REQUIRE THE ASSOCIATION TO ESTABLISH AND MAINTAIN AN INSTALLMENT PLAN FOR PREMIUM PAYMENTS FOR THE EASE OF POLICYHOLDERS; DEFINE AND ESTABLISH WHAT ACTIONS ARE ALLOWED UPON THE OCCURRENCE OF A DEFICIT EVENT, INCLUDING CAPPING ANY CATASTROPHIC ASSESSMENT RECOUPMENT FROM HOMEOWNERS STATEWIDE; IMPOSE AN ADDITIONAL REGULATORY CHARGE ON THE ASSOCIATION TO BE PAID TO THE DEPARTMENT; REQUIRE THAT ASSOCIATION ACTIVITIES BE MADE TRANSPARENT AND AVAILABLE TO ANY MEMBER COMPANY OR BOARD MEMBER; PROVIDE FOR SUCCESSION AND DISSOLUTION OF THE ASSOCIATION; PROVIDE FOR SURCHARGES OF TEN PERCENT FOR SEPARATE WIND AND HAIL COVERAGE, TWENTY PERCENT FOR WIND AND HAIL HOMEOWNERS COVERAGE, AND A MINIMUM WIND AND HAIL DEDUCTIBLE

OF ONE PERCENT FOR COVERAGE WRITTEN BY THE ASSOCIATION; PROVIDE FOR SURCHARGES ON COMMERCIAL AND DWELLING COVERAGE IN ADDITION TO SURCHARGES CURRENTLY IMPOSED ON HOMEOWNERS POLICIES; DELETE THE TIME LIMIT FOR THE COMMISSIONER TO DISAPPROVE A RATE BUREAU FILING AND TO MAKE OTHER CHANGES CONSISTENT WITH THE FINDINGS OF THE JOINT SELECT STUDY COMMITTEE ON THE POTENTIAL IMPACT OF MAJOR HURRICANES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 45 of Chapter 58 of the General Statutes reads as rewritten:

"Article 45.

"Essential Property Insurance for Beach Area Property.

"**§ 58-45-1. Declarations and purpose of Article.**

(a) It is hereby declared by the General Assembly of North Carolina that an adequate market for essential property insurance is necessary to the economic welfare of the beach and coastal areas of the State of North Carolina and that without such insurance the orderly growth and development of those areas would be severely impeded; that furthermore, adequate insurance upon property in the beach and coastal areas is necessary to enable homeowners and commercial owners to obtain financing for the purchase and improvement of their property; and that while the need for such insurance is increasing, the market for such insurance is not adequate and is likely to become less adequate in the future; and that the present plans to provide adequate insurance on property in the beach and coastal areas, while deserving praise, have not been sufficient to meet the needs of this area. It is further declared that the State has an obligation to provide an equitable method whereby every licensed insurer writing essential property insurance in North Carolina is required to meet its public responsibility instead of shifting the burden to a few willing and public-spirited insurers. It is the purpose of this Article to accept this obligation and to provide a mandatory program to assure an adequate market for essential property insurance in the beach and coastal areas of North Carolina.

(b) The General Assembly further declares that it is its intent in creating and, from time to time, amending this Article that the market provided by this Article not be the first market of choice, but the market of last resort.

(c) It is the intent of the General Assembly that except for North Carolina gross premium taxes and the fire and lightning tax, the activities of the Association be exempt from State and federal taxation to the fullest extent permitted by law.

"**§ 58-45-5. Definition of terms.**

As used in this Article, unless the context clearly otherwise requires:

(1) ~~"Association" means~~Association. – ~~the~~ The North Carolina Insurance Underwriting Association established under this Article;

(2) ~~"Beach area" means~~ Beach area. – ~~all~~ All of that area of the State of North Carolina south and east of the inland waterway from the South Carolina line to Fort Macon (Beaufort Inlet); thence south and east of Core, Pamlico, Roanoke and Currituck sounds to the Virginia line, being those portions of land generally known as the Outer Banks;

(2a) ~~"Coastal area" means~~Coastal area. – ~~all~~ All of that area of the State of North Carolina comprising the following counties: Beaufort, Brunswick, Camden, Carteret, Chowan, Craven, Currituck, Dare, Hyde, Jones, New Hanover, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Tyrrell, and Washington. "Coastal area" does not include the portions of these counties that lie within the beach area.

(2b) Coastal Property Insurance Pool. – The name of that which was formerly known as "the Beach Plan", and which is governed by the North Carolina Insurance Underwriting Association. All references to the "Beach Plan" shall

mean the Coastal Property Insurance Pool, which is the market of last resort provided by the Association to the Beach area and the Coastal area.

(3) Repealed by Session Laws 1991, c. 720, s. 6.

(3a) ~~"Crime insurance" means~~Crime insurance. – ~~insurance~~ Insurance against losses resulting from robbery, burglary, larceny, and similar crimes, as more specifically defined and limited in the various crime insurance policies, or their successor forms of coverage, approved by the Commissioner and issued by the Association. Such policies shall not be more restrictive than those issued under the Federal Crime Insurance Program authorized by Public Law 91-609.

(3b) ~~"Directors" means~~Directors. – ~~the~~ The Board of Directors of the Association.

(4) ~~"Essential property insurance" means~~Essential property insurance. – ~~insurance~~ Insurance against direct loss to property as defined in the standard statutory fire policy and extended coverage, vandalism and malicious mischief endorsements thereon, or their successor forms of coverage, as approved by the Commissioner;

(5) ~~"Insurable property" means~~ Insurable property. – ~~real~~ Real property at fixed locations in the beach and coastal area, including travel trailers when tied down at a fixed location, or the tangible personal property located therein, but shall not include insurance on motor vehicles; which property is determined by the Association, after inspection and under the criteria specified in the plan of operation, to be in an insurable condition. However, any one and two family dwellings built in substantial accordance with the Federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards promulgated by the association and approved by the Commissioner, or the North Carolina Uniform Residential Building Code and any structure or building built in substantial compliance with the North Carolina State Building Code, including the design-wind requirements, which is not otherwise rendered uninsurable by reason of use or occupancy, shall be an insurable risk within the meaning of this Article. However, none of the following factors shall be considered in determining insurable condition: neighborhood, area, location, environmental hazards beyond the control of the applicant or owner of the property. Also, any structure begun on or after January 1, 1970, not built in substantial compliance with the Federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards promulgated by the association and approved by the Commissioner, or the North Carolina Uniform Residential Building Code or the North Carolina State Building Code, including the design-wind requirements therein, shall not be an insurable risk. The owner or applicant shall furnish with the application proof in the form of a certificate from a local building inspector, contractor, engineer or architect that the structure is built in substantial accordance with the Federal Manufactured Home Construction and Safety Standards, any predecessor or successor federal or State construction or safety standards, and any further construction or safety standards promulgated by the association and approved by the Commissioner, or the North Carolina Uniform Residential Building Code or the North Carolina State Building Code; however, an individual certificate shall not be necessary where the structure is located within a political

subdivision which has certified to the Association on an annual basis that it is enforcing the North Carolina Uniform Residential Building Code or the North Carolina State Building Code and has no plans to discontinue enforcing these codes during that year.

(6) Repealed by Session Laws 1995 (Regular Session, 1996), c. 592, s. 2.

(6a) ~~"Net direct premiums" means~~Net direct premiums. – ~~gross~~ Gross direct premiums (excluding reinsurance assumed and ceded) written on property in this State for essential property insurance, farmowners insurance, homeowners insurance, and the property portion of commercial multiple peril insurance policies as computed by the Commissioner, less:

a. Return premiums on uncancelled contracts;

b. Dividends paid or credited to policyholders; and

c. The unused or unabsorbed portion of premium deposits.

(6b) Nonrecoupable assessment. – Any assessment levied on and payable by members of the Association that is not directly recoverable from policyholders, but which shall be considered as an appropriate factor in the making of rates by the North Carolina Rate Bureau.

(7) ~~"Plan of operation" or "plan" means~~Plan of operation. – ~~the~~ The plan of operation of the Association approved or promulgated by the Commissioner under this Article.

(8) Catastrophic assessment recoupment. – Any recoupment of assessments on member insurers collected by member insurers from policyholders statewide, including Association and Fair Plan policyholders, upon issuance or renewal of residential and commercial property insurance policies, other than National Flood Insurance policies, after a deficit event has occurred as provided in G.S. 58-45-47. The amount of the catastrophic assessment recoupment or recoupments collected in a particular year shall not exceed an aggregate amount of ten percent (10%) of policy premium. A catastrophic assessment recoupment shall be limited to the recovery of losses resulting from claims for property damage and allocated loss expenses.

(9) Voluntary market. – Insurance written voluntarily by companies other than through this Article or Article 46 of this Chapter.

(10) Voluntary market rates. – Property insurance rates determined or permitted under Articles 36, 40, or 41 of this Chapter.

"§ 58-45-6. Persons who can be insured by the Association.

As used in this Article, "person" includes the State of North Carolina and any county, city, or other political subdivision of the State of North Carolina.

"§ 58-45-10. North Carolina Insurance Underwriting Association created.

There is hereby created the North Carolina Insurance Underwriting Association, consisting of all insurers authorized to write and engage in writing within this State, on a direct basis, essential property insurance, except town and county mutual insurance associations and assessable mutual companies as authorized by G.S. 58-7-75(5)b, 58-7-75(5)d, and 58-7-75(7)b and except an insurer who only writes insurance in this State on property exempted from taxation by the provisions of G.S. 105-278.1 through G.S. 105-278.8. Every such insurer shall be a member of the Association and shall remain a member of the Association so long as the Association is in existence as a condition of its authority to continue to transact the business of insurance in this State.

"§ 58-45-15. Powers and duties of Association.

The Association shall, pursuant to the provisions of this Article and the plan of operation, and with respect to the insurance coverages authorized in this Article, have the power on behalf of its members:

(1) To cause to be issued policies of insurance to applicants;
(2) To assume reinsurance from its members;
(3) To cede reinsurance to its members and to purchase reinsurance in behalf of its ~~members.~~members; and
(4) To require insureds of the Association to purchase federal flood insurance where applicable and available in order to obtain replacement cost, to the extent possible, or other preferential forms, endorsements, or coverages.
(5) To pledge the proceeds of assessments, projected reinsurance recoveries, other recoverables, and any other funds available to the Association as the source of revenue for and to secure lines of credit or other borrowings or financing arrangements necessary to fund any actual, projected, or future deficits of the Association.
(6) To publish in the North Carolina Register all homeowners' rate filings with the Department of Insurance.

"§ 58-45-20. Temporary directors of Association.

Within 10 days after April 17, 1969, the Commissioner shall appoint a temporary board of directors of this Association, which shall consist of 11 representatives of members of the Association. Such temporary board of directors shall prepare and submit a plan of operation in accordance with G.S. 58-45-30 and shall serve until the permanent board of directors shall take office in accordance with said plan of operation.

"§ 58-45-25. Each member of Association to participate in nonrecoupable assessments. ~~its expenses, profits, and losses.~~

(a) Subject to the limitations contained in G.S. 58-45-47, ~~Each~~ each member of the Association shall participate in the ~~expenses, profits, and losses of~~nonrecoupable assessments levied by the Association in the proportion that its net direct premium written in this State during the preceding calendar year for residential and commercial properties outside of the beach and coastal areas bears to the aggregate net direct premiums written in this State during the preceding calendar year for residential and commercial properties outside of the beach and coastal areas by all members of the Association, as certified to the Association by the Commissioner. The Commissioner shall certify each member's participation after review of annual statements and any other reports and data necessary to determine participation and may obtain any necessary information or data from any member of the Association for this purpose. Any insurer that is authorized to write and that is engaged in writing any insurance, the writing of which requires the insurer to be a member of the Association under G.S. 58-45-10, shall become a member of the Association on the first day of January after authorization. The determination of the insurer's participation in the Association shall be made as of the date of membership of the insurer in the same manner as for all other members of the Association.

(b) All member companies shall receive credit each year for essential property insurance, farmowners insurance, homeowners insurance, and the property portion of commercial multiple peril policies voluntarily written in the beach and coastal areas in accordance with guidelines and procedures to be submitted by the Directors to the Commissioner for approval. Such credits shall also apply to any nonrecoupable assessments levied pursuant to G.S. 58-45-47. The participation of each member company in the ~~expenses, profits, and losses of~~ nonrecoupable assessments levied by the Association shall be reduced accordingly; provided, no credit shall be given where coverage for the peril of wind has been excluded. The guidelines and procedures for granting credit shall encourage and assist each member company to voluntarily write these coverages in the beach and coastal areas for commercial and residential properties.

(b1) The accumulated surplus of the Association shall be retained from year to year and used to pay losses, reinsurance costs, and other operating expenses as necessary. No member

company shall be entitled to the distribution of any portion of the Association's surplus, except pursuant to contractual obligations incurred prior to the effective date of this law.

(b2) The premiums, surplus, assessments, investment income, and other revenue of the Association are funds received for the sole purpose of providing insurance coverage, paying claims for Association policyholders, purchasing reinsurance, securing and repaying debt obligations issued by the Association, and conducting all other activities of the Association, as required or permitted by this Article. Accumulated surplus shall not be removed from the Association or used for other purposes except pursuant to contractual obligations incurred by the Association prior to the effective date of this law.

(c) The North Carolina Insurance Underwriting Association shall use the "take out" program, as filed with and approved by the Commissioner, in the coastal area.

"**§ 58-45-30. Directors to submit plan of operation to Commissioner; review and approval; ~~amendments.~~amendments; appeal from Commissioner to superior court.**

(a) The Directors shall submit to the Commissioner for his review and approval, a proposed plan of operation. The plan shall set forth the number, qualifications, terms of office, and manner of election of the members of the board of directors, and shall grant proper credit annually to each member of the Association for essential property insurance, farmowners, homeowners insurance, and the property portion of commercial multiple peril policies voluntarily written in the beach and coastal areas and shall provide for the efficient, economical, fair and nondiscriminatory administration of the Association and for the prompt and efficient provision of essential property insurance in the beach and coastal areas of North Carolina to promote orderly community development in those areas and to provide means for the adequate maintenance and improvement of the property in those areas. The plan may include the establishment of necessary facilities; management of the Association; the assessment of members to defray losses and expenses; underwriting standards; procedures for the acceptance and cession of reinsurance; procedures for determining the amounts of insurance to be provided to specific risks; time limits and procedures for processing applications for insurance; and any other provisions that are considered necessary by the Commissioner to carry out the purposes of this Article.

(b) The proposed plan and any amendments thereto shall be filed with ~~reviewed by~~ the Commissioner and approved by him if he finds that such plan fulfills the purposes provided by G.S. 58-45-1. In the review of the proposed plan the Commissioner may, in his discretion, consult with the directors of the Association and may seek any further information which he deems necessary to his decision. If the Commissioner approves the proposed plan, he shall certify such approval to the directors and the plan shall become effective 10 days after such certification. If the Commissioner disapproves all or any part of the proposed plan of operation he shall return the same to the directors with his written statement for the reasons for disapproval and any recommendations he may wish to make. The directors may alter the plan in accordance with the Commissioner's recommendation or may within 30 days from the date of disapproval return a new plan to the Commissioner. Should the directors fail to submit a plan that meets the requirements of this Article ~~a proposed plan of operation within 90 days of April 17, 1969, or a new plan which is acceptable to the Commissioner~~, or accept the recommendations of the Commissioner within 30 days after his disapproval of the plan, the Commissioner shall promulgate and place into effect a plan of operation that meets the requirements of this Article certifying the same to the directors of the Association. Any such plan promulgated by the Commissioner shall take effect 10 days after certification to the directors: ~~Provided, however, that until a plan of operation is in effect, pursuant to the provisions of this Article, any existing temporary placement facility may be continued in effect on a mandatory basis on such terms as the Commissioner may determine.~~

(c) The directors of the Association may, subject to the approval of the Commissioner, amend the plan of operation at any time. The Commissioner may review the plan of operation at any time the Commissioner deems expedient or prudent, but not less than once in each calendar year. After review of the plan the Commissioner may amend the plan after consultation with the directors and upon certification to the directors of the amendment. Any order of the Commissioner with respect to the proposed plan of operation or any amendments thereto shall be subject to review upon petition by the Association as provided by G.S. 58-2-75.

(d) As used in this subsection, "homeowners' insurance policy" means a multiperil policy providing full coverage of residential property similar to the coverage provided under an HO-2, HO-3, HO-4, or HO-6 policy under Article 36 of this Chapter. The Association shall issue, for principal residences, homeowners' insurance policies approved by the Commissioner. Homeowners' insurance policies shall be available to persons who reside in the beach and coastal areas who meet the Association's underwriting standards and who are unable to obtain homeowners' insurance policies from insurers that are authorized to transact and are actually writing homeowners' insurance policies in this State. The Association shall file for approval by the Commissioner underwriting standards to determine whether property is insurable. The standards shall reflect underwriting standards commonly used in the voluntary homeowners' insurance business. The terms and conditions of the homeowners' insurance policies available under this subsection shall not be more favorable than those of homeowners' insurance policies available in the voluntary market in beach and coastal counties.

(e) The Association shall, subject to the Commissioner's approval or modification, provide in the plan of operation for coverage for appropriate classes of manufacturing risks.

(f) As used in this section, "plan of operation" includes all written rules, practices, and procedures of the Association, except for staffing and personnel matters.

"**§ 58-45-35. Persons eligible to apply to Association for coverage; contents of application.**

(a) Any person having an insurable interest in insurable property, may, on or after the effective date of the plan of operation, be entitled to apply to the Association for such coverage and for an inspection of the property. A broker or agent authorized by the applicant may apply on the applicant's behalf. Each application shall contain a statement as to whether or not there are any unpaid premiums due from the applicant for essential property insurance on the property.

The term "insurable interest" as used in this subsection shall include any lawful and substantial economic interest in the safety or preservation of property from loss, destruction or pecuniary damage.

(b) If the Association determines that the property is insurable and that there is no unpaid premium due from the applicant for prior insurance on the property, the Association, upon receipt of the premium, or part of the premium, as is prescribed in the plan of operation, shall cause to be issued a policy of essential property insurance and shall offer additional extended coverage, optional perils endorsements, business income and extra expense coverage, crime insurance, separate policies of windstorm and hail insurance, or their successor forms of coverage, for a term of one year or three years. Short term policies may also be issued. Any policy issued under this section shall be renewed, upon application, as long as the property is insurable property.

(b1) If the Association determines that the property, for which application for a homeowners' policy is made, is insurable, that there is no unpaid premium due from the applicant for prior insurance on the property, and that the underwriting guidelines established by the Association and approved by the Commissioner are met, the Association, upon receipt of the premium, or part of the premium, as is prescribed in the plan of operation, shall cause to be issued a homeowners' insurance policy.

(c) If the Association, for any reason, denies an application and refuses to cause to be issued an insurance policy on insurable property to any applicant or takes no action on an

application within the time prescribed in the plan of operation, the applicant may appeal to the Commissioner and the Commissioner, or the Commissioner's designee from the Commissioner's staff, after reviewing the facts, may direct the Association to issue or cause to be issued an insurance policy to the applicant. In carrying out the Commissioner's duties under this section, the Commissioner may request, and the Association shall provide, any information the Commissioner deems necessary to a determination concerning the reason for the denial or delay of the application.

(d) An agent who is licensed under Article 33 of this Chapter as an agent of a company which is a member of the Association established under this Article shall not be deemed an agent of the Association. The foregoing notwithstanding, an agent of a company which is a member of the Association shall have the authority, subject to the underwriting guidelines established by the Association, to temporarily bind coverage with the Association. The Association shall establish rules and procedures, including any limitations for binding authority, in the plan of operation.

Any unearned premium on the temporary binder shall be returned to the policyholder if the Association refuses to issue a policy. Nothing in this section shall prevent the Association from suspending binding authority in accordance with its plan of operation.

(e) Policies of windstorm and hail insurance provided for in subsection (b) of this section are available only for risks in the beach and coastal areas for which essential property insurance has been written by licensed insurers. Whenever such other essential property insurance written by licensed insurers includes replacement cost coverage, the Association shall also offer replacement cost coverage. In order to be eligible for a policy of windstorm and hail insurance, the applicant shall provide the Association, along with the premium payment for the windstorm and hail insurance, a certificate that the essential property insurance is in force. The policy forms for windstorm and hail insurance shall be filed by the Association with the Commissioner for the Commissioner's approval before they may be used. Catastrophic losses, as determined by the Association and approved by the Commissioner, that are covered under the windstorm and hail coverage in the beach and coastal areas shall be adjusted by the licensed insurer that issued the essential property insurance and not by the Association. The Association shall reimburse the insurer for reasonable expenses incurred by the insurer in adjusting windstorm and hail losses.

"**§ 58-45-36. Temporary contracts of insurance.**

Consistent with G.S. 58-45-35(d), the Association shall be temporarily bound by a written temporary binder of insurance issued by any duly licensed insurance agent or broker. Coverage shall be effective upon payment to the agent or broker of the entire premium or part of the premium, as prescribed by the Association's plan of operation. Nothing in this section shall impair or restrict the rights of the Association under G.S. 58-45-35(b) to decline to issue a policy based upon a lack of insurability as determined by the Association or the existence of an unpaid premium due from the applicant.

"**§ 58-45-40. Association members may cede insurance to Association.**

Any member of the Association may cede to the Association essential property insurance written on insurable property, to the extent, if any, and on the terms and conditions set forth in the plan of operation.

"**§ 58-45-41. Coverage limits.**

(a) The Association shall cause to be issued insurance up to the reasonable value of the insurable property, subject to a maximum of seven hundred fifty thousand dollars ($750,000) on habitational property. The above limits on habitational property shall apply to the value of the building only. Insurance issued by the Association for commercial property shall not exceed three million dollars ($3,000,000) on any freestanding structure or any building unit within multiple firewall divisions, provided the aggregate insurance on structures with multiple firewall divisions shall not exceed six million dollars ($6,000,000) on all interest at one risk.

(b) Contents of habitational property can be insured up to forty percent (40%) of the building value.

(c) If the value of the property exceeds the maximum coverage limits as described in this section, the Association shall not issue coverage without the insured's purchase of excess coverage to the full value of the property insured.

"§ 58-45-45. Rates, rating plans, rating rules, and forms applicable.

(a) Rates shall not be excessive, inadequate, or unfairly discriminatory. Except as provided in ~~subsection (b)~~ subsections (a1), (a2) and (b) of this section, ~~the~~ rates, rating plans, rating rules, and forms applicable to the insurance written by the Association shall be in accordance with the most recent manual rates or adjusted loss costs and forms that are legally in effect in the State. Except as provided in subsection (c) of this section, no special surcharge, other than those presently in effect, may be applied to the property insurance rates of properties located in the beach and coastal areas.

(a1) Effective January 1, 2010, the Association's rates shall be the North Carolina Rate Bureau Manual Rates plus a surcharge of ten percent (10%) of the applicable North Carolina Rate Bureau Manual Rate for wind and hail coverage and a surcharge of twenty percent (20%) of the applicable North Carolina Rate Bureau Manual Rate for homeowner's insurance including wind and hail coverage. It is the intent of the General Assembly that these surcharges ensure that the Coastal Property Insurance Pool is the market of last resort over and above the manual rate.

(a2) The Association shall offer a deductible for wind and hail coverage of one percent (1%) of the insured value of the property for all policies and may offer any other deductible options provided by the North Carolina Rate Bureau, so long as the deductible is not lower than one percent (1%) of the insured value of the property applicable to wind and hail losses.

(b) The rates, rating plans, and rating rules for the separate policies of windstorm and hail insurance described in G.S. 58-45-35(b) shall be filed by the Association with the Commissioner for the Commissioner's approval, disapproval, or modification. The provisions of Articles 40 and 41 of this Chapter shall govern the filings. Policy deductible plans, consistent with G.S. 58-45-1(b), may be filed by the Association with the Commissioner for the Commissioner's approval, disapproval, or modification.

(c) Notwithstanding subsection (a) of this section, the Association may, subject to the prior approval of the Commissioner, adopt a schedule of special surcharges above corresponding manual rates and the rates set out in subsection (a1) of this section relating to ~~homeowners' insurance~~ homeowner's, dwelling, and commercial policies issued by the ~~Association pursuant to G.S. 58-45-30(d).~~ Association, including coverage for separate policies of windstorm and hail written by the Association pursuant to G.S. 58-45-35(b) and (e) in conjunction with policies written pursuant to Article 36 of this Chapter. Such schedule may reflect any differences in risk that can be demonstrated to have a probable effect on losses or expenses. Notwithstanding subsections (a) and (b) of this section, the provisions of G.S. 58-36-10(1), 36-15(a), 58-36-20, and 58-36-25 shall apply to such filings.

(d) When the Association files rates, classification plans, rating plans, rating systems, or surcharges, the procedures of G.S. 58-40-25 through G.S. 58-40-45 shall apply, and the appeal procedures of G.S. 58-2-80 and G.S. 58-2-85 shall apply to filings under this section, except as otherwise provided.

(e) The Association shall file no later than May 1, 2010, a schedule of credits for policyholders based on the presence of mitigation and construction features and on the condition of buildings that it insures. The Association shall develop rules applicable to the operation of the schedule and mitigation program, with approval by the Commissioner. The schedule shall not be unfairly discriminatory and shall be reviewed by the Association annually, with the results included as part of the Association's annual report to the Commissioner.

(f) The Association shall file not later than May 1, 2010 with the Commissioner an installment plan for premium payments and shall accept other methods of payment which are the same as those filed by the Rate Bureau. The Association shall collect an installment fee if premiums are paid other than on an annual basis.

"**§ 58-45-46. Unearned premium, loss, and loss expense reserves.**

The Association shall make provisions for reserving unearned premiums and reserving for losses, including incurred but not reported losses, and loss expenses, in accordance with G.S. 58-3-71, 58-3-75, and 58-3-81.

"**§ 58-45-47. Deficit event.**

(a) When the Association knows that it has incurred losses and allocated loss expenses in a particular calendar year that result in an assessment of its member companies exceeding one billion dollars ($1,000,000,000), then the Association shall immediately give notice to the Commissioner that a deficit event has occurred.

(b) Upon a determination by the Association that a deficit event has occurred, the Association shall determine, in its discretion, the appropriate means of financing the deficit, which may include, but is not limited to, the purchase of reinsurance, arranging lines of credit or other forms of borrowing or financing. If the Association determines that the member companies have paid one billion dollars ($1,000,000,000) in assessments in any given year pursuant to subsection (a) of this section, the Association may, subject to the approval and order of the Commissioner, authorize member companies to charge a catastrophic assessment recoupment on their residential and commercial property insurance policyholders statewide to recover any assessment paid by member companies exceeding one billion dollars ($1,000,000,000). Catastrophic assessment recoupment or recoupments under this section shall not exceed an aggregate amount of ten percent (10%) of the annual policy premium on any one policy of insurance. The catastrophic assessment recoupment collected under this section shall be transferred directly to the Association on a periodic basis as determined by the Association and ordered by the Commissioner. The Association and the FAIR Plan shall also charge their policyholders the assessment recoupment as provided in this section.

(c) The catastrophic assessment recoupment shall be clearly identified to policyholders on the premium statement, declarations page, or by other appropriate electronic or written method. The identification shall refer to the post-catastrophe loss for which the assessment was imposed. Any such catastrophic assessment recoupment shall not be considered premium for any purpose including premium taxes or commissions, except that failure to pay the catastrophic assessment recoupment shall be treated as failure to pay premium and shall be grounds for termination of insurance. The identified catastrophic assessment recoupment shall be accompanied by an explanation of the assessment recoupment and shall appear on the medium by which the assessment recoupment is conveyed to the policyholder. The explanatory language shall be prescribed by the Commissioner.

(d) The Association shall report quarterly to the Commissioner providing all financial information for each catastrophic assessment recoupment authorized by this section, including total assessment recoupment funds recovered to date and any information reasonably requested by the Commissioner.

(e) Nothing contained in this section prohibits the Association from entering into any financing arrangements for the purpose of financing a deficit, provided that the pledge of catastrophic assessment recoupment amounts under such financing agreements shall not result in the actual levying of any assessment recoupment until after the Association has incurred a deficit and until after the Commissioner has approved implementation of the Association's assessment recoupment plan.

"**§ 58-45-50. Appeal from acts of Association to Commissioner; appeal from Commissioner to superior court.**

(a) Any person or any insurer who may be aggrieved by an act, ruling, or decision of the Association other than an act, ruling, or decision relating to (i) the cause or amount of a claimed loss or (ii) the reasonableness of expenses incurred by an insurer in adjusting windstorm and hail losses, may, within 30 days after the ruling, appeal to the Commissioner. Any hearings held by the Commissioner under the appeal shall be in accordance with rules adopted by the Commissioner: Provided, however, the Commissioner is authorized to appoint a member of the Commissioner's staff as deputy commissioner for the purpose of hearing those appeals and a ruling based upon the hearing shall have the same effect as if heard by the Commissioner. All persons or insureds aggrieved by any order or decision of the Commissioner may appeal as is provided in G.S. 58-2-75.

(b) No later than 10 days before each hearing, the appellant shall file with the Commissioner or the Commissioner's designated hearing officer and shall serve on the appellee a written statement of the appellant's case and any evidence that the appellant intends to offer at the hearing. No later than five days before the hearing, the appellee shall file with the Commissioner or the designated hearing officer and shall serve on the appellant a written statement of the appellee's case and any evidence that the appellee intends to offer at the hearing. Each hearing shall be recorded and may be transcribed. If the matter is between an insurer and the Association, the cost of the recording and transcribing shall be borne equally by the appellant and appellee; provided that upon any final adjudication the prevailing party shall be reimbursed for his share of such costs by the other party. If the matter is between an insured and the Association, the cost of transcribing shall be borne equally by the appellant and appellee; provided that the Commissioner may order the Association to pay recording or transcribing costs for which the insured is financially unable to pay. Each party shall, on a date determined by the Commissioner or the designated hearing officer, but not sooner than 15 days after delivery of the completed transcript to the party, submit to the Commissioner or the designated hearing officer and serve on the other party, a proposed order. The Commissioner or the designated hearing officer shall then issue an order.

"§ 58-45-55. Reports of inspection made available.

All reports of inspection performed by or on behalf of the Association shall be made available to the members of the Association, applicants, agent or broker, and the Commissioner.

"§ 58-45-60. Association and Commissioner immune from liability.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, the Association or its agents or employees, the board of directors, 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.

"§ 58-45-65. Association to file annual report with Commissioner.

The Association shall file in the office of the Commissioner on an annual basis on or before January 1 a statement which shall summarize the transactions, conditions, operations and affairs of the Association during the preceding year. Such statement shall contain such matters and information as are prescribed by the Commissioner and shall be in such form as is approved by him. The Commissioner may at any time require the Association to furnish to him any additional information with respect to its transactions or any other matter which the Commissioner deems to be material to assist him in evaluating the operation and experience of the Association.

"§ 58-45-70. Commissioner may examine affairs of Association.

The Commissioner may from time to time make an examination into the affairs of the Association when he deems it to be prudent and in undertaking such examination he may hold a public hearing pursuant to the provisions of G.S. 58-2-50. The expenses of such examination shall be borne and paid by the Association.

"§ 58-45-71. Report of member companies to Commissioner.

Each member company of the Association shall report by February 1 of each year to the Commissioner the amount of homeowner's coverage, including separate coverage for homeowner's wind and hail, written in the preceding calendar year by that member company in the Beach area and the Coastal area. The report shall include the number and type of homeowner's policies written by the member company in each area, the total amount of homeowner's coverage for each area, any increases and decreases in homeowner's coverage written in each area from the prior year, and other information as prescribed by the Commissioner and in such form as approved by him.

"§ 58-45-75. Commissioner authorized to promulgate reasonable rules and regulations.

The Commissioner shall have authority to make reasonable rules and regulations, not inconsistent with law, to enforce, carry out and make effective the provisions of this Article. The Commissioner shall not be liable for any act or omission in connection with the administration of the duties imposed upon him by the provisions of this Article.

"§ 58-45-80. Premium taxes to be paid through Association.

All premium taxes due on insurance written under this Article shall be remitted by each insurer to the Association; and the Association, as collecting agent for its member companies, shall forward all such taxes to the Secretary of Revenue as provided in Article 8B of Chapter 105 of the General Statutes.

"§ 58-45-85. Assessment; inability to pay.

(a) If any insurer fails, by reason of insolvency, to pay any assessment as provided in this Article, the amount assessed each insurer shall be immediately recalculated, excluding the insolvent insurer, so that its assessment is assumed and redistributed among the remaining insurers. Any assessment against an insolvent insurer shall not be a charge against any special deposit fund held under the provisions of Article 5 of this Chapter for the benefit of policyholders.

(b) The nonrecoupable assessment of a member insurer may be ordered deferred in whole or in part upon application by the insurer if, in the opinion of the Commissioner or his designee, payment of the assessment would render the insurer insolvent or in danger of insolvency or would otherwise leave the insurer in a condition so that further transaction of the insurer's business would be hazardous to its policyholders. If payment of an assessment against a member insurer is deferred by order of the Commissioner or his designee in whole or in part, the amount by which the assessment is deferred must be assessed against other member insurers in the same manner as provided in this Article. In its order of deferral, or in necessary subsequent orders, the Commissioner or his designee shall prescribe a plan by which the assessment so deferred must be repaid to the Association by the impaired insurer with interest at the six-month treasury bill rate adjusted semi-annually. The plan shall also provide for the reimbursement of excess assessments paid by member companies as a result of a deferral of assessments for an impaired insurer.

"§ 58-45-90. Open meetings.

The Association is subject to the Open Meetings Act, Article 33C of Chapter 143 of the General Statutes, as amended.

"§ 58-45-95. Information availability.

Information concerning the Association's activities shall be made fully available upon request by any company or Board member of the Association; provided, that no competitive information concerning an individual company's business plans, data, or operations may be disclosed by the Association if such company has properly designated such information as being a trade secret pursuant to G.S. 66-152(3) upon submitting such information to the Association. No confidential information may be disclosed by the Association identifying individual policyholders without such policyholder's consent unless such information is provided pursuant to reasonable rules adopted by the Association permitting such information

to be disclosed for the purpose of enhancing the availability of insurance that is written in the voluntary market.

"**§ 58-45-96. Succession and dissolution.**

In the event that a successor organization is created to perform the Association's general functions, the surplus, assets, and liabilities then held by the Association shall be transferred to such successor organization. The pledge or sale of, the lien upon, and the security interest in any rights, revenues, or other assets of the Association created pursuant to any financing arrangements entered into by the Association shall be and remain valid and enforceable on the successor organization, notwithstanding the commencement of any rehabilitation, insolvency, liquidation, bankruptcy, conservatorship, reorganization, or similar proceeding against the Association. No such proceeding shall relieve the Association of its obligation to continue to collect assessments or other revenues pledged pursuant to any financing arrangements. In the event of dissolution, surplus then held shall not be distributed to member insurers."

SECTION 2. Article 6 of Chapter 58 of the General Statues is amended by adding a new section to read:

"**§ 58-6-26. Additional insurance regulatory charge for the North Carolina Underwriting Association.**

There is levied an annual charge on the North Carolina Underwriting Association, created under G.S. 58-45-10, for the purpose of reimbursing the General Fund for the appropriations to the Department of Insurance to pay its expenses incurred in regulating the Association. The percentage rate shall be set by the Department each year. The minimum rate the Department may impose is one and one-half percent (1.5%). The percentage rate may not exceed the rate necessary to defray the costs incurred by the Department for the additional responsibilities of the Department imposed under G.S. 58-45-30. The percentage rate is applied to the premium taxes remitted to the Association by its members in G.S. 58-45-80. The charge levied on the Association is payable at the time the Association forwards the taxes remitted by its members to the Department of Revenue. The proceeds of the charge levied under this section shall be credited to the Insurance Regulatory Fund created under G.S. 58-6-25 and used in the manner set forth in that section. This charge is in addition to the charge imposed under G.S. 25-6-25."

SECTION 3. G.S. 58-36-10 reads as rewritten:

"**§ 58-36-10. Method of rate making; factors considered.**

The following standards shall apply to the making and use of rates:

(1) Rates or loss costs shall not be excessive, inadequate or unfairly discriminatory.

(2) Due consideration shall be given to actual loss and expense experience within this State for the most recent three-year period for which that information is available; to prospective loss and expense experience within this State; to the hazards of conflagration and catastrophe; to a reasonable margin for underwriting profit and to contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers; to investment income earned or realized by insurers from their unearned premium, loss, and loss expense reserve funds generated from business within this State; to past and prospective expenses specially applicable to this State; and to all other relevant factors within this State: Provided, however, that countrywide expense and loss experience and other countrywide data may be considered only where credible North Carolina experience or data is not available.

(3) In the case of property insurance rates under this Article, consideration may be given to the experience of property insurance business during the most recent five-year period for which that experience is available. In the case of property insurance rates under this Article, consideration shall be given to

the insurance public protection classifications of fire districts established by the Commissioner. The Commissioner shall establish and modify from time to time insurance public protection districts for all rural areas of the State and for cities with populations of 100,000 or fewer, according to the most recent annual population estimates certified by the State Budget Officer. In establishing and modifying these districts, the Commissioner shall use standards at least equivalent to those used by the Insurance Services Office, Inc., or any successor organization. The standards developed by the Commissioner are subject to Article 2A of Chapter 150B of the General Statutes. The insurance public protection classifications established by the Commissioner issued pursuant to the provisions of this Article shall be subject to appeal as provided in G.S. 58-2-75, et seq. The exceptions stated in G.S. 58-2-75(a) do not apply.

(4) Risks may be grouped by classifications and lines of insurance for establishment of rates, loss costs, and base premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in hazards or expense provisions or both. Those standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. The Bureau shall establish and implement a comprehensive classification rating plan for motor vehicle insurance under its jurisdiction. No such classification plans shall base any standard or rating plan for private passenger (nonfleet) motor vehicles, in whole or in part, directly or indirectly, upon the age or gender of the persons insured. The Bureau shall at least once every three years make a complete review of the filed classification rates to determine whether they are proper and supported by statistical evidence, and shall at least once every 10 years make a complete review of the territories for nonfleet private passenger motor vehicle insurance to determine whether they are proper and reasonable.

(5) In the case of workers' compensation insurance and employers' liability insurance written in connection therewith, due consideration shall be given to the past and prospective effects of changes in compensation benefits and in legal and medical fees that are provided for in General Statutes Chapter 97.

(6) To ensure that policyholders in the Beach and Coastal areas of the North Carolina Insurance Underwriting Association whose risks are of the same class and essentially the same hazard are charged premiums that are commensurate with the risk of loss and premiums that are actuarially correct, the North Carolina Rate Bureau shall revise, monitor and review the existing territorial boundaries used by the Bureau when appropriate to establish geographic territories in the Beach and Coastal areas of the Association for rating purposes. In revising these territories, the Bureau shall use statistical data sources available to define such territories to represent relative risk factors that are actuarially sound and not unfairly discriminatory. The new territories and any subsequent amendments proposed by the Bureau or Association shall be subject to the Commissioner's approval and shall appear on the Bureau Web site, the Association's Web site, and the Department's Web site once approved."

SECTION 4. G.S. 58-36-20(a) reads as rewritten:

"(a) At any time within 50 days after the date of any filing, the Commissioner may give written notice to the Bureau specifying in what respect and to what extent the Commissioner

contends the filing fails to comply with the requirements of this Article and fixing a date for hearing not less than 30 days from the date of mailing of such notice. At the hearing the factors specified in G.S. 58-36-10 shall be considered. If the Commissioner after hearing finds that the filing does not comply with the provisions of this Article, he may issue his order determining wherein and to what extent such filing is deemed to be improper and fixing a date thereafter, within a reasonable time, after which the filing shall no longer be effective. ~~Any order of disapproval under this section must be entered within 210 days after the date the filing is received by the Commissioner.~~"

SECTION 5. Article 36 of Chapter 58 is amended by adding a new section to read:

"**§ 58-36-120. Public notice of certain filings.**

Whenever the Rate Bureau files for an increase in insurance rates for residential property insurance, the Bureau shall give public notice in at least two newspapers with statewide distribution and in the North Carolina Register, within 10 business days after the filing, which notice shall state that the Commissioner may or may not schedule and conduct a hearing with respect to the filing. The same information shall be posted on the web site for the North Carolina Rate Bureau and the North Carolina Department of Insurance website within three days after the filing."

SECTION 6. G.S. 58-46-55 reads as rewritten:

"**§ 58-46-55. Rates, rating plans, rating rules, and forms applicable.**

(a) The rates, rating plans, rating rules, and forms applicable to the insurance written by the association shall be in accordance with the most recent manual rates or adjusted loss costs and forms that are legally in effect in this State. No special surcharge, other than those presently in effect, may be applied to the property insurance rates of properties located in the geographic areas to which this Article applies.

(b) The surcharges set out in G.S. 58-45-45 shall not apply to policies written in the FAIR plan."

SECTION 7. This act is effective when it becomes law and applies to policies filed, issued, and renewed on or after that date.

HOUSE BILL 1305:
Beach Plan Changes

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Finance	**Date:**	June 24, 2009
Introduced by:	Rep. Holliman	**Prepared by:**	Tim Hovis
Analysis of:	PCS to First Edition H1305-CSTH-2		Committee Counsel

OVERVIEW: The North Carolina Insurance Underwriting Asssociation (NCIUA), also known as the Beach Plan was created to serve as a market of last resort to make property insurance available to people who are unable to buy insurance through the standard or voluntary market. The Association is not a public body, but is a private entity comprised of all property and casualty insurers in the State. By statute, the Plan covers two areas: (1) the barrier islands, referred to under the Plan as the Beach area; and (2) 18 coastal counties, referred to as the Coastal area. The Plan offers commercial, homeowners, dwelling, and wind only coverage.

All member companies share in the expenses, profits, and losses of the Plan. Each year that the Plan generates revenues in excess of claims paid, the Plan may elect to return the excess funds to the member companies or hold those funds as "surplus." The surplus is used to cover Plan losses where claims filed are greater than the premium received. Should claims exceed the revenues from premiums, the amount of surplus, and any applicable reinsurance, member companies are assessed by the Plan to pay the claims.

The Plan also files with the Commissioner for his or her approval rates for separate policies of windstorm and hail, policy deductible plans to be paid by property owners, and the percentage differential or surcharge for coverage offered by the Plan. The surcharge is a percentage amount above the voluntary market rate approved by the Commissioner which all beach and coastal property owners must pay to purchase homeowners coverage through the Plan. The surcharge applies to homeowner's coverage and homeowner's wind and hail coverage only.

Since 1995, exposure to losses for all properties covered by the Plan has grown exponentially. The NCIUA estimates that in 1995 total exposure under the Plan was $3.6B. By 2008, exposure had grown to $72B, leading to concern that assessments on insurers for losses resulting from a hurricane may cause financial difficulties for many insurers.

SUMMARY: Proposed Committee Substitute for House Bill 1305 makes various changes to Article 45 of Chapter 58 of the General Statutes. These changes include the following:

- Renames the Beach Plan the "Coastal Property Insurance Pool."
- Requires that the surplus of the Association be retained to pay losses, purchase reinsurance, and pay operating expenses and provides that the surplus may not be distributed to member companies.
- Sets maximum coverage limits by statute and decrease those limits to $750,000 for homeowners and dwelling policies (currently $1.5M) and limits contents coverage to 40% of building value (currently 70%).

- Increases homeowners coverage surcharges to 10% above approved voluntary market rates for separate wind and hail coverage (currently 5%) and 20% for wind and hail as a part of a homeowner's policy (currently 15%).
- Provides that surcharges may be applied to dwelling and commercial policies, not just homeowners policies.
- Requires the Association to file a schedule of credits for policyholders based on mitigation and construction features.
- Requires the Association to submit to the Commissioner an installment plan for premium payments.
- Provides that when losses incurred by the Association result in an assessment against insurers of $1B, the Association may, subject to the approval and order of the Commissioner, institute a catastrophic assessment recoupment on residential and commercial property holders statewide to recover any assessment exceeding $1B. Recoupment or recoupments shall not exceed an aggregate amount of 10% of the annual policy premium on any one policy of insurance.
- Requires insurers to report by February 1 of each year the amount of homeowner's insurance written in the Beach and Coastal areas.
- Requires the N.C. Rate Bureau to revise, monitor, and review territories in the Beach and Coastal areas.
- Requires public notice in at least two newspapers with statewide distribution of filings for increases in residential property insurance rates.

EFFECTIVE DATE: The Proposed Committee Substitute for House Bill 1305 is effective when it becomes law and applies to policies filed, issued, or renewed on or after that date.

H1305-SMRG-76(CSTH-2) v1

ATTACHMENT #2

Comments to the House Standing Committee on Insurance

June 30, 2009

Chairman Goforth, Chairman Wray, Representative Holliman, Ladies and Gentlemen of the Insurance Committee.

I am Mac Montgomery, the Mayor of Kure Beach NC.

The school bus stops down the street from my house. Five of the 14 houses on my street have school age children and I've watched them go from Kindergarten to High School. We are typical NC community that happens to be on the coast.

We have 2100 full-time residents, an equal number of part-time residents, 35 employees and an absolutely beautiful 2 miles of coast with 19 public beach accesses for all the people of NC.

I am concerned about insurance provided under the North Carolina Beach Plan and the future of fair and equitable insurance coverage on the Coast. I am concerned for the citizens of Kure Beach and for all of us who live along the NC Coast.

Thus I find it troubling that a large portion of insurance rate increases seem to fall on the coastal counties. Damages and claims from storms have not been limited to our area. Other areas have also suffered significant damage. Perhaps the risk should shared.

I appreciate the efforts of this Committee and Representative Holliman in considering legislation to address issues with the **Beach Plan**. For a long time there has been an adversarial approach to solving this problem. If this is everyone's problem, as I propose, then all of us need to work together to come up with a better solution.

My Council and I are committed to working with you on this issue and to developing alternatives that benefit all our residents.

We are stewards of our part of the Coast for the people of North Carolina and we want to keep it a vibrant and welcoming part of the State.

We ask your help in this effort.

The coastal areas of North Carolina are a treasure to our entire state. Aside from the obvious recreational value the NC Coast is one of the greatest economic assets we have. The revenue and jobs generated on the Coast benefit all residents of North Carolina.

North Carolina prides itself on our Coast being available for everyone. And everyone visits, and invests on the Coast. **In NC you don't have to be rich and famous to enjoy the Coast; its there for us all and we want it to stay that way.**

I represent one small Coastal Town but we are quite typical. We are not a gated closed community. Families have come to Kure Beach for generations to vacation and to live. Family cottages still abound as do new homes with residents from Asheville, Winston-Salem, Durham and Salisbury.

My neighbors come from Hickory, Raleigh, Charlotte and Cary. Our street includes a retired Army officer and retired College Dean, a retired NC Park Ranger, a school teacher, a Professor, a project manager, a Physician and an Engineer and kids from 6 to 18. It's a lot like your neighborhoods.

ATTACHMENT #3

MANNING FULTON

Attorneys

June 29, 2009

Rep. Michael H. Wray
NC House of Representatives
300 N. Salisbury Street, Room 405
Raleigh, NC 27603-5925

Dear Rep. Wray:

I represent the Insurance Federation of North Carolina. IFNC is a N.C. trade association made up of the largest writers of property and casualty insurance in North Carolina. We have worked with Rep. Holliman who co-chaired the Beach Plan Study Commission, Rep. Goforth who served on that Commission, and Commissioner Goodwin all of whom have worked diligently since last fall and winter to seek solutions to the problems with the Beach Plan.

Last week you heard Commissioner Goodwin explain why it is essential that some significant changes be made to the Beach Plan. HB 1305 is a step in the right direction but still needs some modifications. This is not an industry bill but is essentially a Study Commission bill that has had input from the Commissioner, the industry, and many other organizations.

The North Carolina Insurance Underwriting Association (the Beach Plan) was created by the General Assembly in 1968. The Association issues policies in its name and pays losses and expenses. It is a free-standing entity. It was created to be a market of last resort for property insurance only on the barrier islands of North Carolina and only for limited coverages.

Because of legislative changes over the years and because of inadequate rates in the voluntary market, the Beach Plan now writes coverage on $74 billion worth of property. It has a reserve of about $750 million, and it will do fine in years where there are no major hurricanes. However, if a major hurricane comes ashore in North Carolina, these reserves will not be sufficient to pay for the losses that will follow.

The Beach Plan Board has prudently purchased a significant amount of reinsurance- $2 billion for the current year - but those reinsurance arrangements have two conditions: 1) they don't come into play until the Beach Plan itself has paid $1.2 billion in losses; and 2) they require a co-payment of 25%. This means that the Beach Plan has to pay $500 million to receive $1.5 billion in reinsurance coverage.

Since the Beach Plan does not have that amount of money, where would the money come from to pay these potential losses? Under the current statutes, all the property and casualty insurance companies writing in North Carolina would be required to pay for excess losses not covered by reinsurance. This raises the following concerns:

- These are losses on policies not written by any of these companies.
- These companies have not been paid a penny of premium on those policies.
- Yet they have to pay these losses, and they have to pay in proportion to how much they business do in North Carolina- the more policies they write in the voluntary market, the more they have to pay.
- And they don't get it back.

This bill changes part of this, but not much. In a nutshell, it does the following:

- The $750 million in retained earnings of the Beach Plan is taken forever to be used to pay losses and expenses.
- The insurance companies still don't get any premiums on policies issued by the Beach Plan, and they still have to pay excess losses.
- But under the bill, what they have to pay is capped at $1 billion per year.
- In the event of a catastrophic hurricane- more severe than any North Carolina has ever experienced- losses in excess of Beach Plan resources would be spread across the state but with a number of safeguards.
    1) No statewide surcharge would take place until the Beach Plan has used its assets to pay toward those losses;
    2) No surcharge would take place until the insurance companies have paid an additional $1 billion toward those losses- each year;
    3) No statewide surcharge would take place until the reinsurance was exhausted;
    4) In fact, under conditions as they exist in 2009, no surcharge could be imposed until the Beach Plan has paid out $2.4 billion in losses to its policyholders.
    5) Surcharges would be capped at 10% of the policyholder's premium per year. (the average annual policy premium in N.C. is $600- so the average policyholder would receive a $60 surcharge.)
    6) Put in perspective, the most losses the Beach Plan has ever paid in one year on policies the Beach Plan issued was $149.7 million when Hurricane Fran hit N.C. in 1996;
- Attached is a copy of the chart that was explained in committee last Thursday.

What do other southeastern coastal states do? Most have no company assessments- all excess losses are passed on to policyholders.

What is the alternative?

1) Do what other states do.
2) Charge higher premiums so companies will be encouraged to write policies in coastal areas.
3) Do nothing. The Commissioner and the companies say that is not an option.

The industry still has a number of objections to this bill. Yet, without this legislation, according to the Commissioner, the insurance market in North Carolina is a ticking time bomb. I won't speculate on what will happen to the insurance market in North Carolina if this problem is not addressed. The Commissioner has expressed his opinion. The Insurance Federation of North Carolina joins with the Commissioner and urges you to pass HB 1305.

Sincerely yours,

John B. McMillan

Attachment

NORTH CAROLINA BEACH PLAN 2009

RETAINED EARNINGS	NON RECOUPABLE ASSESSMENTS	REINSURANCE WITH 25% CO-PAY		
$250 Million	$700 Million	$250 Million Co-Pay	$50 Million Co-Pay	$200 Million Catastrophic Surcharges
$500 Million		$750 Million Reinsurance	$150 Million Reinsurance	$600 Million Reinsurance

$2.4 Billion in Losses Before Catastrophic Surcharges

ATTACHMENT #1

VISITOR REGISTRATION SHEET

House Insurance — June 30, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Brad T. Tidwell, Jr.	IIANC (Hedrick Ireland & Marshall)
Charlotte Hicks	IIANC (OTC-GlasgowHicks)
Stuart Bowell	IIANC
Neil Annas	IIANC - (Granite Insurance)
Kristin Milam	NCDOT
Kevin Conley	NC DOT
Wayne Goodwin	NC Commissioner of Insurance
Patrick Hannah	Liberty Mutual
Tyler Newman	BASE
Cameron Mann	BASE
Louis Belo	NCDOI

VISITOR REGISTRATION SHEET

House Insurance — June 30, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Alicia [illegible]	NMC
[illegible]	NMRS
Michelle Frazier	MFHS
David Ranii	N&O
Mary Selvidge	IFNC
Bob BIRD	
Brett Matteson	Rep. McComas office
John Miller	Travelers
Jennifer Cohen	IFNC
John McMillan	MFHS
[illegible]	UNC School of Law

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Carroll	NC Farm Bureau Ins.
Steve Woodson	NCFB
Anna Boles	NC Policy Watch
Rob Schofield	NC Policy Watch
James Rumley	
Bill Tibbens	Farmers Group, Inc
David Stollen	State Farm
Matthew Meany	State Farm
Russ Dubisky	State Farm
FRANK FOLGER	NATIONWIDE
Ed Gehrke	Nationwide

VISITOR REGISTRATION SHEET

Insurance — 6/30/09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tony Riddick	NCDOI
Ra E	NCDOI
Sonny WATTS	NCDOT
J.M. Cooke	Brunswick County Commissioner
Bobby Dutten	DARE County
Roger Langley	Reg. & Corp. Services, Ltd.
Chris Valauri	Valauri Group, LLC
Becki Gray	John Locke Foundation —
Marianne Suarez	
LAWLESS BEAN	City of Wilmington
David McGowan	NC Realtors

VISITOR REGISTRATION SHEET

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lisa Martin	NC Home Builders
Rick Zechini	NC Assoc. of Realtors
RAY EVANS	NC RATE BUREAU
Bill Trott	Young Moore Henderson PA
Debra DeCamillis	UNC-IOG
Seth Pelo	Rep. Hall
Lacey Meshaw	NCIUA
Lee E. Dunn	NCIUA
Alvin Ashworth	NCIUA
Fred Fuller	NCDOI
Paul Griffin	Young Moore Henderson P.A.

VISITOR REGISTRATION SHEET

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robert PASchal	Young Morris
Mark Humphrey	Pappas Consulting
[signature]	BCS
Bob Mack	NCDOT

VISITOR REGISTRATION SHEET

House Committee on Insurance

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kathleen Kelly	
Willis Kelly	
Peter	JP Morgan
Drew Saunders	Electricities
R. Paul Wilms	WGR
Hugh Tilson	NCHA

HOUSE PAGES

NAME OF COMMITTEE Insurance DATE 6/30/09

1. Name: Andrew Daniel
   County: Guilford
   Sponsor: Martha Alexander

2. Name: Caroline Weller
   County: Cabarrus
   Sponsor: Sarah Stevens

3. Name: Abby Wilkerson
   County: Vance
   Sponsor: Michael Wray

4. Name: Kaitlyn Deal
   County: Catawba
   Sponsor: Mitchell Setzer

5. Name: Bekah Blake
   County: Catawba
   Sponsor: Mitchell Setzer

6, Jake Little
Mecklenburg
Martha Alexander

SGT-AT-ARM

1. Name: Charles Williams
2. Name: Martha Gadison
3. Name: Robert Ross
4. Name:

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 1305 A BILL TO BE ENTITLED AN ACT TO MAKE CHANGES TO THE NORTH CAROLINA BEACH PLAN AS RECOMMENDED BY THE JOINT SELECT STUDY COMMITTEE ON THE POTENTIAL IMPACT OF MAJOR HURRICANES ON THE NORTH CAROLINA INSURANCE INDUSTRY.

☒ With a favorable report as to the committee substitute bill, which changes the title, unfavorable as to the original bill, and recommendation that the 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.

MINUTES
HOUSE COMMITTEE ON INSURANCE
July 2, 2009

The House Committee on Insurance met at 11:00 AM on Thursday, July 2, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael Wray; Vice Chairs: M. Dickson, J. Dockham and M. Setzer. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Cole, Current, Faison, Howard, Hughes, Lewis and Pierce.

Chairman Wray called the meeting to order and welcomed visitors. He recognized Sgt-At Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachments)

Chairman Wray recognized Sen. Clodfelter to explain SB 749 – Revise UM/UIM Liability Coverage. Rep. Goforth moved for the PCS to be before the Committee. Sen. Clodfelter said this bill makes changes to uninsured and underinsured motorist coverage to provide that uninsured motorists (UM) coverage may be purchased at limits less than bodily injury liability coverage for any one vehicle insured under the policy, but may not be less than the minimum liability limits for bodily injury and property damage required under the law. The PCS removes language creating an irrefutable presumption that the statutory requirements of reasonable notice of the insured's right to purchase UM/UIM coverage with limits up to $1,000,000 has been given, and evidence that the coverage limits were stated in the policy constitutes irrefutable proof of the amount of coverage provided by the policy. The PCS also add language requiring the insurer to notify the insured upon issuance and renewal that the "default" coverage limit for UM and UM/UIM will be the same limits as the limits of uninsured bodily injury liability coverage purchased by the insured unless the insured elects to have a different level of coverage.

Rep. Brubaker made the motion for a favorable report and it will be referred to the Ways and Means Committee.

The meeting adjourned at 11:45.

Representative Michael Wray, Chairman

Ann Jordan – Committee Assistant

HOUSE INSURANCE COMMITTEE

July 2, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

SB 749 – REVISE UM/UIM LIABILITY COVERAGE REQUIREMENTS – Senator Clodfelter

SB 877 – HEALTH PLAN PROVIDER CONTRACTS/TRANSPARENCY – Senator Clodfelter

SB 1029 – PEO AMENDMENTS – Senator Bingham

Adjourn

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 749
Commerce Committee Substitute Adopted 5/7/09
PROPOSED HOUSE COMMITTEE SUBSTITUTE S749-CSRC-46 [v.6]

7/2/2009 10:23:32 AM

Short Title: Revise UM/UIM Liability Coverage Requirements. (Public)

Sponsors:

Referred to:

March 24, 2009

A BILL TO BE ENTITLED

AN ACT TO REVISE AND CLARIFY THE REQUIREMENTS FOR UNINSURED AND UNDERINSURED MOTORIST COVERAGE IN MOTOR VEHICLE LIABILITY INSURANCE POLICIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 20-279.21 reads as rewritten:

"**§ 20-279.21. "Motor vehicle liability policy" defined.**

(a) A "motor vehicle liability policy" as said term is used in this Article shall mean an owner's or an operator's policy of liability insurance, certified as provided in G.S. 20-279.19 or 20-279.20 as proof of financial responsibility, and issued, except as otherwise provided in G.S. 20-279.20, by an insurance carrier duly authorized to transact business in this State, to or for the benefit of the person named therein as insured.

(b) Such owner's policy of liability insurance:

(1) Shall designate by explicit description or by appropriate reference all motor vehicles with respect to which coverage is thereby to be granted;

(2) Shall insure the person named therein and any other person, as insured, using any such motor vehicle or motor vehicles with the express or implied permission of such named insured, or any other persons in lawful possession, against loss from the liability imposed by law for damages arising out of the ownership, maintenance or use of such motor vehicle or motor vehicles within the United States of America or the Dominion of Canada subject to limits exclusive of interest and costs, with respect to each such motor vehicle, as follows: thirty thousand dollars ($30,000) because of bodily injury to or death of one person in any one accident and, subject to said limit for one person, sixty thousand dollars ($60,000) because of bodily injury to or death of two or more persons in any one accident, and twenty-five thousand dollars ($25,000) because of injury to or destruction of property of others in any one accident; and

(3) No policy of bodily injury liability insurance, covering liability arising out of the ownership, maintenance, or use of any motor vehicle, shall be delivered or issued for delivery in this State with respect to any motor vehicle registered or principally garaged in this State unless coverage is provided therein or supplemental thereto, under provisions filed with and approved by

the Commissioner of Insurance, for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured motor vehicles and hit-and-run motor vehicles because of bodily injury, sickness or disease, including death, resulting therefrom. ~~therefrom, with limits equal to the highest limits of bodily injury liability coverage for any one vehicle insured under the policy. The named insured may purchase uninsured motorist bodily injury coverage with greater limits, subject to the limitation that in no event shall uninsured motorist bodily injury coverage limits exceed one million dollars ($1,000,000) per person and one million dollars ($1,000,000) per accident.~~ The limits of such uninsured motorist bodily injury coverage shall be equal to the highest limits of bodily injury liability coverage for any one vehicle insured under the policy; provided, however, that (i) the limits shall not exceed one million dollars ($1,000,000) per person and one million dollars ($1,000,000) per accident regardless of whether the highest limits of bodily injury liability coverage for any one vehicle insured under the policy exceed those limits and (ii) a named insured may purchase greater or lesser limits, except that the limits shall not be less than the bodily injury liability limits required pursuant to subdivision (2) of this subsection, and in no event shall an insurer be required by this subdivision to sell uninsured motorist bodily injury coverage at limits that exceed one million dollars ($1,000,000) per person and one million dollars ($1,000,000) per accident. ~~The~~ When the policy is issued or renewed, the insurer shall notify the named insured as provided in subsection (m) of this section. ~~of his or her right to purchase uninsured motorist bodily injury coverage with greater limits, when the policy is issued and renewed, as provided in subsection (m) of this section.~~ The provisions shall include coverage for the protection of persons insured ~~thereunder~~ under the policy who are legally entitled to recover damages from owners or operators of uninsured motor vehicles because of injury to or destruction of the property of such insured. ~~insured, with a limit in the aggregate for all insureds in any one accident equal to the highest limits of property damage liability coverage for any one vehicle insured in the owner's policy of liability insurance, and~~ The limits of such uninsured motorist property damage coverage shall be equal to the highest limits of property damage liability coverage for any one vehicle insured under the policy; provided, however, that (i) the limits shall not exceed one million dollars ($1,000,000) per accident regardless of whether the highest limits of property damage liability coverage for any one vehicle insured under the policy exceed those limits and (ii) a named insured may purchase lesser limits, except that the limits shall not be less than the property damage liability limits required pursuant to subdivision (2) of this subsection. When the policy is issued or renewed, the insurer shall notify the named insured as provided in subsection (m) of this section. For uninsured motorist property damage coverage, the limits purchased by the named insured shall be subject, for each insured, to an exclusion of the first one hundred dollars ($100.00) of such damages. The provision shall further provide that a written statement by the liability insurer, whose name appears on the certification of financial responsibility made by the owner of any vehicle involved in an accident with the insured, that the other motor vehicle was not covered by insurance at the time of the accident with the insured shall operate as a prima facie presumption that the operator of the other motor vehicle was uninsured

at the time of the accident with the insured for the purposes of recovery under this provision of the insured's liability insurance policy.

If a person who is legally entitled to recover damages from the owner or operator of an uninsured motor vehicle is an insured under the uninsured motorist coverage of a policy that insures more than one motor vehicle, that person shall not be permitted to combine the uninsured motorist limit applicable to any one motor vehicle with the uninsured motorist limit applicable to any other motor vehicle to determine the total amount of uninsured motorist coverage available to that person. If a person who is legally entitled to recover damages from the owner or operator of an uninsured motor vehicle is an insured under the uninsured motorist coverage of more than one policy, that person may combine the highest applicable uninsured motorist limit available under each policy to determine the total amount of uninsured motorist coverage available to that person. The previous sentence shall apply only to insurance on nonfleet private passenger motor vehicles as described in G.S. 58-40-10(1) and (2).

In addition to the above requirements relating to uninsured motorist insurance, every policy of bodily injury liability insurance covering liability arising out of the ownership, maintenance or use of any motor vehicle, which policy is delivered or issued for delivery in this State, shall be subject to the following provisions which need not be contained therein.

a. A provision that the insurer shall be bound by a final judgment taken by the insured against an uninsured motorist if the insurer has been served with copy of summons, complaint or other process in the action against the uninsured motorist by registered or certified mail, return receipt requested, or in any manner provided by law; provided however, that the determination of whether a motorist is uninsured may be decided only by an action against the insurer alone. The insurer, upon being served as herein provided, shall be a party to the action between the insured and the uninsured motorist though not named in the caption of the pleadings and may defend the suit in the name of the uninsured motorist or in its own name. The insurer, upon being served with copy of summons, complaint or other pleading, shall have the time allowed by statute in which to answer, demur or otherwise plead (whether the pleading is verified or not) to the summons, complaint or other process served upon it. The consent of the insurer shall not be required for the initiation of suit by the insured against the uninsured motorist: Provided, however, no action shall be initiated by the insured until 60 days following the posting of notice to the insurer at the address shown on the policy or, after personal delivery of the notice to the insurer or its agent setting forth the belief of the insured that the prospective defendant or defendants are uninsured motorists. No default judgment shall be entered when the insurer has timely filed an answer or other pleading as required by law. The failure to post notice to the insurer 60 days in advance of the initiation of suit shall not be grounds for dismissal of the action, but shall automatically extend the time for the filing of an answer or other pleadings to 60 days after the time of service of the summons, complaint, or other process on the insurer.

b. Where the insured, under the uninsured motorist coverage, claims that he has sustained bodily injury as the result of collision between

motor vehicles and asserts that the identity of the operator or owner of a vehicle (other than a vehicle in which the insured is a passenger) cannot be ascertained, the insured may institute an action directly against the insurer: Provided, in that event, the insured, or someone in his behalf, shall report the accident within 24 hours or as soon thereafter as may be practicable, to a police officer, peace officer, other judicial officer, or to the Commissioner of Motor Vehicles. The insured shall also within a reasonable time give notice to the insurer of his injury, the extent thereof, and shall set forth in the notice the time, date and place of the injury. Thereafter, on forms to be mailed by the insurer within 15 days following receipt of the notice of the accident to the insurer, the insured shall furnish to insurer any further reasonable information concerning the accident and the injury that the insurer requests. If the forms are not furnished within 15 days, the insured is deemed to have complied with the requirements for furnishing information to the insurer. Suit may not be instituted against the insurer in less than 60 days from the posting of the first notice of the injury or accident to the insurer at the address shown on the policy or after personal delivery of the notice to the insurer or its agent. The failure to post notice to the insurer 60 days before the initiation of the suit shall not be grounds for dismissal of the action, but shall automatically extend the time for filing of an answer or other pleadings to 60 days after the time of service of the summons, complaint, or other process on the insurer.

Provided under this section the term "uninsured motor vehicle" shall include, but not be limited to, an insured motor vehicle where the liability insurer thereof is unable to make payment with respect to the legal liability within the limits specified therein because of insolvency.

An insurer's insolvency protection shall be applicable only to accidents occurring during a policy period in which its insured's uninsured motorist coverage is in effect where the liability insurer of the tort-feasor becomes insolvent within three years after such an accident. Nothing herein shall be construed to prevent any insurer from affording insolvency protection under terms and conditions more favorable to the insured than is provided herein.

In the event of payment to any person under the coverage required by this section and subject to the terms and conditions of coverage, the insurer making payment shall, to the extent thereof, be entitled to the proceeds of any settlement for judgment resulting from the exercise of any limits of recovery of that person against any person or organization legally responsible for the bodily injury for which the payment is made, including the proceeds recoverable from the assets of the insolvent insurer.

For the purpose of this section, an "uninsured motor vehicle" shall be a motor vehicle as to which there is no bodily injury liability insurance and property damage liability insurance in at least the amounts specified in subsection (c) of G.S. 20-279.5, or there is that insurance but the insurance company writing the insurance denies coverage thereunder, or has become bankrupt, or there is no bond or deposit of money or securities as provided in G.S. 20-279.24 or 20-279.25 in lieu of the bodily injury and property damage liability insurance, or the owner of the motor vehicle has not qualified as a self-insurer under the provisions of G.S. 20-279.33, or a vehicle that is not subject to the provisions of the Motor Vehicle Safety and

Financial Responsibility Act; but the term "uninsured motor vehicle" shall not include:

a. A motor vehicle owned by the named insured;

b. A motor vehicle that is owned or operated by a self-insurer within the meaning of any motor vehicle financial responsibility law, motor carrier law or any similar law;

c. A motor vehicle that is owned by the United States of America, Canada, a state, or any agency of any of the foregoing (excluding, however, political subdivisions thereof);

d. A land motor vehicle or trailer, if operated on rails or crawler-treads or while located for use as a residence or premises and not as a vehicle; or

e. A farm-type tractor or equipment designed for use principally off public roads, except while actually upon public roads.

For purposes of this section "persons insured" means the named insured and, while resident of the same household, the spouse of any named insured and relatives of either, while in a motor vehicle or otherwise, and any person who uses with the consent, expressed or implied, of the named insured, the motor vehicle to which the policy applies and a guest in the motor vehicle to which the policy applies or the personal representative of any of the above or any other person or persons in lawful possession of the motor vehicle.

Notwithstanding any language or provision to the contrary, no motor vehicle other than a motor vehicle covered under a personal auto policy, the form for which is promulgated by the North Carolina Rate Bureau pursuant to Article 36 of Chapter 58 of the General Statutes and approved by the Commissioner, shall be required by this subdivision to be covered by uninsured motorist coverage or in any way be subject to the requirements of this subdivision. For the purposes of this subdivision, a personal auto policy shall not include any endorsement to any policy other than a personal auto policy, even if the form for such endorsement is promulgated by the North Carolina Rate Bureau and approved by the Commissioner.~~the provisions of this subsection, no policy of motor vehicle liability insurance applicable solely to commercial motor vehicles as defined in G.S. 20-4.01(3d) or applicable solely to fleet vehicles shall be required to provide uninsured motorist coverage. Any motor vehicle liability policy that insures both commercial motor vehicles as defined in G.S. 20-4.01(3d) and noncommercial motor vehicles shall provide uninsured motorist coverage in accordance with the provisions of this subsection in amounts equal to the highest limits of bodily injury and property damage liability coverage for any one noncommercial motor vehicle insured under the policy, subject to the right of the insured to purchase higher uninsured motorist bodily injury liability coverage limits as set forth in this subsection. For the purpose of the immediately preceding sentence, noncommercial motor vehicle shall mean any motor vehicle that is not a commercial motor vehicle as defined in G.S. 20-4.01(3d), but that is otherwise subject to the requirements of this subsection.~~

(4) Shall, in addition to the coverages set forth in subdivisions (2) and (3) of this subsection, provide underinsured motorist coverage, to be used only with a policy that is written at limits that exceed those prescribed by subdivision (2) of this subsection. ~~section, with limits equal to the highest limits of bodily injury liability coverage for any one vehicle insured under the policy. The~~

~~named insured may purchase underinsured motorist coverage with greater limits, subject to the limitation that in no event shall the underinsured motorist coverage limits exceed one million dollars ($1,000,000) per person and one million dollars ($1,000,000) per accident.~~ The limits of such underinsured motorist bodily injury coverage shall be equal to the highest limits of bodily injury liability coverage for any one vehicle insured under the policy; provided, however, that (i) the limits shall not exceed one million dollars ($1,000,000) per person and one million dollars ($1,000,000) per accident regardless of whether the highest limits of bodily injury liability coverage for any one vehicle insured under the policy exceed those limits, (ii) a named insured may purchase greater or lesser limits, except that the limits shall exceed the bodily injury liability limits required pursuant to subdivision (2) of this subsection, and in no event shall an insurer be required by this subdivision to sell underinsured motorist bodily injury coverage at limits that exceed one million dollars ($1,000,000) per person and one million dollars ($1,000,000) per accident, and (iii) the limits shall be equal to the limits of uninsured motorist bodily injury coverage purchased pursuant to subdivision (3) of this subsection. When the policy is issued or renewed, the ~~The~~ insurer shall notify the named insured as provided in subsection (m) of this section. ~~his or her right to purchase underinsured motorist coverage with greater limits, when the policy is issued and renewed, as provided in subsection (m) of this section.~~ An "uninsured motor vehicle," as described in subdivision (3) of this subsection, includes an "underinsured highway vehicle," which means a highway vehicle with respect to the ownership, maintenance, or use of which, the sum of the limits of liability under all bodily injury liability bonds and insurance policies applicable at the time of the accident is less than the applicable limits of underinsured motorist coverage for the vehicle involved in the accident and insured under the owner's policy. For purposes of an underinsured motorist claim asserted by a person injured in an accident where more than one person is injured, a highway vehicle will also be an "underinsured highway vehicle" if the total amount actually paid to that person under all bodily injury liability bonds and insurance policies applicable at the time of the accident is less than the applicable limits of underinsured motorist coverage for the vehicle involved in the accident and insured under the owner's policy. Notwithstanding the immediately preceding sentence, a highway vehicle shall not be an "underinsured motor vehicle" for purposes of an underinsured motorist claim under an owner's policy insuring that vehicle unless the owner's policy insuring that vehicle provides underinsured motorist coverage with limits that are greater than that policy's bodily injury liability limits. For the purposes of this subdivision, the term "highway vehicle" means a land motor vehicle or trailer other than (i) a farm-type tractor or other vehicle designed for use principally off public roads and while not upon public roads, (ii) a vehicle operated on rails or crawler-treads, or (iii) a vehicle while located for use as a residence or premises. The provisions of subdivision (3) of this subsection shall apply to the coverage required by this subdivision. Underinsured motorist coverage is deemed to apply when, by reason of payment of judgment or settlement, all liability bonds or insurance policies providing coverage for bodily injury caused by the ownership, maintenance, or use of the underinsured highway vehicle have been exhausted. Exhaustion of that liability coverage for the purpose of any single

liability claim presented for underinsured motorist coverage is deemed to occur when either (a) the limits of liability per claim have been paid upon the claim, or (b) by reason of multiple claims, the aggregate per occurrence limit of liability has been paid. Underinsured motorist coverage is deemed to apply to the first dollar of an underinsured motorist coverage claim beyond amounts paid to the claimant under the exhausted liability policy.

In any event, the limit of underinsured motorist coverage applicable to any claim is determined to be the difference between the amount paid to the claimant under the exhausted liability policy or policies and the limit of underinsured motorist coverage applicable to the motor vehicle involved in the accident. Furthermore, if a claimant is an insured under the underinsured motorist coverage on separate or additional policies, the limit of underinsured motorist coverage applicable to the claimant is the difference between the amount paid to the claimant under the exhausted liability policy or policies and the total limits of the claimant's underinsured motorist coverages as determined by combining the highest limit available under each policy; provided that this sentence shall apply only to insurance on nonfleet private passenger motor vehicles as described in G.S. 58-40-15(9) and (10). The underinsured motorist limits applicable to any one motor vehicle under a policy shall not be combined with or added to the limits applicable to any other motor vehicle under that policy.

An underinsured motorist insurer may at its option, upon a claim pursuant to underinsured motorist coverage, pay moneys without there having first been an exhaustion of the liability insurance policy covering the ownership, use, and maintenance of the underinsured highway vehicle. In the event of payment, the underinsured motorist insurer shall be either: (a) entitled to receive by assignment from the claimant any right or (b) subrogated to the claimant's right regarding any claim the claimant has or had against the owner, operator, or maintainer of the underinsured highway vehicle, provided that the amount of the insurer's right by subrogation or assignment shall not exceed payments made to the claimant by the insurer. No insurer shall exercise any right of subrogation or any right to approve settlement with the original owner, operator, or maintainer of the underinsured highway vehicle under a policy providing coverage against an underinsured motorist where the insurer has been provided with written notice before a settlement between its insured and the underinsured motorist and the insurer fails to advance a payment to the insured in an amount equal to the tentative settlement within 30 days following receipt of that notice. Further, the insurer shall have the right, at its election, to pursue its claim by assignment or subrogation in the name of the claimant, and the insurer shall not be denominated as a party in its own name except upon its own election. Assignment or subrogation as provided in this subdivision shall not, absent contrary agreement, operate to defeat the claimant's right to pursue recovery against the owner, operator, or maintainer of the underinsured highway vehicle for damages beyond those paid by the underinsured motorist insurer. The claimant and the underinsured motorist insurer may join their claims in a single suit without requiring that the insurer be named as a party. Any claimant who intends to pursue recovery against the owner, operator, or maintainer of the underinsured highway vehicle for moneys beyond those paid by the underinsured motorist insurer shall before doing so give notice to the insurer and give the insurer, at its expense, the opportunity to participate

in the prosecution of the claim. Upon the entry of judgment in a suit upon any such claim in which the underinsured motorist insurer and claimant are joined, payment upon the judgment, unless otherwise agreed to, shall be applied pro rata to the claimant's claim beyond payment by the insurer of the owner, operator or maintainer of the underinsured highway vehicle and the claim of the underinsured motorist insurer.

A party injured by the operation of an underinsured highway vehicle who institutes a suit for the recovery of moneys for those injuries and in such an amount that, if recovered, would support a claim under underinsured motorist coverage shall give notice of the initiation of the suit to the underinsured motorist insurer as well as to the insurer providing primary liability coverage upon the underinsured highway vehicle. Upon receipt of notice, the underinsured motorist insurer shall have the right to appear in defense of the claim without being named as a party therein, and without being named as a party may participate in the suit as fully as if it were a party. The underinsured motorist insurer may elect, but may not be compelled, to appear in the action in its own name and present therein a claim against other parties; provided that application is made to and approved by a presiding superior court judge, in any such suit, any insurer providing primary liability insurance on the underinsured highway vehicle may upon payment of all of its applicable limits of liability be released from further liability or obligation to participate in the defense of such proceeding. However, before approving any such application, the court shall be persuaded that the owner, operator, or maintainer of the underinsured highway vehicle against whom a claim has been made has been apprised of the nature of the proceeding and given his right to select counsel of his own choice to appear in the action on his separate behalf. If an underinsured motorist insurer, following the approval of the application, pays in settlement or partial or total satisfaction of judgment moneys to the claimant, the insurer shall be subrogated to or entitled to an assignment of the claimant's rights against the owner, operator, or maintainer of the underinsured highway vehicle and, provided that adequate notice of right of independent representation was given to the owner, operator, or maintainer, a finding of liability or the award of damages shall be res judicata between the underinsured motorist insurer and the owner, operator, or maintainer of underinsured highway vehicle.

As consideration for payment of policy limits by a liability insurer on behalf of the owner, operator, or maintainer of an underinsured motor vehicle, a party injured by an underinsured motor vehicle may execute a contractual covenant not to enforce against the owner, operator, or maintainer of the vehicle any judgment that exceeds the policy limits. A covenant not to enforce judgment shall not preclude the injured party from pursuing available underinsured motorist benefits, unless the terms of the covenant expressly provide otherwise, and shall not preclude an insurer providing underinsured motorist coverage from pursuing any right of subrogation.

Notwithstanding <u>any language or provision to the contrary, no motor vehicle other than a motor vehicle covered under a personal auto policy, the form for which is promulgated by the North Carolina Rate Bureau pursuant to Article 36 of Chapter 58 of the General Statutes and approved by the Commissioner, shall be required by this subdivision to be covered by</u>

underinsured motorist coverage or in any way be subject to the requirements of this subdivision. For the purposes of this subdivision, a personal auto policy shall not include any endorsement to any policy other than a personal auto policy, even if the form for such endorsement is promulgated by the North Carolina Rate Bureau and approved by the Commissioner.~~the provisions of this subsection, no policy of motor vehicle liability insurance applicable solely to commercial motor vehicles as defined in G.S. 20-4.01(3d) or applicable solely to fleet vehicles shall be required to provide underinsured motorist coverage. Any motor vehicle liability policy that insures both commercial motor vehicles as defined in G.S. 20-4.01(3d) and noncommercial motor vehicles shall provide underinsured motorist coverage in accordance with the provisions of this subsection in an amount equal to the highest limits of bodily injury liability coverage for any one noncommercial motor vehicle insured under the policy, subject to the right of the insured to purchase higher underinsured motorist bodily injury liability coverage limits as set forth in this subsection. For the purpose of the immediately preceding sentence, noncommercial motor vehicle shall mean any motor vehicle that is not a commercial motor vehicle as defined in G.S. 20-4.01(3d), but that is otherwise subject to the requirements of this subsection.~~

(c) Such operator's policy of liability insurance shall insure the person named as insured therein against loss from the liability imposed upon him by law for damages arising out of the use by him of any motor vehicle not owned by him, and within 30 days following the date of its delivery to him of any motor vehicle owned by him, within the same territorial limits and subject to the same limits of liability as are set forth above with respect to an owner's policy of liability insurance.

(d) Such motor vehicle liability policy shall state the name and address of the named insured, the coverage afforded by the policy, the premium charged therefor, the policy period and the limits of liability, and shall contain an agreement or be endorsed that insurance is provided thereunder in accordance with the coverage defined in this Article as respects bodily injury and death or property damage, or both, and is subject to all the provisions of this Article.

(e) Uninsured or underinsured motorist coverage that is provided as part of a motor vehicle liability policy shall insure that portion of a loss uncompensated by any workers' compensation law and the amount of an employer's lien determined pursuant to G.S. 97-10.2(h) or (j). In no event shall this subsection be construed to require that coverage exceed the applicable uninsured or underinsured coverage limits of the motor vehicle policy or allow a recovery for damages already paid by workers' compensation. The policy need not insure a loss from any liability for damage to property owned by, rented to, in charge of or transported by the insured.

(f) Every motor vehicle liability policy shall be subject to the following provisions which need not be contained therein:

(1) Except as hereinafter provided, the liability of the insurance carrier with respect to the insurance required by this Article shall become absolute whenever injury or damage covered by said motor vehicle liability policy occurs; said policy may not be canceled or annulled as to such liability by any agreement between the insurance carrier and the insured after the occurrence of the injury or damage; no statement made by the insured or on his behalf and no violation of said policy shall defeat or void said policy. As to policies issued to insureds in this State under the assigned risk plan or through the North Carolina Motor Vehicle Reinsurance Facility, a default judgment taken against such an insured shall not be used as a basis for

obtaining judgment against the insurer unless counsel for the plaintiff has forwarded to the insurer, or to one of its agents, by registered or certified mail with return receipt requested, or served by any other method of service provided by law, a copy of summons, complaint, or other pleadings, filed in the action. The return receipt shall, upon its return to plaintiff's counsel, be filed with the clerk of court wherein the action is pending against the insured and shall be admissible in evidence as proof of notice to the insurer. The refusal of insurer or its agent to accept delivery of the registered mail, as provided in this section, shall not affect the validity of such notice and any insurer or agent of an insurer refusing to accept such registered mail shall be charged with the knowledge of the contents of such notice. When notice has been sent to an agent of the insurer such notice shall be notice to the insurer. The word "agent" as used in this subsection shall include, but shall not be limited to, any person designated by the insurer as its agent for the service of process, any person duly licensed by the insurer in the State as insurance agent, any general agent of the company in the State of North Carolina, and any employee of the company in a managerial or other responsible position, or the North Carolina Commissioner of Insurance; provided, where the return receipt is signed by an employee of the insurer or an employee of an agent for the insurer, shall be deemed for the purposes of this subsection to have been received. The term "agent" as used in this subsection shall not include a producer of record or broker, who forwards an application for insurance to the North Carolina Motor Vehicle Reinsurance Facility.

The insurer, upon receipt of summons, complaint or other process, shall be entitled, upon its motion, to intervene in the suit against its insured as a party defendant and to defend the same in the name of its insured. In the event of such intervention by an insurer it shall become a named party defendant. The insurer shall have 30 days from the signing of the return receipt acknowledging receipt of the summons, complaint or other pleading in which to file a motion to intervene, along with any responsive pleading, whether verified or not, which it may deem necessary to protect its interest: Provided, the court having jurisdiction over the matter may, upon motion duly made, extend the time for the filing of responsive pleading or continue the trial of the matter for the purpose of affording the insurer a reasonable time in which to file responsive pleading or defend the action. If, after receiving copy of the summons, complaint or other pleading, the insurer elects not to defend the action, if coverage is in fact provided by the policy, the insurer shall be bound to the extent of its policy limits to the judgment taken by default against the insured, and noncooperation of the insured shall not be a defense.

If the plaintiff initiating an action against the insured has complied with the provisions of this subsection, then, in such event, the insurer may not cancel or annul the policy as to such liability and the defense of noncooperation shall not be available to the insurer: Provided, however, nothing in this section shall be construed as depriving an insurer of its defenses that the policy was not in force at the time in question, that the operator was not an "insured" under policy provisions, or that the policy had been lawfully canceled at the time of the accident giving rise to the cause of action.

Provided further that the provisions of this subdivision shall not apply when the insured has delivered a copy of the summons, complaint or other

pleadings served on him to his insurance carrier within the time provided by law for filing answer, demurrer or other pleadings.

(2) The satisfaction by the insured of a judgment for such injury or damage shall not be a condition precedent to the right or duty of the insurance carrier to make payment on account of such injury or damage;

(3) The insurance carrier shall have the right to settle any claim covered by the policy, and if such settlement is made in good faith, the amount thereof shall be deductible from the limits of liability specified in subdivision (2) of subsection (b) of this section;

(4) The policy, the written application therefor, if any, and any rider or endorsement which does not conflict with the provisions of the Article shall constitute the entire contract between the parties.

(g) Any policy which grants the coverage required for a motor vehicle liability policy may also grant any lawful coverage in excess of or in addition to the coverage specified for a motor vehicle liability policy and such excess or additional coverage shall not be subject to the provisions of this Article. With respect to a policy which grants such excess or additional coverage the term "motor vehicle liability policy" shall apply only to that part of the coverage which is required by this section.

(h) Any motor vehicle liability policy may provide that the insured shall reimburse the insurance carrier for any payment the insurance carrier would not have been obligated to make under the terms of the policy except for the provisions of this Article.

(i) Any motor vehicle liability policy may provide for the prorating of the insurance thereunder with other valid and collectible insurance.

(j) The requirements for a motor vehicle liability policy may be fulfilled by the policies of one or more insurance carriers which policies together meet such requirements.

(k) Any binder issued pending the issuance of a motor vehicle liability policy shall be deemed to fulfill the requirements for such a policy.

(l) A party injured by an uninsured motor vehicle covered under a policy in amounts less than those set forth in G.S. 20-279.5, may execute a contractual covenant not to enforce against the owner, operator, or maintainer of the uninsured vehicle any judgment that exceeds the liability policy limits, as consideration for payment of any applicable policy limits by the insurer where judgment exceeds the policy limits. A covenant not to enforce judgment shall not preclude the injured party from pursuing available uninsured motorist benefits, unless the terms of the covenant expressly provide otherwise, and shall not preclude an insurer providing uninsured motorist coverage from pursuing any right of subrogation.

(m) Every insurer that sells motor vehicle liability policies subject to the requirements of subdivisions (b)(3) and (b)(4) of this section ~~shall~~ shall, when issuing or renewing a policy, give reasonable notice to the named ~~insured, when the policy is issued and renewed,~~ insured of all of the following:

(1) The named insured is required to purchase uninsured motorist bodily injury coverage, uninsured motorist property damage coverage, and, if applicable, underinsured motorist bodily injury coverage.

(2) The named insured's uninsured motorist bodily injury coverage limits shall be equal to the highest limits of bodily injury liability coverage for any one vehicle insured under the policy unless the insured elects to purchase greater or lesser limits for uninsured motorist bodily injury coverage.

(3) The named insured's uninsured motorist property damage coverage limits shall be equal to the highest limits of property damage liability coverage for any one vehicle insured under the policy unless the insured elects to purchase greater or lesser limits for uninsured motorist property damage coverage.

(4) The named insured's underinsured motorist bodily injury coverage limits, if applicable, shall be equal to highest limits of bodily injury liability coverage for any one vehicle insured under the policy unless the insured elects to purchase greater or lesser limits for underinsured motorist bodily injury coverage.

(5) ~~that the~~ The named insured may purchase uninsured motorist bodily injury coverage and, if applicable, underinsured motorist coverage with limits up to one million dollars ($1,000,000) per person and one million dollars ($1,000,000) per accident.

An insurer shall be deemed to have given reasonable notice if it includes the following or substantially similar language on the policy's original and renewal declarations pages or in a separate notice accompanying the original and renewal declarations pages in at least 10 point type:

"NOTICE: YOU ARE REQUIRED TO PURCHASE UNINSURED MOTORIST BODILY INJURY COVERAGE, UNINSURED MOTORIST PROPERTY DAMAGE COVERAGE AND, IN SOME CASES, UNDERINSURED MOTORIST BODILY INJURY COVERAGE. THIS INSURANCE PROTECTS YOU AND YOUR FAMILY AGAINST INJURIES AND PROPERTY DAMAGE CAUSED BY THE NEGLIGENCE OF OTHER DRIVERS WHO MAY HAVE LIMITED OR ONLY MINIMUM COVERAGE OR EVEN NO LIABILITY INSURANCE. YOU MAY PURCHASE UNINSURED MOTORIST BODILY INJURY COVERAGE, UNINSURED MOTORIST PROPERTY DAMAGE COVERAGE AND, IF APPLICABLE, UNDERINSURED MOTORIST COVERAGE WITH LIMITS UP TO ONE MILLION DOLLARS ($1,000,000) PER PERSON AND ONE MILLION DOLLARS ($1,000,000) PER ~~ACCIDENT.~~ ACCIDENT OR AT SUCH LESSER LIMITS YOU CHOOSE, BUT IN NO CASE LESS THAN THE MINIMUM LIMITS FOR THE BODILY INJURY AND PROPERTY DAMAGE COVERAGE THAT ARE REQUIRED FOR YOUR OWN VEHICLE. **IF YOU DO NOT CHOOSE A GREATER OR LESSER LIMIT FOR UNINSURED MOTORIST (BODILY INJURY AND PROPERTY DAMAGE) AND/OR UNDERINSURED MOTORIST COVERAGE (BODILY INJURY), THEN THE LIMITS FOR EACH TYPE OF COVERAGE IN YOUR POLICY WILL BE THE SAME AS THE HIGHEST LIMITS FOR THAT TYPE OF COVERAGE FOR ANY ONE OF YOUR OWN VEHICLES INSURED UNDER YOUR POLICY.** IF YOU WISH TO PURCHASE UNINSURED MOTORIST AND, IF APPLICABLE, UNDERINSURED MOTORIST COVERAGE AT DIFFERENT LIMITS THAN THE LIMITS FOR YOUR OWN VEHICLE INSURED UNDER THE POLICY THAN YOU SHOULD ~~THIS INSURANCE PROTECTS YOU AND YOUR FAMILY AGAINST INJURIES CAUSED BY THE NEGLIGENCE OF OTHER DRIVERS WHO MAY HAVE LIMITED OR ONLY MINIMUM COVERAGE OR EVEN NO LIABILITY INSURANCE. YOU SHOULD~~ CONTACT YOUR INSURANCE COMPANY OR AGENT TO DISCUSS YOUR OPTIONS FOR OBTAINING ~~THIS ADDITIONAL COVERAGE.~~ DIFFERENT COVERAGE LIMITS. YOU SHOULD ALSO READ YOUR ENTIRE POLICY TO UNDERSTAND WHAT IS COVERED UNDER UNINSURED AND UNDERINSURED MOTORIST COVERAGES."

(n) Nothing in this section shall be construed to provide greater amounts of uninsured or underinsured motorist coverage in a liability policy than the insured has purchased from the insurer under this section.

(o) An insurer that fails to comply with subsection (m) of this section is subject to a civil penalty under G.S. 58-2-70."

SECTION 2. This act becomes effective October 1, 2009, and applies to motor vehicle liability insurance policies issued or renewed on or after that date.

SENATE BILL 749: Revise UM/UIM Liability Coverage Requirements

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Ways and Means/Broadband Connectivity	**Date:**	July 2, 2009
Introduced by:	Sen. Clodfelter	**Prepared by:**	Kory Goldsmith Committee Counsel
Analysis of:	PCS to Second Edition S749-CSRC-46		

SUMMARY: ***Senate Bill 749 makes changes to uninsured and underinsured motorist coverages to provide that uninsured motorist (UM) coverage may be purchased at limits less than bodily injury liability coverage for any one vehicle insured under the policy, but may not be less than the minimum liability limits for bodily injury and property damage required under law. Underinsured motorist (UIM) coverage may also be purchased at limits less than liability coverage, but the coverage must exceed the minimum bodily injury liability limits required by law and must equal the limits of uninsured motorist bodily injury coverage purchased by the insured.***

The PCS to the 2nd Edition removes language creating an irrebuttable presumption that the statutory requirements of reasonable notice of the insured's right to purchase UM/UIM coverage with limits up to $1,000,000 has been given, and evidence that the coverage limits were stated in the policy constitutes irrebuttable proof of the amount of coverage provided by the policy. The PCS also adds language requiring the insurer to notify the insured upon issuance and renewal that the "default" coverage limit for UM and UM/UIM will be the same limits as the limits of uninsured bodily injury liability coverage purchased by the insured unless the insured elects to have a different level of coverage.

CURRENT LAW: In 2008, S.L. 2008-124 (House Bill 738) was enacted to require motor vehicle liability policies to include uninsured motorist coverage equal to the highest limits of bodily injury liability coverage and property damage liability coverage, and underinsured coverage equal to the highest limits of bodily injury liability coverage, for any for any one vehicle insured under the policy. This provision did not allow insureds the option of purchasing UM/UIM coverage at less than the highest limits under the insured's policy. Prior to this change, UM/UIM coverage could be rejected by an insured in writing.

BILL ANALYSIS: The PCS to Senate Bill 749 makes the following changes in the current law:

- Amends G.S. 20-279.21(b)(3) to retain compulsory UM coverage. However, this coverage may be purchased at amounts lesser or greater amounts than an insured's liability coverage, but the coverage may not be less than the liability limits required under State law. ($30,000 per person/$60,000 per accident/$25,000 property damage)
- Amends G.S. 20-279.21(b)(4) to retain compulsory UM/UIM combined coverage. However, as with UM coverage, UIM coverage may be purchased at lesser or greater amounts, but the coverage must **exceed** the bodily injury liability limits required under State law and must be equal to the limits of uninsured bodily injury liability coverage purchased by the insured. (Only UM coverage is available to an insured who purchases the minimum limits of bodily injury coverage. UIM coverage is not available.)

- Amends G.S. 20-279.21(b)(3) and (4) to clarify that commercial vehicles are not subject to the compulsory UM or UM/UIM combined coverage, even if the commercial vehicle is a private passenger vehicle. This was the intended result in 2008.
- Requires the insurer to notify the insured when a policy is issued or renewed that the coverage limits for UM and UM/UIM will be the same as the coverage for bodily injury liability limits unless the insured elects to purchase a different level of coverage.

EFFECTIVE DATE: Senate Bill 749 becomes effective October 1, 2009 and applies to policies issued on or after that date.

Tim Hovis, counsel to Senate Commerce, substantially contributed to this summary.

S749-SMRC-64(CSRC-46) v1

ATTACHMENT #1

VISITOR REGISTRATION SHEET

House Insurance — July 2, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Haigwood	NCDOL
Curt Brown	NCDOL
[signature]	JD, AL, PA
Cam Cook	BPMHC
Leslie Bullard Cox	Capstrat
Dana Simpson	Smith Anderson
Andrew Cagle	DLC + Assoc.
Leslie Arnold	SOG - Daily Bulletin
CURT LEONARD	A-C-L-I.
[signature]	[signature]

VISITOR REGISTRATION SHEET

House Committee on Insurance

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	Nationwide
[illegible]	520 W. [illegible]
[illegible] Barlow	NCAJ
Colleen Kochanek	KLG
Bob Mack	NCDOI
Rose Williams	NCDOT
David Stoller	State Farm
[illegible] Dalton	NCRMA
Jessie Conan	Capitol
[illegible]	SA
[illegible]	NC Delegation Med Society

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Doug Miskew	Capstrat
David Barnes	Power Square
John McMillan	MFAS
Michelle Frazier	MFAS
Robert Marshall	Young Moore
Dick Zeh	NCAJ
Patrick Hannah	Liberty Mutual
Paul Pulley	NCAJ
John Robinson	NCAJ
CS Hollis	K&L Gates
Frank Folger	Nationwide

HOUSE PAGES

NAME OF COMMITTEE INSURANCE DATE 7-2-09

1. Name: KAITLYN DEAL
   County: CATAWBA
   Sponsor: REP. SETZER
2. Name: REBEKAH BLAKE
   County: CATAWBA
   Sponsor: REP. SETZER
3. Name: ABBY WILKERSON
   County: VANCE
   Sponsor: REP. WRAY
4. Name:
   County:
   Sponsor:
5. Name:
   County:
   Sponsor:

SGT-AT-ARM

1. Name: CHARLES WILLIAMS
2. Name: MARTHA GADISON
3. Name: ROBERT ROSSI
4. Name:

Correct version 7/6/09

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☒Committee Substitute for

SB 749 A BILL TO BE ENTITLED AN ACT TO REVISE AND CLARIFY THE REQUIREMENTS FOR UNINSURED AND UNDERINSURED MOTORIST COVERAGE IN MOTOR VEHICLE LIABILITY INSURANCE POLICIES.

☒ With a favorable report as to the House committee substitute bill, unfavorable as to Senate Committee Substitute Bill and recommendation that the House committee substitute bill be re-referred to the Committee on WAYS AND MEANS/BROADBAND CONNECTIVITY.

(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.

MINUTES

HOUSE COMMITTEE ON INSURANCE
July 7, 2009

The House Committee on Insurance met at 11:00 AM on Tuesday, July 7, 2009, in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael H. Wray; Vice Chair: J. Dockham and M. Setzer. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Current, Faison, Howard and Hughes.

Chairman Goforth called the meeting to order and welcomed visitors. He recognized Sgt-At-Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachment #1)

Chairman Goforth called upon staff to explain SB 1029 – PEO Amendments in Sen. Stan Bingham's absence. Chairman Wray moved that a PCS for SB 1029 be before the committee. Mr. Tim Hovis explained the bill. The PCS for SB 1029 clarifies that the bond posted by an applicant for a professional employer organization (PEO) license who was licensed prior to October 1, 2008 shall be in the amount of $100,000. The bill does not change the bonding requirements for applicants that were licensed on or after that date. The PCS clarifies that tax credits and other economic incentives provided by a political subdivision of the State should be treated in the same manner as incentives provided by the State.

After committee discussion, Rep. Faison moved for a favorable report for the PCS, unfavorable to the original bill, and re-referred to the Finance Committee. The motion carried.

Chairman Goforth adjourned the meeting at 11:20 AM.

Bruce Goforth

Representative Bruce Goforth, Chair

Mary Capps

Mary Capps, Committee Assistant

HOUSE INSURANCE COMMITTEE

July 7, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

SB 877 – HEALTH PLAN PROVIDER CONTRACTS/TRANSPARENCY – Senator Clodfelter

SB 1029 – PEO AMENDMENTS – Senator Bingham

Adjourn

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 1029
Commerce Committee Substitute Adopted 5/4/09
House Committee Substitute Favorable 6/10/09
PROPOSED HOUSE COMMITTEE SUBSTITUTE S1029-CSRG-46 [v.2]

7/6/2009 7:58:00 PM

Short Title: PEO Amendments. (Public)

Sponsors:

Referred to:

March 31, 2009

A BILL TO BE ENTITLED

AN ACT TO AMEND THE NORTH CAROLINA PROFESSIONAL EMPLOYER ORGANIZATION ACT CONCERNING BONDING PROVISIONS AND MAINTENANCE OF EMPLOYEE BENEFITS, AND TO CLARIFY THE APPLICATION OF TAX CREDITS AND OTHER INCENTIVES TO PROFESSIONAL EMPLOYER ORGANIZATIONS.

The General Assembly of North Carolina enacts:

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

"(a) An applicant for licensure shall file with the Commissioner a surety bond for the benefit of the Commissioner as follows:

(1) If the applicant was initially licensed prior to October 1, 2008, the bond, or other items as provided for in subsection (f) of this section, shall be in the amount of one hundred thousand dollars ($100,000).

(2) If the applicant was not initially licensed prior to October 1, 2008, the bond, or other items as provided for in subsection (f) of this section, shall be in an amount equal to five percent (5%) of the applicant's prior year's total North Carolina wages, benefits, workers compensation premiums, and unemployment compensation contributions, but not greater than five hundred thousand dollars ($500,000), or such greater amount as the Commissioner may require."

SECTION 2. G.S. 58-89A-105 reads as rewritten:

"**§ 58-89A-105. Employee benefit plans; required disclosure; other reports.**

(a) A licensee may sponsor and maintain employee benefit plans for the benefit of assigned employees. Any health insurance plan sponsored and maintained by a licensee shall only be fully insured by one of the following:

(1) A licensed insurance company that is authorized to write accident and health insurance, as defined in G.S. 58-7-15(3).

(2) A service corporation organized and licensed under Article 65 of this Chapter.

(3) A health maintenance organization organized and licensed under Article 67 of this Chapter.

(b), (c) Repealed by Session Laws 2008-124, s. 7.4, effective October 1, 2008.

(d) For the purposes of this section, a health insurance plan is fully insured only if all of the benefits provided under the plan are covered by an approved policy issued by one or more of the entities specified in subsection (a) of this section. A health insurance plan is not fully insured if the plan is any form of stop-loss insurance or any other form of reinsurance.

(e) Existing licensees shall comply with subsection (a) of this section by October 1, 2009. ~~Before~~ If on October 1, 2009, ~~if~~ an existing licensee sponsors and maintains any health insurance plan that is not fully insured by one or more of the entities specified in subsection (a) of this section, the licensee ~~shall do all of the following:~~

~~(1) Use a third-party administrator licensed or registered under Article 56 of this Chapter.~~

~~(2) Hold all plan assets, including participant contributions, in a trust account.~~

~~(3) Provide sound reserves for the plan as determined by generally accepted actuarial standards.~~

may continue to sponsor and maintain the health insurance plan if it complies with G.S. 58-89A-106."

SECTION 3. Article 89A of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-89A-106. Health insurance plan requirements.**

(a) In order for a licensee to sponsor and maintain a health benefit plan that is not fully insured by one or more of the entities specified in subsection (a) of G.S. 58-89A-109, on and after October 1, 2009 as authorized by subsection (e) of that section, the licensee shall:

(1) Use a third-party administrator licensed or registered under Article 56 of this Chapter.

(2) Hold all health insurance plan assets, including participant contributions, in a separate trust account for use only with the health benefit plan.

(3) Provide sound reserves for the health benefit plan as determined by generally accepted actuarial standards.

(4) Maintain the health benefit plan for only employees of the licensee or employees of the client company, and neither offer nor advertise the health insurance benefit plan to the public generally.

(5) Issue to each covered employee a policy, contract, certificate, summary plan description, or other evidence of the benefits and coverages provided. The evidence of benefits and coverages provided shall contain, in boldface print in a conspicuous location, the following statement: "THE BENEFITS UNDER THIS PLAN MAY NOT BE EQUAL TO THE MANDATED BENEFITS REQUIRED OF FULLY INSURED PLANS. THE BENEFITS AND COVERAGES DESCRIBED HEREIN ARE PROVIDED THROUGH A SELF-FUNDED HEALTH BENEFIT PLAN ESTABLISHED BY [name of PEO]. EXCESS INSURANCE IS PROVIDED BY AN AUTHORIZED INSURANCE COMPANY TO COVER HIGH AMOUNT MEDICAL CLAIMS. THE HEALTH BENEFIT PLAN IS NOT PROTECTED BY ANY INSURANCE GUARANTY ASSOCIATION. OTHER RELATED FINANCIAL INFORMATION IS AVAILABLE FROM YOUR EMPLOYER OR FROM THE [name of PEO]." Any statement required by this subsection is not required on identification cards issued to covered employees or other insureds.

(6) File all contracts with third-party administrators with the Commissioner, and report any changes to those contracts to the Commissioner before their implementation.

(7) Obtain and maintain stop-loss insurance from an insurer authorized to write insurance in this State, which insurance meets the following requirements:

a. Individual stop-loss insurance that is actuarially appropriate for the size of the group and the expected losses, as determined by a certified actuary.

b. Aggregate stop-loss insurance that is actuarially appropriate for the size of the group and the expected losses as determined by a certified actuary.

If the licensee is unable to obtain aggregate stop-loss insurance that is actuarially appropriate, the licensee shall maintain at least a thirty percent (30%) lag reserve above expected losses, as determined by a certified actuary.

(8) File with the Commissioner for information the summary plan description and the evidence of the benefits and coverages provided under the health benefit plan that is issued to the person covered by the health benefit plan.

(9) The health benefit plans developed under this section are not required to provide coverage that meets the requirements of other provisions of this Chapter that mandate either coverage or the offer of coverage by the type or level of health care services or health care provider.

(10) Establish and maintain a written plan of operation for the health benefit plan.

(11) File with the Commissioner the plan of operation for the health benefit plan and any updates to the plan of operation within 30 days of implementation.

(b) Notwithstanding Chapter 132 of the General Statutes, all documents filed by a licensee under this section 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. The Commissioner, however, may use the contracts filed under this subsection in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties.

"**§ 58-89A-107. Examinations of self-funded health benefit plans.**

(a) The Commissioner may conduct an examination of a licensee's self-funded employee benefit plan as often as the Commissioner considers appropriate.

(b) An examination under this Article shall be conducted in accordance with the Examination Law of this Chapter, G.S. 58-2-131 through G.S. 58-2-133.

(c) In lieu of an examination of any foreign or alien licensee's self-funded employee benefit plan, the Commissioner may, in the Commissioner's discretion, accept an examination report on the licensee's self-funded employee benefit plan prepared by the appropriate regulator for the licensee's state of domicile.

(d) When making an examination under this section, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, the reasonable cost of which shall be borne by the licensee that is the subject of the examination.

(e) The amount paid by a PEO for an examination of its health benefit plan under this section shall not exceed sixty thousand dollars ($60,000), unless the PEO and the Commissioner agree on a higher amount. The State Treasurer shall deposit all funds received under this section in the Insurance Regulatory Fund established under G.S. 58-6-25. Funds received under this section shall be used by the Department for offsetting the actual expenses incurred by the Department for examinations under this section."

SECTION 4. G.S. 58-89A-31 reads as rewritten:

"**§ 58-89A-31. Tax credits and other incentives.**

For purposes of determination of tax credits and other economic incentives provided by the State or a political subdivision and based on employment, covered employees are considered

employees solely of the client. A client shall be entitled to the benefit of any tax credit, economic incentive, or other benefit arising as the result of the employment of covered employees of the client. Each professional employer organization must provide, upon request by a client, employment information that is required by any agency or department of the State or a political subdivision responsible for administration of any tax credit or economic incentive and that is necessary to support a request, claim, application, or other action by a client seeking the tax credit or economic incentive. For purposes of this section, the term "political subdivision" has the same meaning as in G.S. 162A-65(a)(8)."

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

SENATE BILL 1029: PEO Amendments

2009-2010 General Assembly

Committee:	House Insurance	**Date:**	July 7, 2009
Introduced by:	Sen. Bingham	**Prepared by:**	Tim Hovis
Analysis of:	PCS to Third Edition S1029-CSRG-47		Committee Counsel

SUMMARY: ***The Proposed Committee Substitute for Senate Bill 1029 clarifies that the bond posted by an applicant for a professional employer organization (PEO) license who was licensed prior to October 1, 2008 shall be in the amount of $100,000. The bill does not change the bonding requirements for applicant's that were licensed on or after that date.***

The PCS clarifies that tax credits and other economic incentives provided by a political subdivision of the State should be treated in the same manner as incentives provided by the State.

CURRENT LAW: A PEO is defined under G.S. 58-89A-5(14) as a "person that offers professional employer services." As provided in G.S. 58-89A-5(16), professional employer services means "an arrangement by which employees of a [PEO] are assigned to work at a client company and in which employment responsibilities are in fact shared by the [PEO] and the client company." PEO's typically provide services to companies such as the management of payroll and health benefits.

In 2008, the General Assembly amended the Professional Employer Organization Act to require an applicant for licensure to post a bond in an amount equal to 5% of the applicant's prior year's total NC wages, benefits, workers compensation premiums, and unemployment contributions, but not greater than $500,000, or such greater amount as the Commissioner may require. This change became effective October 1, 2008.

Prior to this change, applicants were required to post a bond in the amount of $100,000.

Also in 2008, the General Assembly amended the Act to no longer allow a PEO to self-insure and instead required health benefit plans maintained by PEOs to be fully insured by an insurance company, service corporation, or HMO. This provision became effective for existing PEOs on October 1, 2009.

BILL ANALYSIS: **Section 1** of the bill clarifies that PEOs licensed prior to October 1, 2008 (the effective date of the 2008 changes) must post a bond in the amount of $100,000, as required prior to the 2008 change. The new bonding requirements would only apply to those applicants who were not already licensed when the 2008 changes took effect.

Amendments to the Act in 2008 also deleted language allowing a client company of a PEO to sponsor and maintain employee benefit plans for the benefit of assigned employees. **Section 2** of the PCS adds a new subsection (a1) to reinstate this language.

Section 2 of the PCS also authorizes PEOs that self-insure their health insurance benefit plans on October 1, 2009 to continue to self-insure provided the conditions outlined in the new G.S. 58-89A-106, as enacted by Section 3 of the bill, are met.

Section 3 enacts a new G.S. 58-89A-106 to allow a PEO that self-insures its health benefit plan on October 1, 2009 to continue to self-insure provided the PEO meets the following conditions:

- Uses a third-party administrator
- Holds all health insurance plan assets in a separate trust account

- Provides sound reserves
- Maintains the plan for employees only
- Issues a policy or summary plan, with conspicuous notice, to all employees
- Files all third-party administrator contracts with the Commissioner
- Maintains actuarially sound, aggregate and individual stop-loss insurance
- Files summary plan with the Commissioner
- Maintains a written plan of operation for the plan filed with the Commissioner

All documents filed by the PEO are confidential, are not open for public inspection, are not discoverable, or admissible in a civil action other than a civil action brought by the Department against a person regulated by the Department. The documents may be admissible or discoverable if the court finds that admission or discovery is in the interests of justice.

Section 3 also adds a new G.S. 58-89A-107 authorizing the Commissioner to conduct an examination of a licensee's self-funded plan. This section also provides that the cost to the Department of the examination shall be borne by the PEO, shall not exceed $60,000 (unless a higher amount is agreed to), and that all funds received by the Department shall be deposited in the Insurance Regulatory Fund by the State Treasurer.

Section 4 amends the law governing tax credits and other economic incentives provided by the State and based on employment. The law provides that the client company is entitled to the incentive and covered employees are considered employees solely of the client. Section 4 clarifies that incentives provided by a political subdivision of the State are to be treated in the same manner as incentives provided by the State.

EFFECTIVE DATE: Senate Bill 1029 is effective when it becomes law.

*Karen Cochrane-Brown, Staff Attorney, substantially contributed to this summary.

S1029-SMRG-83(CSRG-46) v1

S1029-SMRG-84(CSRG-47) v1

ATTACHMENT #1

VISITOR REGISTRATION SHEET

House Committee on Insurance — 7/7/09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tina Gordon	NC Nurses Assoc
Elizabeth French	NCMS
Allison Clipp	NCMS
JR [illegible]	DOI
LT Watts	DOI
Adam Peer	NAPEO
Ed Turlington	BP/ Atty for NAPEO
Carol Durrell	State Health Plan
Lacey Barnes	State Health Plan
Paul Mahony	CAPSTRAT
Leslie Bonacorsa Cone	Capstrat

VISITOR REGISTRATION SHEET

House Committee on Insurance — 7/7/09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ashley J Bell	American Cancer Society
Bill Scoggin	AHG
David Boaz	MWC
Harry Kaplan	MWC
Betsy Vetter	American Heart Assn
ANN LOVE	DVLE
Mattie L McKenzie	Carolinas Healthcare System
Gary Salamido	BIC
Dennis Patterson	OSA
Barbara Cansler	BBCGA
Scott Mooney	The Insider

VISITOR REGISTRATION SHEET

House Committee on Insurance — 7/7/09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
PATRICK HANNAH	LIBERTY

VISITOR REGISTRATION SHEET

House Committee on Insurance — 7-7-09

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
KARL STEIN	RALEIGH ORTHOPAEDIC CLINIC 3515 GLENWOOD RALEIGH
Sheria Reid	IOG
Stephen Wohlers	NCDOI
Doug Miskew	Capstrat
Maeve Groff	Smith Anderson
Andrew P. [illegible]	Young Moore Henderson
Robert Paschal	Young Moore
Colleen Kochanek	KLG
Tony Riddick	NCDOI
TED HAMBY	NCDOI
PEYTON MAYNARD	

VISITOR REGISTRATION SHEET

House Committee on Insurance — 7-7-

Name of Committee — **Date** 7-7-09

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DAVID BARNES	Pagan Spruill
Hugh Wilson	NCHA
Amy McConkey	Smith Anderson
Dave Horne	Smith Anderson
Marce Foreman	NCAE
[signature]	NMRS

HOUSE PAGES

NAME OF COMMITTEE INSURANCE DATE 7-7-09

1. Name: BRYAN WIMBERLY
   County: AIKEN, SC
   Sponsor: REP. MICHAUX
2. Name: DAVIS WELCH
   County: FORSYTH
   Sponsor: REP. BROWN
3. Name: ASHLEY KILLIAM
   County: MECKLENBURG
   Sponsor: REP. KILLIAM
4. Name: JAQUELINE VAUGHAN-JONES
   County: DAVIE
   Sponsor: REP HACKNEY
5. Name: BRADLEY JAMES
   County: NEW HANOVER
   Sponsor: REP. MCCOMAS

SGT-AT-ARM

1. Name: CHARLES WILLIAMS
2. Name: Rod Finger
3. Name: Ken Burroughs
4. Name: [illegible]

Mary Capps (Rep. Wray)

From: Ann Jordan (Rep. Goforth)
Sent: Thursday, July 02, 2009 12:44 PM
To: Sen. Daniel Clodfelter; Sen. Stan Bingham
Subject: Insurance Meeting Notice for July 7.doc

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

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

DAY & DATE: **Tuesday - July 7, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

SB 877 – HEALTH PLAN PROVIDER CONTRACTS/TRANSPARENCY – Senator Clodfelter

SB 1029 – PEO AMENDMENTS – Senator Bingham

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at: **1:00 pm on July 2, 2009.**

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☒House Committee Substitute for
SB 1029 A BILL TO BE ENTITLED AN ACT TO AMEND THE NORTH CAROLINA PROFESSIONAL EMPLOYER ORGANIZATION ACT CONCERNING BONDING PROVISIONS AND MAINTENANCE OF EMPLOYEE BENEFITS, AND TO CLARIFY THE APPLICATION OF TAX CREDITS AND OTHER INCENTIVES TO PROFESSIONAL EMPLOYER ORGANIZATIONS.

☒ With a favorable report as to House Committee Substitute Bill #2, unfavorable as to House Committee Substitute Bill #1 and recommendation that House Committee Substitute Bill #2 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.

MINUTES
HOUSE COMMITTEE ON INSURANCE
July 9, 2009

The House Committee on Insurance met at 11:00 AM on Thursday, July 9, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael Wray; Vice Chairs: M. Dickson, J. Dockham and M. Setzer. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Cole, Current, Faison, Holliman, Howard, Hughes, Lewis and Pierce.

Chairman Wray called the meeting to order and welcomed visitors. He recognized Sgt-At Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachments)

Chairman Wray recognized Sen. Clodfelter to explain SB 777 – Health Plan Provider Contracts/Transparency. Sen. Clodfelter said the bill add a new part of Article 50 of Chapter 58 establishing procedures relating to contracts between health care providers and health benefit plans or insurers. He said the single most important part is that parties will agree to a contract before signing. Presumption doesn't always work. Now if a contract is amended it has to be a consenting agreement. Brad Aycock with Blue Cross and Blue Shield said he did not think the bill should pass. He said only two states have anything like this and there is a huge cost implication for both insurer and insured. The Medical Society was asking for the change but thought the bill is poorly drafted. Sen. Clodfelter responded that the "fee schedule" was provided to him by BC&BS. Dana Simpson, a lobbyist with Smith, Anderson, Blount, Dorsett, Mitchell and Jernigan was recognized to speak. He said he would like to echo Sen. Clodfelter's comments and thought it was a good bill.

Chairman Wray recognized Rep. Lewis for a motion. Rep. Lewis moved for a favorable report. Motion carried.

The meeting adjourned at 11:45.

Representative Michael Wray, Chairman

Ann Jordan – Committee Assistant

HOUSE INSURANCE COMMITTEE

July 9, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

SB 877 – HEALTH PLAN PROVIDER CONTRACTS/TRANSPARENCY – Senator Clodfelter

SB 660 – AUTO INSURANCE/DIMINUTION IN VALUE – Sen. Rucho

Adjourn

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 3

SENATE BILL 877
Health Care Committee Substitute Adopted 5/12/09
Third Edition Engrossed 5/13/09

Short Title: Health Plan Provider Contracts/Transparency. (Public)

Sponsors:

Referred to:

March 26, 2009

A BILL TO BE ENTITLED

AN ACT RELATING TO CONTRACTS BETWEEN HEALTH BENEFIT PLANS AND HEALTH CARE PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 50 of Chapter 58 of the General Statutes is amended by adding the following new Part to read:

"Part 7. Contracts between health benefit plans and health care providers.

"**§ 58-50-270. Definitions.**

Unless the context clearly requires otherwise, the following definitions apply in this Part.

(1) 'Amendment' – Any change to the terms of a contract, including terms incorporated by reference, that modifies fee schedules. A change required by federal or State law, rule, regulation, administrative hearing, or court order is not an amendment.

(2) 'Contract' – An agreement between an insurer and a health care provider for the provision of health care services by the provider on a preferred or in-network basis.

(3) 'Health benefit plan' – A policy, certificate, contract, or plan as defined in G.S. 58-3-167.

(4) 'Insurer' – An entity as defined in G.S. 58-3-227(a)(4).

"**§ 58-50-271. Notice contact provisions.**

(a) All contracts shall contain a "notice contact" provision listing the name or title and address of the person to whom all correspondence, including proposed amendments and other notices, pertaining to the contractual relationship between parties shall be provided. Each party to a contract shall designate its notice contact under such contract.

(b) Date of receipt for all notices provided under a contract shall be calculated as five business days following the date the notice is placed, first-class postage prepaid, in the United States mail.

"**§ 58-50-272. Contract amendments.**

(a) A health benefit plan or insurer shall send any proposed contract amendment to the notice contact of a health care provider pursuant to G.S. 58-50-271. The proposed amendment shall be dated, labeled "Amendment," signed by the health benefit plan or insurer, and include an effective date for the proposed amendment.

(b) A health care provider receiving a proposed amendment shall be given at least 60 days from the date of receipt to object to the proposed amendment. The proposed amendment shall be effective upon the health care provider failing to object in writing within 60 days.

(c) If a health care provider objects to a proposed amendment, then the proposed amendment is not effective and the initiating health benefit plan or insurer shall be entitled to terminate the contract upon 60 days written notice to the health care provider.

"**§ 58-50-273. Policies and procedures.**

(a) A health benefit plan or insurer shall provide a copy of its policies and procedures to a health care provider prior to execution of a new or amended contract and annually to all contracted health care providers. Such policies and procedures may be provided to the health care provider in hard copy, CD, or other electronic format, and may also be provided by posting the policies and procedures on the Web site of the health plan or insurer.

(b) The policies and procedures of a health benefit plan or insurer shall not conflict with or override any term of a contract, including contract fee schedules. In the event of a conflict between a policy or procedure and the language in a contract, the contract language shall prevail."

SECTION 2. This act becomes effective January 1, 2010, and applies to health benefit plan contracts between health care providers and health benefit plans or insurers delivered, amended, or renewed on and after that date.

SENATE BILL 877:
Health Plan Provider Contracts/Transparency

2009-2010 General Assembly

Committee:	House Insurance	**Date:**	July 6, 2009
Introduced by:	Sen. Clodfelter	**Prepared by:**	Bill Patterson
Analysis of:	Third Edition		Committee Counsel

SUMMARY: Senate Bill 877 adds a new part to Article 50 (General Accident and Health Insurance Regulations) of Chapter 58 (Insurance Law of North Carolina) establishing procedures relating to contracts between health care providers and health benefit plans or insurers.

BILL ANALYSIS: Senate Bill 877 adds a new Part 7 to Article 50 of the North Carolina General Statutes setting forth procedural requirements for proposing amendments that modify fee schedules in contracts between health benefit plans or insurers and health care providers for provision of health care services on a preferred or in-network basis:

- **G.S. 58-50-270** defines the terms "amendment," "contract," "health benefit plan," and "insurer" as used in the new Part. "Amendment" is defined as any change to a contract that modifies fee schedules.
- **G.S. 58-50-271** requires all contracts to list the name or title and address of the contact person who is designated to receive all correspondence on behalf of each party to the contract, and provides that notices shall be deemed to have been received 5 business days after the date it is properly placed in the mail.
- **G.S. 58-50-272** sets forth the process for proposing, accepting, or objecting to contract amendments. Proposed amendments must be sent to the provider's contact person and must contain an effective date and be dated, properly labeled, and signed by the health benefit plan or insurer. The provider must be given at least 60 days from the date of receipt to object to the proposed amendment. The amendment goes into effect upon failure to object within the permitted time. If objected to in apt time, the amendment does not go into effect, and the health benefit plan or insurer is entitled to terminate the contract upon 60 days written notice to the provider.
- **G.S. 58-50-273** requires a health benefit plan or insurer to provide a copy of its policies and procedures to the health care provider prior to execution of a new or amended contract and annually to all providers under contract. If the policies and procedures of the plan/insurer contradict language in a contract, the contract language prevails.

EFFECTIVE DATE: This act is effective January 1, 2010 and applies to contracts delivered, amended, or renewed on or after that date.

Shawn Parker, legislative analyst with the House Health Committee, substantially contributed to this summary.

S877-SMTG-71(e3) v3

ATTACHMENT #1

VISITOR REGISTRATION SHEET

House Insurance — July 9, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Herlong	PCI
Elizabeth French	NCMS
Barbara Cansler	BCBS
[illegible]	[illegible] Assn
[illegible]	IND Assoc
Greg Griggs	NCAFP / Henderson, NC
Carol Durrell	State Health Plan
Lacey Barnes	State Health Plan
[illegible] Goff	Smith Anderson
Kathryn Mullican	BCBSNC
Mark Gentry	BCBSNC

VISITOR REGISTRATION SHEET

House Insurance — July 9, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Cohen	IFNC
Mary Selvidge	IFNC
Michelle Frazier	MFTS
Alicia Davis	MWC
Johnny Tillett	MWC
Loki Ann Harris	UAHA
[illegible]	NC Nurses Assoc
Dana Simpson	Smith Anderson
[illegible]	

VISITOR REGISTRATION SHEET

House Insurance — July 9, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Margie Freeman	NCAE
Michael Jackson	Plastics
Joyce Peters	JP Assoc
David Stoller	State Farm
Chip Bigelow	NCMS
[illegible]	BMAC Ins.
[illegible]	[illegible]
Allison Clapp	NCMS
Rose Williams	NCDOT
[illegible]	"
Stephen Wilkins	"
[illegible]	[illegible]

VISITOR REGISTRATION SHEET

House Insurance — July 9, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ann Lamb	OVE
Mark McLennan	Carolinas HealthCare Sys.
Michelle Brooks	University Health Systems
Betsy Vetter	American Heart Assn
Ashley Bell	American Cancer Society
Amy McConkey	Smith Anderson
Joel Maynard	NCAFP
Ted Hamby	NCDOI
Penny Griffin	School of Gov.
Robert Paschal	Young Moore
Cam Cuen	BPMHL

HOUSE PAGES

NAME OF COMMITTEE INSURANCE DATE 7-9-09

1. Name: BRYAN WIMBERLY
   County: AIKEN S.C.
   Sponsor: REP. MICHAUX
2. Name: ALEXANDRIA MACCIOLI
   County: WAKE
   Sponsor: REP. HARRELL
3. Name: STUART WELCH
   County: FORSYTH
   Sponsor: REP BROWN
4. Name:
   County:
   Sponsor:
5. Name:
   County:
   Sponsor:

SGT-AT-ARM

1. Name: CHARLES WILLIAMS
2. Name: REGGIE SILLS
3. Name: EARL COKER
4. Name:

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☒Committee Substitute for

SB 877 A BILL TO BE ENTITLED AN ACT RELATING TO CONTRACTS BETWEEN HEALTH BENEFIT PLANS AND HEALTH CARE PROVIDERS.

☒ 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 _____.

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

ADD SB 660

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

DAY & DATE: **Thursday - July 9, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

SB 877 – HEALTH PLAN PROVIDER CONTRACTS/TRANSPARENCY – Senator Clodfelter

SB 660 – AUTO INSURANCE/DIMINUTION IN VALUE – Senator Rucho

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at: **11:50 am on July 8, 2009.**

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

MINUTES

HOUSE COMMITTEE ON INSURANCE
July 14, 2009

The House Committee on Insurance met at 11:00 AM on Tuesday, July 14, 2009, in Room 1228. The following Representatives attended, Chairman Bruce Goforth and Michael H. Wray; Vice Chairs: M. Dickson, J. Dockham and M. Setzer. Members attending were Reps. Blust, Braxton, Cole, Current, Faison, Holliman, Howard, Hughes, Pierce and Wainwright.

Chairman Goforth called the meeting to order and welcomed visitors. He recognized Sgt-At-Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachment #1)

Chairman Goforth recognized Chairman Wray for a motion to bring a PCS for SB 660 – Auto Insurance/Diminution in Value before the committee. Chairman Goforth called upon Rep. Carolyn H. Justice to explain Sen. Robert Rucho's bill. SB 660 amends G.S. 20-279.21 by adding a new subsection to provide a procedure for determining the amount of damage to a motor vehicle resulting from the difference in fair market value of the vehicle immediately before and immediately after an accident. This subsection only applies when liability for coverage is not in dispute and only if the difference in the claimant's and the insurer's estimate of fair market is greater than $2,000 or twenty-five percent of the fair market value of the vehicle. This procedure would typically be used for third party claims by a driver who was not at fault against the insurer of a driver who was liable for damages resulting from an accident.

Ms. Jennifer Cohen, Executive Director, Insurance Federation of North Carolina, was recognized to speak on SB 660. She stated mediation is always available and if people request it they can have it so the bill does not need to add an additional benefit that does not already exist although clearly it does put it into law. Secondly, she has been informed from the industry that making mediation mandatory in these situations will increase costs substantially.

Rep. Justice stated people do not know about the mediation process. Ms. Rose Williams, Department of Insurance, stated that Department has not taken a position on SB 660. It has not done a study on how much insurance would go up in costs.

Rep. Cole was recognized to send forth a technical amendment (Attachment #2) and the amendment was adopted. Rep. Cole moved for a favorable report on the PCS for SB 660 as amended rolled into new PCS, and unfavorable as to the original bill.

Chairman Goforth adjourned the meeting at 11:40 AM.

Bruce Goforth

Representative Bruce Goforth, Chairman

Mary Capps

Mary Capps – Committee Assistant

HOUSE INSURANCE COMMITTEE

July 14, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

SB 660 – AUTO INSURANCE/DIMINUTION IN VALUE – Sen. Rucho

Adjourn

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 660
Commerce Committee Substitute Adopted 5/12/09
House Committee Substitute Favorable 6/29/09
PROPOSED HOUSE COMMITTEE SUBSTITUTE S660-CSRG-48 [v.2]

7/7/2009 6:08:22 PM

Short Title: Auto Insurance/Diminution in Value. (Public)

Sponsors:

Referred to:

March 19, 2009

A BILL TO BE ENTITLED

AN ACT TO PROVIDE AN ALTERNATIVE METHOD OF DETERMINING PROPERTY DAMAGES AS A PART OF MOTOR VEHICLE LIABILITY INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 20-279.21 is amended by adding a new subsection to read:

"**§ 20-279.21. "Motor vehicle liability policy" defined.**

...

(d1) Such motor vehicle liability policy shall provide an alternative method of determining the amount of property damage to a motor vehicle when liability for coverage for the claim is not in dispute. For a claim for property damage to a motor vehicle against an insurer, the policy shall provide that if:

(1) The claimant and the insurer fail to agree as to the difference in fair market value of the vehicle immediately before the accident and immediately after the accident; and

(2) The difference in the claimant's and the insurer's estimate of fair market value is greater than two thousand dollars ($2,000) or twenty-five percent (25%) of the fair market value of the vehicle as determined by the latest edition of the National Automobile Dealers Association Pricing Guide Book or other publications approved by the Commissioner of Insurance, whichever is less, then on the written demand of either the claimant or the insurer, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within 20 days after the demand. The appraisers shall then appraise the loss. Should the appraisers fail to agree, they shall then select a competent and disinterested appraiser to serve as an umpire. If the appraisers cannot agree upon an umpire within 15 days, either the claimant or the insurer may request that a magistrate resident in the county where the insured motor vehicle is registered or the county where the accident occurred select the umpire. The appraisers shall then submit their differences to the umpire. The umpire then shall prepare a report determining the amount of the loss and shall file the report with the insurer and the claimant. The agreement of the two appraisers or the report of the umpire, when filed with the insurer and the claimant, shall determine the

amount of the damages. In preparing the report, the umpire shall not award damages that are higher or lower than the determinations of the appraisers. In no event shall appraisers or the umpire make any determination as to liability for damages or as to whether the policy provides coverage for claims asserted. The claimant or the insurer shall have 15 days from the filing of the report to reject the report and notify the other party of such rejection. If the report is not rejected within 15 days from the filing of the report, the report shall be binding upon both the claimant and the insurer. Each appraiser shall be paid by the party selecting the appraiser, and the expenses of appraisal and umpire shall be paid by the parties equally. For purposes of this section, "appraiser" and "umpire" shall mean a person who as a part of his or her regular employment is in the business of advising relative to the nature and amount of motor vehicle damage and the fair market value of damaged and undamaged motor vehicles.

...."

SECTION 2. G.S. 7A-292 is amended by adding a new subdivision to read:

"**§ 7A-292. Additional powers of magistrates.**

In addition to the jurisdiction and powers assigned in this Chapter to the magistrate in civil and criminal actions, each magistrate has the following additional powers:

...

(15) To appoint an umpire to determine motor vehicle liability policy diminution in value, as provided in G.S. 20-279.21(d1)."

SECTION 3. This act becomes effective January 1, 2010, and applies to motor vehicle liability insurance policies issued or renewed on or after that date.

SENATE BILL 660:
Auto Insurance/Diminution in Value

2009-2010 General Assembly

Committee:	House Insurance	**Date:**	July 8, 2009
Introduced by:	Sen. Rucho	**Prepared by:**	Tim Hovis
Analysis of:	PCS to Third Edition S660-CSRG-48		Committee Counsel

SUMMARY: ***Senate Bill 660 amends G.S. 20-279.21 by adding a new subsection to provide a procedure for determining the amount of damage to a motor vehicle resulting from the difference in fair market value of the vehicle immediately before and immediately after an accident. This subsection only applies when liability for coverage is not in dispute and only if the difference in the claimant's and the insurer's estimate of fair market is greater than $2000.00 or twenty-five percent of the fair market value of the vehicle.***

This procedure would typically be used for third party claims by a driver who was not at fault against the insurer of a driver who was liable for damages resulting from an accident.

[As introduced, this bill was identical to H893, as introduced by Reps. Justice, Grady, which is currently in House Judiciary III, if favorable, Insurance.]

CURRENT LAW: 11 NCAC 4.0421 provides that "if a release or full payment of claim is executed by a third party claimant, involving a repair to a motor vehicle, it shall not bar the right of the third party claimant to promptly assert a claim for diminished value, which diminished value was directly caused by the accident and which diminished value could not be determined or known until after the repair or attempted repair of the motor vehicle."

BILL ANALYSIS: Section 1 of the bill amends G.S. 20-279.21, *"Motor vehicle liability policy" defined*, to provide an alternative method for determining motor vehicle property damage when coverage for the claim is not in dispute.

Specifically, the bill provides that (1) if the parties fail to agree as to the difference in fair market value of the vehicle immediately before and immediately after the accident and (2) if the difference in the parties' estimates of fair market value is greater than $2000.00 or twenty-five percent (25%) of the fair market value of the vehicle, then, on the written demand of the claimant or the insurer, each shall select a competent and disinterested appraiser and notify the other party of the appraiser within 20 days of the written demand. The appraisers may then appraise the loss. If the appraisers fail to agree, the appraisers shall select a competent and disinterested appraiser to serve as an umpire. If the appraisers cannot agree on an umpire within 15 days, the claimant or the insurer may request a magistrate in the county where the vehicle is registered or the accident occurred to select the umpire. The appraisers must then submit their differences to the umpire and the umpire shall file a report determining the amount of the loss. The umpire may not award damages that are higher or lower than the determinations of the appraisers. The umpire may not make a determination as to liability or the existence of coverage.

Either party has 15 days to reject the report. If the report is not rejected, it shall be binding upon the parties.

Each appraiser shall be paid by the party selecting the appraiser. The expenses of appraisal and the umpire shall be paid equally by the parties.

An "appraiser" and "umpire" is defined as a person who as a part of his or her regular employment is in the business of advising relative to the nature and amount of motor vehicle damage and the fair market value of damaged and undamaged motor vehicles.

Section 2 gives a magistrate the power to appoint an umpire as provided in Section 1 of the Proposed Committee Substitute.

EFFECTIVE DATE: The bill becomes effective January 1, 2010 and applies to policies issued or renewed on or after that date.

S660-SMRG-86(CSRG-48) v1

ATTACHMENT #2

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE 7/14/09

S. B. No. 660 Amendment No. _____ (to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.) Sen.) Cole

1 moves to amend the bill on page 1, line 17

2 ( ) WHICH CHANGES THE TITLE

3 by inserting between the word "vehicle" and the

4 word "as" the words "prior to the accident"

5

6 and on page 1, line 17

7 by inserting between the word "market" and the

word "value" the word "retail".

9

10 and on page 2, line 23

11 by deleting "January 1, 2010," and

12 substituting "August 1, 2010,".

13

14

15

16

17

18

19

SIGNED Helen Cole

ADOPTED ✓ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

ATTACHMENT #1

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Madeline Louden	Governor's Page
Maya Cuthbertson	Governor's page
alexis Craghead	Governor's Page
Deja Williams	Governers Page
Courtney Graham	Govenor's Page
Bill Tibbens	Farmers Group Inc.
Alex Pully	DST
A. SOLARI	DST
Bill Rowe	NC Justice Center
John Bowdish	Astra Zeneca
Chad Mortz	Reden

VISITOR REGISTRATION SHEET

House Committee on Insurance
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sheria Reid	IOG
Bob Mack	NCDOI
Jennifer Cahyn	IFNC
FRANK FOLGER	NATIONWIDE
Mary Selwidge	IFNC
David Bragg	MWC
PATRICK HANNAH	LIBERTY
Michelle Frazier	MF+S
DAVID RICE	MANNING FULTON
David Spoller	State Farm
Stephen Wahlen	NCDOI

VISITOR REGISTRATION SHEET

House Committee on Insurance

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rose Williams	NCDOI
Ed Linkster	Brooks Pierce
[illegible]	[illegible]
Shannon Smith	NCBA

VISITOR REGISTRATION SHEET

House Committee on Insurance

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John McMullan	MFDS
	NEMAC

HOUSE PAGES

NAME OF COMMITTEE Ins DATE 1-14-09

1. Name: Madison Inman
   County: Stanly
   Sponsor: Rep Burr
2. Name: Katheryn Woolard
   County: Wake
   Sponsor: Rep. Spear
3. Name: Logan Brawley
   County: Forsyth
   Sponsor: Mcgee
4. Name:
   County:
   Sponsor:
5. Name:
   County:
   Sponsor:

SGT-AT-ARM

1. Name: Charles Williams
2. Name: Martha Gadison
3. Name: Robert Rossi
4. Name:

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☒ House Committee Substitute # 1 for
SB 660 A BILL TO BE ENTITLED AN ACT TO PROVIDE AN ALTERNATIVE METHOD OF DETERMINING PROPERTY DAMAGES AS A PART OF MOTOR VEHICLE LIABILITY INSURANCE.

☒ With a favorable report as to House committee substitute bill 2, unfavorable as to House 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.

Mary Capps (Rep. Wray)

---

m: Ann Jordan (Rep. Goforth)
ıt: Thursday, July 09, 2009 12:50 PM
To: Sen. Bob Rucho
Subject: Insurance Meeting Notice for July 14.doc

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

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

DAY & DATE: **Tuesday - July 14, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

660 – AUTO INSURANCE/DIMINUTION IN VALUE – Senator Rucho

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at: **12:48 pm on July 9, 2009.**

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

ATTACHMENT #1

MINUTES

HOUSE COMMITTEE ON INSURANCE

July 16, 2009

The House Committee on Insurance met at 11:00 AM on Thursday, July 16, 2009 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael Wray; Vice Chairs: J. Dockham, and M. Setzer. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Cole, Current, Faison, Hughes, Lewis and Pierce.

Chairman Wray called the meeting to order and welcomed visitors. He recognized Sgt-At Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachments)

Chairman Wray recognized Rep. Goforth to explain HB 1183 – Health and Other Insurance Law Changes. Rep. Goforth said the bill was back in this committee for concurrence. He asked Rose Williams with Dept. of Insurance to explain the changes made by the Senate. She said there was an effective date change and the Department was OK with the change. Rep. Goforth made a motion to concur. Motion carried.

Chairman Wray recognized Rep. Goforth to explain HB 1314 – Annual Financial Reporting. Rep Goforth said this bill was also back for concurrence and asked Rose William with the Dept of Insurance to explain the changes. Ms. Williams said there was only a formatting change. Rep. Pierce made a motion to concur with the Senate changes. Motion carried.

The meeting adjourned at 11:05.

Representative Michael Wray, Chairman

Ann Jordan – Committee Assistant

HOUSE INSURANCE COMMITTEE

July 16, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

*** For Concurrence**

HB 1183 – HEALTH AND OTHER INSURANCE LAW CHANGES – AB - Rep. Goforth and Wray

HB 1314 – ANNUAL FINANCIAL REPORTING - AB– Rep. Goforth and Wray

Adjourn

HOUSE BILL 1183

Short Title:	Health and Other Insurance Law Changes.-AB	(Public)
Sponsors:	Representatives Goforth, Wray (Primary Sponsors); and Lucas.	
Referred to:	Health, if favorable, Insurance.	

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS CHANGES IN THE LAWS GOVERNING HEALTH INSURANCE AND MANAGED CARE; TO CHANGE CERTAIN HEALTH INSURANCE LAWS TO COMPORT WITH RECENT CONGRESSIONAL ENACTMENTS; TO MAKE A TECHNICAL CORRECTION IN A CREDIT INSURANCE LAW; AND TO REPEAL THE EXPIRATION DATE OF THE INTERSTATE INSURANCE PRODUCT REGULATION COMPACT ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-51-17(a)(1)a. and b. read as rewritten:

"**§ 58-51-17. Portability for accident and health insurance.**

(a) Rules Relating to Crediting Previous Coverage.

(1) Creditable coverage defined. – For the purposes of this section, "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.~~group health plan as defined in G.S. 58-68-25(a)(4a.)

b. ~~Group or individual health insurance coverage.~~Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market, or otherwise."

SECTION 2. G.S. 58-68-25(a) is amended by adding the following new subdivisions to read:

"**§ 58-68-25. Definitions; excepted benefits; employer size rule.**

(a) Definitions. – In addition to other definitions throughout this Article, the following definitions and their cognates apply in this Article:

...

(4a) 'Group health insurance coverage.' – Health insurance coverage offered in connection with a group health plan.

(4b) 'Group health plan.' – The meaning given the term under 45 C.F.R.§ 146.145(a).

(4c) 'Group market.' – The market for health insurance coverage offered in connection with a group health plan.

...."

SECTION 3. G.S. 58-58-25(a)(5) reads as rewritten:

"(5) "Health insurance coverage" or "coverage" or "health insurance plan" or "plan". – Benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical

care, under any accident and health insurance policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, written by a health insurer. Health insurance coverage includes group health insurance coverage and individual health insurance coverage."

SECTION 4. G.S. 58-68-30(c)(1) 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.~~group health plan.

b. ~~Group or individual health insurance coverage.~~ Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market, or otherwise.

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. 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.~~ section."

SECTION 5. G.S. 58-68-60(b)(1) reads as rewritten:

"(b) Eligible Individual Defined. – In this Part, "eligible individual" means an individual:

(1) (i) For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is 18 or more months and (ii) whose most recent prior creditable coverage was under ~~an ERISA~~ a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);

...."

SECTION 6. G.S. 58-65-2 is amended by adding two new statutory references to read:

"**§ 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:

...

58-51-15(a)(2)b. Accident and health policy provisions.

58-51-17 Portability for accident and health insurance."

SECTION 7. G.S. 58-67-171 is amended by adding two new statutory references to read:

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

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

...

58-51-15(a)(2)b. Accident and health policy provisions.

58-51-17 Portability for accident and health insurance."

SECTION 8. G.S. 58-51-15 is amended by adding the following new subsection to read:

"(i) Applicability. – This section applies to all accident and health insurance policies delivered or issued for delivery in this State, including certificates issued under group policies that are delivered or issued for delivery in this State. This section also applies to certificates issued under a policy issued and delivered to a trust or association outside this State and covering persons residing in this State."

SECTION 9. G.S. 58-51-17 is amended by adding the following new subsection to read:

"(d) Applicability. – This section applies to all health benefit plans of individual health insurance coverage delivered or issued for delivery in this State, including certificates issued under group policies that are delivered or issued for delivery in this State. This section also applies to certificates issued under a policy issued and delivered to a trust or association outside this State and covering persons residing in this State."

SECTION 10. G.S. 58-51-17(b) reads as rewritten:

"**§ 58-51-17. Portability for accident and health insurance.**

...

(b) Exceptions.

(1) Exclusion not applicable to certain newborns. – Subject to subdivision (3) of this subsection, an individual health insurer shall not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the individual's date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children. – Subject to subdivision (3) of this subsection, ~~a group~~ an individual health insurer shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence does not apply to coverage before the date of the adoption or placement for adoption.

(3) Loss if break in coverage. – Subdivisions (1) and (2) of this subsection shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage."

SECTION 11. 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~~ Plan A available to persons eligible for Medicare by reason of disability before age ~~65.~~ 65 and also standardized Plan C or F if marketing either Plan to persons eligible for Medicare due to age. 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 12. G.S. 58-56-26(c) reads as rewritten:

"(c) In cases where a TPA administers benefits for more than 100 certificate holders on behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the TPA. At least one semiannual review shall be an on-site audit of the operations of the TPA. On July 1, 2010, and annually thereafter, every insurer shall file with the Commissioner a certification of completion of the audits as required by this subsection and performed during the previous calendar year, in the format, content, and manner as specified by the Commissioner. The insurer shall maintain in its corporate records documentation of the audits conducted to support its certification of audits for a period of five years or, if a domestic insurer, until the completion of the next quinquennial examination."

SECTION 13. G.S. 58-56-26 is amended by adding the following new subsection to read:

"**§ 58-56-26. Responsibilities of the insurer.**

...

(d) The Commissioner may adopt rules necessary to implement, administer, and enforce the provisions of this section."

SECTION 14. G.S. 58-58-146 reads as rewritten:

"**§ 58-58-146. Application for annuities required.**

(a) Each individual (non-group) annuity contract shall be issued only upon application of the ~~applicant.~~ annuitant or proposed owner. Any application ~~or enrollment form~~ form, whether paper or electronic, is subject to G.S. 58-3-150, and if taken by an agent, broker, or other producer, shall include the certificate of the ~~agent~~ agent, broker, or other producer that the ~~agent~~ agent, broker, or other producer has truly and accurately recorded on the application ~~or enrollment~~ form the information provided by the ~~applicant.~~ annuitant or proposed owner. Every annuity contract subject to this section shall contain as part of the contract the original or reproduction of the application required by this section.

(b) The agent, broker, or other producer shall provide to the annuitant or proposed owner a copy of any application executed in applying for any individual annuity contract. The delivery may be electronic unless the annuitant, the proposed owner, or the insurer instructs the agent, broker, or other producer to deliver the copy in paper form. The agent, broker, or other producer shall obtain from the proposed owner an acknowledgement of receipt of the copy of the executed application."

SECTION 15. G.S. 58-58-147 reads as rewritten:

"**§ 58-58-147. Surrender fees on death benefits.**

(a) ~~No authorized insurer shall deliver or issue for delivery in this State any~~ Any deferred annuity contract that contains a provision that reduces the death benefit of the contract by a surrender fee when death occurs during the surrender ~~period.~~ period shall include a statement to that effect in prominent print on the cover page of the first specifications page.

(b) Any deferred annuity for which the death benefit in any year is less than the account value shall include a statement to that effect in prominent print on the coverage page or the first specifications page."

SECTION 16. Article 63 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-63-70. Senior-specific certifications and professional designations; rules.**

The Commissioner may adopt rules to set forth standards to protect consumers from misleading and fraudulent marketing practices with respect to the use of senior-specific certifications and professional designations in the solicitation, sale, or purchase of, or advice made in connection with, a life insurance or annuity product. These rules shall be substantially similar to the NAIC Model Regulation on the Use of Senior-Specific Certifications and

Professional Designations in the Sale of Life Insurance and Annuities, as amended. The Commissioner may adopt, amend, or repeal provisions of these rules under G.S. 150B-21.1 in order to keep these rules current with the NAIC model rule."

SECTION 17. G.S. 58-3-225(h) reads as rewritten:

"(h) Subject to the time lines required under this section, the insurer may recover overpayments made to the health care provider or health care facility by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of this section. Not less than 30 calendar days before an insurer seeks overpayment recovery or offsets future payments, the insurer shall give written notice to the health care provider or health care facility, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments ~~may be made not more than~~ shall be made within the two years after the date of the original claim payment unless the insurer has reasonable belief of fraud or other intentional misconduct by the health care provider or health care facility or its agents, or the claim involves a health care provider or health care facility receiving payment for the same service from a government payor. The health care provider or health care facility may recover underpayments or nonpayments by the insurer by making demands for refunds. Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by the insurer may include applicable interest under this section. ~~The period for which such recoveries may be made may not exceed~~ The recovery of underpayments or nonpayments shall be made within the two years after the date of the original claim adjudication, unless the claim involves a health provider or health care facility receiving payment for the same service from a government payor."

SECTION 18. G.S. 58-51-25 reads as rewritten:

"**§ 58-51-25. Policy coverage to continue as to mentally retarded or physically handicapped ~~children.~~children; coverage of dependent students on medically necessary leave of absence.**

(a) An individual or group accident and health insurance policy, hospital service plan policy, or medical service plan ~~policy, delivered or issued for delivery in this State after July 1, 1969, which~~ policy that provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract, shall also provide in substance that attainment of such limiting age shall not operate or terminate the coverage of such child while the child is and continues to be (i) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and (ii) chiefly dependent upon the policyholder or subscriber for support and maintenance: Provided, proof of such incapacity and dependency is furnished to the insurer, hospital service plan corporation, or medical service plan corporation by the policyholder or subscriber within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or corporation, but not more frequently than annually after the child's attainment of the limiting age.

(b) All health benefit plans, as defined in G.S. 58-3-167, that provide that coverage of a dependent child shall terminate upon a change in enrollment of the child in a postsecondary educational institution shall provide for the continued eligibility of the dependent child during a medically necessary leave of absence from the postsecondary educational institution in accordance with all applicable requirements of Public Law 110-381, known as 'Michelle's Law.'"

SECTION 19. G.S. 58-3-215 is amended by adding the following new subsection to read:

"(d) Notwithstanding any other provision of this section, a health benefit plan, as defined in G.S. 58-3-157, and insurers, as defined in G.S. 58-3-157, shall comply with all applicable

standards of Public Law 110-233 known as the 'Genetic Information Nondiscrimination Act of 2008' as amended by Public Law 110-343, and as further amended."

SECTION 20. G.S. 58-3-220 is amended by adding the following new subsections to read:

"(i) Notwithstanding any other provisions of this section, a group health benefit plan that covers both medical and surgical benefits and mental health benefits shall, with respect to the mental health benefits, comply with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

(j) Subsection (i) of this section applies only to a group health benefit plan covering a large employer as defined in G.S. 58-68-255(a)(10)."

SECTION 21. G.S. 58-51-50 is amended by adding the following new subsections to read:

"(f) Notwithstanding any other provisions of this section, a group health benefit plan that covers both medical and surgical benefits and chemical dependency treatment benefits shall, with respect to the chemical dependency treatment benefits, comply with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

(g) Subsection (f) of this section applies only to a group health benefit plan covering a large employer as defined in G.S. 58-68-255(a)(10)."

SECTION 22. G.S. 58-65-75 is amended by adding the following new subsections to read:

"(f) Notwithstanding any other provisions of this section, a group health benefit plan that covers both medical and surgical benefits and chemical dependency treatment benefits shall, with respect to the chemical dependency treatment benefits, comply with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

(g) Subsection (f) of this section applies only to a group health benefit plan covering a large employer as defined in G.S. 58-68-255(a)(10)."

SECTION 23. G.S. 58-67-70 is amended by adding the following new subsections to read:

"(g) Notwithstanding any other provisions of this section, a group health benefit plan that covers both medical and surgical benefits and chemical dependency treatment benefits shall, with respect to the chemical dependency treatment benefits, comply with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

(h) Subsection (g) of this section applies only to a group health benefit plan covering a large employer as defined in G.S. 58-68-255(a)(10)."

SECTION 24. G.S. 58-68-30(f) is amended by adding a new subdivision to read:

"(4) Special rules for application in case of Medicaid or State Children's Health Insurance Program (Title XXI of the Social Security Act). – 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 either of the following conditions is met:

a. Termination of Medicaid or State Children's Health Insurance Program. – The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State children's health plan under Title XXI of the Social Security Act and coverage of the employee or dependent under such a plan is

terminated as a result of the loss of eligibility for such coverage and the employee requests coverage under the group health insurance coverage not later than 60 days after the termination of such coverage.

b. Eligibility for employment assistance under Medicaid or State Children's Health Insurance Program. – The employee or dependent becomes eligible for assistance, with respect to coverage under the group health insurance coverage, under such Medicaid plan or State child health plan (including any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance."

SECTION 25. G.S. 58-50-75(b) reads as rewritten:

"(b) This Part applies to all insurers that offer a health benefit plan and that provide or perform utilization review pursuant to G.S. 58-50-61, the State Health Plan for Teachers and State Employees, any optional plans or programs operating under Part 2 of ~~Article 3~~ Article 3A of Chapter 135 of the General Statutes, the North Carolina Health Insurance Risk Pool, and the Health Insurance Program for Children. With respect to second-level grievance review decisions, this Part applies only to second-level grievance review decisions involving no certification decisions."

SECTION 26. G.S. 58-50-79(b) reads as rewritten:

"(b) A covered person shall be considered to have exhausted the insurer's internal grievance process for purposes of this section, if the covered person:

(1) Has filed a second-level grievance involving a no certification appeal decision under G.S. 58-50-61 and G.S. 58-50-62, and

(2) Except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the insurer within 60 days since the date the covered person ~~filed the grievance with the insurer.~~can demonstrate that a grievance was filed with the insurer."

SECTION 27. G.S. 58-50-80(a) reads as rewritten:

"(a) Within ~~60~~ 120 days after the date of receipt of a notice under G.S. 58-50-77, a covered person may file a request for an external review with the Commissioner."

SECTION 28. G.S. 58-50-80(c) reads as rewritten:

"(c) If the finding of the preliminary review under subdivision (b)(2) of this section is that the request is not complete, the Commissioner shall request from the covered person the information or materials needed to make the request complete. The covered person shall furnish the Commissioner with the requested information or materials within ~~90~~ 150 days after the date of the insurer's decision for which external review is requested."

SECTION 29. The introductory paragraph of G.S. 58-50-82(a) reads as rewritten:

"(a) Except as provided in subsection (g) of this section, a covered person may ~~make a written or oral~~ file a request for an expedited external review with the Commissioner at the time the covered person receives:"

SECTION 30. G.S. 58-80-82(b)(1) reads as rewritten:

"(b) Within three business days of receiving a request for an expedited external review, the Commissioner shall complete all of the following:

(1) Notify the insurer that made the no certification, no certification appeal decision, or second-level grievance review decision which is the subject of the request that the request has been received and provide a copy of the ~~request or verbally convey all of the information included in the~~ request. The Commissioner shall also request any information from the insurer necessary

to make the preliminary review set forth in G.S. 58-50-80(b)(2) and require the insurer to deliver the information not later than one business day after the request was made.

...."

SECTION 31. G.S. 58-50-82(f) reads as rewritten:

"(f) If the notice provided under subsection (e) of this section was not in writing, within two days after the date of providing that notice, the assigned organization shall provide written confirmation of the decision to the covered person, the covered person's provider who performed or requested the service, the insurer, and the Commissioner and include the information set forth in ~~G.S. 58-50-80(m).~~ G.S. 58-50-80(k).

Upon receipt of the notice of a decision under subsection (e) of this section that reverses the no certification, no certification appeal decision, or second-level grievance review decision, the insurer shall within one day reverse the no certification, noncertification appeal decision, or second-level grievance review decision that was the subject of the review and shall provide coverage or payment for the requested health care service or supply that was the subject of the noncertification, noncertification appeal decision, or second-level grievance review decision."

SECTION 32. G.S. 58-50-85(c) reads as rewritten:

"(c) ~~The Commissioner may determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet the minimum qualifications established under G.S. 58-50-87 will cause an independent review organization to be deemed to have met, in whole or in part, the requirements of this section and G.S. 58-50-87. A decision by the Commissioner to recognize an accreditation program for the purpose of granting deemed status may be made only after reviewing the accreditation standards and program information submitted by the accrediting body. An independent review organization seeking deemed status due to its accreditation shall submit original documentation issued by the accrediting body to demonstrate its accreditation.~~ In order to be eligible for approval by the Commissioner, an independent review organization shall be accredited by a nationally recognized private accrediting entity that the Commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications established under G.S. 58-50-87. The Commissioner may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation."

SECTION 33. G.S. 58-50-90(b) reads as rewritten:

"(b) Each organization required to maintain written records on all requests for external review under subsection (a) of this section for which it was assigned to conduct an external review shall submit to the Commissioner, ~~at least annually,~~ upon the Commissioner's request, a report in the format specified by the Commissioner."

SECTION 34. G.S. 58-50-94(b) reads as rewritten:

"(b) After the public opening, the Commissioner shall review the proposals, examining the ~~costs and~~ quality of the services offered by the independent review organizations, the reputation and capabilities of the independent review organizations submitting the proposals, and the provisions in G.S. 58-50-85 and G.S. 58-50-87. The Commissioner shall determine which proposal or proposals would satisfy the provisions of this Part. The Commissioner shall make his determination in consultation with an evaluation committee whose membership includes representatives of insurers subject to Part 4 of Article 50 of Chapter 58 of the General Statutes, health care providers, and insureds. In selecting the review organizations, in addition to considering cost, quality, and adherence to the requirements of the request for proposals, the Commissioner shall consider the desirability and feasibility of contracting with multiple review organizations and shall ensure that, for any given type of case involving highly specialized

services and treatments, at least one review organization is available and capable of reviewing the case."

SECTION 35. G.S. 58-57-100(a) reads as rewritten:

"(a) Single interest or dual interest physical damage insurance may be written on nonfleet private passenger motor vehicles, as defined in G.S. 58-40-10, that are used as collateral for loans made under Article 15 of Chapter 53 of the General Statutes. Automobile physical damage insurance as described in this section is a form of credit property insurance, as referred to in G.S. 53-189. It is subject to the following conditions:

(1) Such insurance may be written only on a motor vehicle ~~on which there is a valid inspection sticker.~~that is in compliance with the inspection requirements of Part 2 of Article 3A of Chapter 20 of the General Statutes.

(2) If a motor vehicle is already insured and the lender is named loss payee and that insurance continues in force, then no other physical damage insurance may be written.

(3) Notification must be given orally and in writing to the borrower that he has the option to provide his own insurance coverage at any point during the term of the loan.

(4) The creditor must have either a first or second lien on the motor vehicle to be insured.

(5) The amount of insurance coverage may not exceed the lesser of (i) the principal amount of the loan plus allowable charges, excluding interest, plus two scheduled installment payments or (ii) the actual fair market value of the collateral at the time the insurance is written.

(6) When a creditor accepts other collateral in addition to a motor vehicle as herein defined, the combined insurance on all collateral may not exceed the initial indebtedness of the loan."

SECTION 36. Section 3 of S.L. 2005-183 reads as rewritten:

"**SECTION 3.** This act becomes effective October 1, ~~2005, and expires October 1, 2009.~~ 2005."

SECTION 37. Sections 34 and 35 are effective when this act becomes law. The remainder of this act becomes effective October 1, 2009.

HOUSE BILL 1183:
Health and Other Insurance Law Changes.-AB

2009-2010 General Assembly

Committee:	House Insurance	**Date:**	July 15, 2009
Introduced by:	Reps. Goforth, Wray	**Prepared by:**	Ben Popkin
Analysis of:	Fifth Edition		Committee Counsel

SUMMARY: House Bill 1183 would amend the following Articles of Chapter 58 - Insurance:

- Article 3 – General Regulations for Insurance.
- Article 50 – General Accident and Health Insurance Regulations.
- Article 51 – Nature of Policies.
- Article 54 – Medicare Supplement Insurance Minimum Standards.
- Article 56 – Third Party Administrators.
- Article 57 – Regulation of Credit Insurance.
- Article 58 – Life Insurance and Viatical Settlements.
- Article 63 – Unfair Trade Practices.
- Article 65 – Hospital, Medical, and Dental Service Corporations.
- Article 67 – Health Maintenance Organization Act.
- Article 68 – Health Insurance Portability and Accountability.
- Article 91 – Interstate Insurance Product Regulation Compact Act

BILL ANALYSIS:

Section 1 – would amend the definition of 'creditable coverage' in G.S. 58-57-17 "Portability for accident and health insurance", to ensure that State law provides for portability of coverage between group and individual market.

Sections 2 & 3 – would amend Article 68 " Health Insurance Portability and Accountability" of Chapter 58 to insert definitions relating to group coverage and clarify that both individual and group health insurance coverage are considered to be health insurance coverage.

Section 4 – would amend the definition section of Article 68 regarding creditable service to ensure that health insurance coverage includes both group and individual coverage and would remove reference to G.S. 58-51-15(a)(2)b (required policy provision relating to calculation of preexisting condition waiting period).

Section 5 – would delete incorrect reference to ERISA.

Sections 6 & 7 – would amend Articles 65 (Hospital, Medical, and Dental Service Corporations) and 67 (Health Maintenance Organization Act) to clarify applicability of preexisting condition calculation provision (G.S. 58-51-15(a)(2)b.) and portability provision (G.S. 58-51-17) to entities operating under the provisions of those articles.

Sections 8 & 9 – would amend accident and health policy provision (G.S. 58-51-15) and portability provision (G.S. 58-51-17) to apply these provisions to all accident and health insurance policies issued or delivered in the State and to certificates issued under policies issued and delivered to trusts or associations outside of the State that cover persons residing in the State.

Section 10 – would correct erroneous statutory provision in portability provision to identify individual not group health insurer.

Section 11 – would update reference to currently available standardized Medicare supplemental (Medigap) plans available.

Section 12 & 13 – would require that insurers who engage third party administrators (TPAs) of benefit plans with more than 100 certificate holders file audits with the Commissioner, in the manner specified by the Commissioner, on an annual basis, and that insurers maintain records of the audits for five years or, if a domestic insurer, until completion of its next quinquennial examination. Section 13 authorizes the Commissioner to adopt rules to implement this section.

Section 14 – would allow applications for annuities to be delivered electronically, unless paper copies are requested, and would receipts be provided for executed applications.

Section 15– would add a new section to Article 63 (Unfair Trade Practices) to authorize the Commissioner to adopt rules to protect consumers from misleading and fraudulent practices regarding senior-specific certifications and professional designations for a life insurance or annuity product.

Section 16 – would amend existing provision to clarify that time period within which over and underpayments of claims must be resolved is two years from date of original claim payment or adjudication.

Section 17 – would allow for continuation of health benefit plan coverage of dependent students on medically necessary leaves of absence from postsecondary educational institutions (Michelle's Law).

Section 18 – would require that health benefit plans and insurers comply with the Genetic Information Nondiscrimination Act of 2008 (Public Law 110-343).

Sections 19, 20, 21 & 22 – would require that group health benefit plans of large employees (at least 51 employees) covering medical and surgical benefits and mental health benefits must comply with the Mental Health Parity and Addiction Equity Act of 2008 (Subtitle B of Title V of P. L. 110-343).

Section 23 – would allow for enrollment of eligible employees and their dependents into Medicaid or the State Children's Health Insurance Program (SCHIP) if they request enrollment within 60 days of termination of coverage or determination of eligibility.

Section 24 – would make external review of health benefit plan provisions applicable to the North Carolina Health Insurance Risk Pool.

Sections 25, 26, 27, 28, 29, 30, 31, 32 & 33 – would amend provisions of Part 4 (Health Benefit Plan External Review) of Article 50 of Chapter 58 to incorporate provisions of the NAIC Model Act (#76), modifying filing provisions and extending filing timelines relating to the grievance process.

Section 34 – would amend G.S. 58-57-100(a)(1) to reflect discontinuation of use of inspection stickers.

Section 35 – would repeal the sunset of Article 91 (Interstate Insurance Product Regulation Compact).

Section 36 – would add a new subsection to G.S. 58-60-170 to update the suitability law to comply with a recent Securities and Exchange Commission rule.

EFFECTIVE DATE: Sections 34, 35 and 37 of the act would become effective when it becomes law. The reminder becomes effective October 1, 2009.

Kory Goldsmith, counsel to Senate Commerce, substantially contributed to this summary.

HOUSE BILL 1314

Senate Commerce Committee Substitute Adopted 6/15/09

Short Title: Annual Financial Reporting.-AB (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO IMPROVE THE INSURANCE COMMISSIONER'S ABILITY TO MONITOR THE FINANCIAL CONDITION OF INSURERS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 10 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 7. Annual Financial Reporting.

"**§ 58-10-185. Purpose and scope.**

(a) The purpose of this Part is to improve the Commissioner's ability to monitor the financial condition of insurers by requiring (i) an annual audit of financial statements reporting the financial position and the results of operations of insurers by independent certified public accountants, (ii) communication of internal control related matters noted in an audit, and (iii) management's report of internal control over financial reporting.

(b) Every insurer, as defined in G.S. 58-10-190, shall be subject to this Part. Insurers having direct premiums written in this State of less than one million dollars ($1,000,000) in any calendar year and fewer than 1,000 policyholders or certificate holders of direct written policies nationwide at the end of the calendar year shall be exempt from this Part for the year, unless the Commissioner makes a specific finding that compliance is necessary for the Commissioner to carry out statutory responsibilities, except that insurers having assumed premiums pursuant to contracts of reinsurance of one million dollars ($1,000,000) or more will not be exempt.

(c) Foreign or alien insurers filing the audited financial report in another state, pursuant to that state's requirement for filing of audited financial reports, which has been found by the Commissioner to be substantially similar to the requirements in this Part, are exempt from G.S. 58-10-195 through G.S. 58-10-240 if:

(1) A copy of the audited financial report, communication of internal control related matters noted in an audit, and the accountant's letter of qualifications that are filed with the other state are filed with the Commissioner in accordance with the filing dates specified in G.S. 58-10-195, 58-10-230, and 58-10-235, respectively. Canadian insurers may submit accountants' reports as filed with the Office of the Superintendent of Financial Institutions, Canada.

(2) A copy of any notification of adverse financial condition report filed with the other state is filed with the Commissioner within the time specified in G.S. 58-10-225.

(d) Foreign or alien insurers required to file management's report of internal control over financial reporting in another state are exempt from filing the report in this State provided

the other state has substantially similar reporting requirements and the report is filed with the Commissioner of the other state within the time specified.

(e) This Part shall not prohibit, preclude, or in any way limit the Commissioner from ordering, conducting, or performing examinations of insurers in accordance with G.S. 58-2-131 through G.S. 58-2-134, known as the Examination Law.

"**§ 58-10-190. Definitions.**

As used in this Part:

(1) "Accountant" or "independent certified public accountant" means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants (AICPA) and in all states in which he or she is licensed to practice; for Canadian and British companies, it means a Canadian-chartered or British-chartered accountant.

(2) An "affiliate" of, or person "affiliated" with, a specific person has the same meaning set forth in G.S. 58-19-5.

(3) "Audit committee" means a committee, or equivalent body, established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers and audits of financial statements of the insurer or group of insurers. The audit committee of any entity that controls a group of insurers may be deemed to be the audit committee for one or more of these controlled insurers at the election of the controlling person as provided in G.S. 58-10-245(f). If an audit committee is not designated by the insurer, the insurer's entire board of directors shall constitute the audit committee.

(4) "Audited financial report" means and includes those items specified in G.S. 58-10-200.

(5) "Controlling person" has the same meaning set forth in G.S. 58-19-5.

(6) "Group of insurers" means those licensed insurers included in the reporting requirements of Article 19 of this Chapter, or a set of insurers as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting.

(7) "Indemnification" means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting from other known misrepresentations made by the insurer or its representatives.

(8) "Insurer" means any insurance entity as identified in Articles 7, 8, 11, 15, 17, 23, 24, 25, 26, 65, and 67 of this Chapter and regulated by the Commissioner.

(9) "Internal control over financial reporting" means a process effected by an entity's board of directors, management, and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements, that is, those items specified in G.S. 58-10-200(b)(2) through G.S. 58-10-200(b)(6) and includes those policies and procedures that meet all of the following criteria:

a. Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets.

b. Provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements, that is, those items specified in G.S. 58-10-200(b)(2) through G.S. 58-10-200(b)(6) and that receipts and expenditures are being

made only in accordance with authorizations of management and directors.

c. Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of assets that could have a material effect on the financial statements, including those items specified in G.S. 58-10-200(b)(2) through G.S. 58-10-200(b)(6).

(10) "SEC" means the United States Securities and Exchange Commission, or any successor agency.

(11) "Section 404" means Section 404 of the Sarbanes-Oxley Act of 2002 and the SEC's rules and regulations promulgated under that act.

(12) "Section 404 report" means management's report on "internal control over financial reporting" as defined by the SEC and the related attestation report of the independent certified public accountant as described in Section 3A of the Sarbanes-Oxley Act of 2002.

(13) "SOX-compliant entity" means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002: (i) Section 202. Preapproval requirements of Title II, Auditor Independence; (ii) Section 301. Audit Committees independence requirements of Title III, Corporate Responsibility; and (iii) Section 404. Management assessment of internal controls requirements of Title IV, Enhanced Financial Disclosures.

"**§ 58-10-195. General requirements related to filing and extensions for filing of annual audited financial reports and audit committee appointment.**

(a) All insurers shall have an annual audit by an independent certified public accountant and shall file an audited financial report with the Commissioner on or before June 1 for the year ended December 31 immediately preceding. The Commissioner may require an insurer to file an audited financial report earlier than June 1 with 90 days' advance notice to the insurer.

(b) Extensions of the June 1 filing date may be granted by the Commissioner for 30-day periods upon a showing by the insurer and its independent certified public accountant of the reasons for requesting an extension and determination by the Commissioner of good cause for an extension. The request for extension must be received in writing not less than 10 days before the due date and in sufficient detail to permit the Commissioner to make an informed decision with respect to the requested extension.

(c) If an extension is granted in accordance with the provisions in subsection (b) of this section, a similar extension of 30 days is granted to the filing of management's report of internal control over financial reporting.

(d) Every insurer required to file an annual audited financial report pursuant to this Part shall designate a group of individuals as constituting its audit committee, as defined in G.S. 58-10-190. The audit committee of an entity that controls an insurer may be deemed to be the insurer's audit committee at the election of the controlling person.

"**§ 58-10-200. Contents of annual audited financial report.**

(a) The annual audited financial report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows, and changes in capital and surplus for the year then ended in conformity with G.S. 58-2-165(c). The financial statements included in the audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the Commissioner, and the financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. However, in the first year in which an insurer is required to file an audited financial report, the comparative data may be omitted.

(b) The annual audited financial report shall include the following:

(1) Report of independent certified public accountant.

(2) Balance sheet reporting admitted assets, liabilities, capital, and surplus.

(3) Statement of operations.

(4) Statement of cash flows.

(5) Statement of changes in capital and surplus.

(6) Notes to financial statements, which shall be those required by the appropriate NAIC Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual. The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to G.S. 58-2-165(c) with a written description of the nature of these differences.

"**§ 58-10-205. Designation of independent certified public accountant.**

(a) Each insurer required by this Part to file an annual audited financial report must, within 60 days after becoming subject to the requirement, register with the Commissioner in writing the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit. Insurers not retaining an independent certified public accountant on the effective date of this Part shall register the name and address of their retained independent certified public accountant not less than six months before the date when the first audited financial report is to be filed.

(b) The insurer shall obtain a letter from the accountant and file a copy with the Commissioner stating that the accountant is aware of the provisions of the insurance laws and the regulations of the State of North Carolina that relate to accounting and financial matters and affirming that the accountant will express his or her opinion on the financial statement in terms of its conformity to the statutory accounting practices prescribed or otherwise permitted by the Commissioner, specifying such exceptions as he or she may believe appropriate.

(c) If an accountant for the immediately preceding filed audited financial report is dismissed or resigns, the insurer shall within five business days notify the Commissioner of this event. The insurer shall also furnish the Commissioner with a separate letter within 10 business days after the notification stating whether in the 24 months preceding such event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure; which disagreements, if not resolved to the satisfaction of the former accountant, would have caused him or her to make reference to the subject matter of the disagreement in connection with his or her opinion. The disagreements required to be reported in response to this section include both those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction. Disagreements contemplated by this section could include, but are not limited to, disagreements between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer shall also in writing request the former accountant to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for which he or she does not agree; and the insurer shall furnish the responsive letter from the former accountant to the Commissioner together with its own.

"**§ 58-10-210. Qualifications of independent certified public accountant.**

(a) The Commissioner shall not recognize a person or firm as a qualified independent certified public accountant if the person or firm:

(1) Is not in good standing with the North Carolina State Board of Certified Public Accountant Examiners and in all other states in which the accountant is licensed to practice, or, for a Canadian or British company, that is not a chartered accountant; or

(2) Has either directly or indirectly entered into an agreement of indemnity or release from liability, collectively referred to as indemnification, with respect to the audit of the insurer.

(b) Except as otherwise provided in this Part, the Commissioner shall recognize an independent certified public accountant as qualified as long as he or she conforms to the standards of his or her profession, as contained in the Code of Professional Ethics of the AICPA 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.

(c) A qualified independent certified public accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under Article 30 of this Chapter, the mediation or arbitration provisions shall operate at the option of the statutory successor.

(d) Lead Audit Partner Rotation Required.

(1) The lead or coordinating audit partner, having primary responsibility for the audit, may not act in that capacity for more than five consecutive years. The person shall be disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for a period of five consecutive years. An insurer may apply to the Commissioner for relief from the rotation requirement on the basis of unusual circumstances. This application shall be made at least 30 days before the end of the calendar year. The Commissioner may consider any of the following factors in determining if the relief should be granted:

a. The number of partners, expertise of the partners, or the number of insurance clients in the currently registered firm.

b. The premium volume of the insurer.

c. The number of jurisdictions in which the insurer transacts business.

(2) The insurer shall file, with its annual statement filing, the approval for relief granted pursuant to subdivision (1) of this subsection with the states in which it is licensed or doing business and with the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format.

(e) The Commissioner shall neither recognize as a qualified independent certified public accountant, nor accept an annual audited financial report prepared, in whole or in part, by a natural person who meets any of the following criteria:

(1) The person has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. §§ 1961 to 1968k, or any dishonest conduct or practices under federal or state law.

(2) The person has been found to have violated the insurance laws of this State with respect to any previous reports submitted under this Part.

(3) The person has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this Part.

(f) The Commissioner may, as provided in G.S. 58-2-50, hold a hearing to determine whether an independent certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing his or her opinion on the financial statements in the annual audited financial report made pursuant to this Part and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this Part.

(g) Independence of Services.

(1) The Commissioner shall not recognize as a qualified independent certified public accountant nor accept an annual audited financial report prepared, in whole or in part, by an accountant who provides to an insurer, contemporaneously with the audit, any of the following nonaudit services:

a. Bookkeeping or other services related to the accounting records or financial statements of the insurer.

b. Financial information systems design and implementation.

c. Appraisal or valuation services, fairness opinions, or contribution-in-kind reports.

d. Actuarially oriented advisory services involving the determination of amounts recorded in the financial statements. The accountant may assist an insurer in understanding the methods, assumptions, and inputs used in the determination of amounts recorded in the financial statement only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification on an insurer's reserves if all of the following conditions have been met:

1. Neither the accountant nor the accountant's actuary has performed any management functions or made any management decisions.

2. The insurer has competent personnel, or engages a third-party actuary to estimate the reserves for which management takes responsibility.

3. The accountant's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the reserves.

e. Internal audit outsourcing services.

f. Management functions or human resources.

g. Broker or dealer, investment adviser, or investment banking services.

h. Legal services or expert services unrelated to the audit.

i. Any other services that the Commissioner determines, by administrative rule, are impermissible.

(2) In general, the principles of independence with respect to services provided by the qualified independent certified public accountant are largely predicated on three basic principles, violations of which would impair the accountant's independence. The principles are that the accountant cannot function in the role of management, cannot audit his or her own work, and cannot serve in an advocacy role for the insurer.

(h) Insurers having direct written and assumed premiums of less than one hundred million dollars ($100,000,000) in any calendar year may request an exemption from subdivision (1) of subsection (g) of this section. The insurer shall file with the Commissioner a written statement discussing the reasons why the insurer should be exempt from these provisions. If the Commissioner finds, upon review of this statement, that compliance with this Part would constitute a financial or organizational hardship upon the insurer, an exemption may be granted.

(i) A qualified independent certified public accountant who performs the audit may engage in other nonaudit services, including tax services, that are not described in subdivision (1) of subsection (g) of this section or that do not conflict with the principles set forth in subdivision (2) of subsection (g) of this section, only if the activity is approved in advance by the audit committee, in accordance with subsection (j) of this section.

(j) All auditing services and nonaudit services provided to an insurer by the qualified independent certified public accountant of the insurer shall be preapproved by the audit committee. The preapproval requirement is waived with respect to nonaudit services if the insurer is a SOX-compliant entity or is a direct or indirect wholly owned subsidiary of a SOX-compliant entity or all of the following apply:

(1) The aggregate amount of all such nonaudit services provided to the insurer constitutes not more than five percent (5%) of the total amount of fees paid by the insurer to its qualified independent certified public accountant during the fiscal year in which the nonaudit services are provided.

(2) The services were not recognized by the insurer at the time of the engagement to be nonaudit services.

(3) The services are promptly brought to the attention of the audit committee and approved before the completion of the audit by the audit committee or by one or more members of the audit committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the audit committee.

(k) The audit committee may delegate to one or more designated members of the audit committee the authority to grant the preapprovals required by subsection (j) of this section. The decisions of any member to whom this authority is delegated shall be presented to the full audit committee at each of its scheduled meetings.

(l) Cooling-Off Period.

(1) The Commissioner shall not recognize an independent certified public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for that insurer was employed by the independent certified public accountant and participated in the audit of that insurer during the one-year period preceding the date that the most current statutory opinion is due. This section shall only apply to partners and senior managers involved in the audit. An insurer may apply to the Commissioner for relief from this requirement on the basis of unusual circumstances.

(2) The insurer shall file, with its annual statement filing, the approval for relief granted pursuant to subdivision (1) of this subsection with the states in which it is licensed or doing business and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format.

"**§ 58-10-215. Consolidated or combined audits.**

An insurer may make written application to the Commissioner for approval to file audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies that utilizes a pooling or one hundred percent (100%) reinsurance agreement that affects the solvency of the insurer and affects the integrity of the insurer's reserves and the insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining worksheet that meets all of the following criteria shall be filed with the report:

(1) Amounts shown on the consolidated or combined audited financial report shall be shown on the worksheet.

(2) Amounts for each insurer subject to this section shall be stated separately.

(3) Noninsurance operations may be shown on the worksheet on a combined or individual basis.

(4) Explanations of consolidating and eliminating entries shall be included.

(5) A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual statements of the insurers.

"**§ 58-10-220. Scope of audit and report of independent certified public accountant.**

Financial statements furnished pursuant to G.S. 58-10-200 shall be examined by the independent certified public accountant. The audit of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. In accordance with AU Section 319 of the Professional Standards of the AICPA, Consideration of Internal Control in a Financial Statement Audit, the independent certified public accountant should obtain an understanding of internal control sufficient to plan the audit. To the extent required by AU Section 319, for those insurers required to file a management's report of internal control over financial reporting pursuant to G.S. 58-10-255, the independent certified public accountant should consider, as that term is defined in "Statement on Auditing Standards No. 102 of the AICPA Professional Standards, Defining Professional Requirements in Statements on Auditing Standards" or its replacement, the most recently available report in planning and performing the audit of the statutory financial statements. Consideration shall be given to the procedures illustrated in the Financial Condition Examiners Handbook promulgated by the NAIC as the independent certified public accountant deems necessary.

"**§ 58-10-225. Notification of adverse financial condition.**

(a) The insurer required to furnish the annual audited financial report shall require the independent certified public accountant to report, in writing, within five business days to the board of directors or its audit committee any determination by the independent certified public accountant that the insurer has materially misstated its financial condition as reported to the Commissioner as of the balance sheet date currently under audit or that the insurer does not meet the minimum capital and surplus requirement of G.S. 58-7-75 as of that date. An insurer that has received a report pursuant to this subsection shall forward a copy of the report to the Commissioner within five business days after receipt of the report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the Commissioner. If the independent certified public accountant fails to receive the evidence within the required five-business-day period, the independent certified public accountant shall furnish to the Commissioner a copy of its report within the next five business days.

(b) No independent certified public accountant shall be liable in any manner to any person for any statement made in connection with subsection (a) of this section if the statement is made in good faith in compliance with that subsection.

(c) If the accountant, subsequent to the date of the audited financial report filed pursuant to this Part, becomes aware of facts that might have affected his or her report, the Commissioner notes the obligation of the accountant to take such action as prescribed in Volume 1, Section AU 561 of the Professional Standards of the AICPA.

"**§ 58-10-230. Communication of internal control related matters noted in an audit.**

(a) In addition to the annual audited financial report, each insurer shall furnish the Commissioner with a written communication as to any unremediated material weaknesses in its internal control over financial reporting noted during the audit. Such communication shall be prepared by the accountant within 60 days after the filing of the annual audited financial report and shall contain a description of any unremediated material weakness, as the term "material weakness" is defined by "Statement on Auditing Standards No. 112 of the AICPA Professional Standards, Communication of Internal Control Related Matters Noted in an Audit," or its replacement, as of December 31 immediately preceding, so as to coincide with the audited financial report described in G.S. 58-10-195(a) in the insurer's internal control over financial reporting noted by the accountant during the course of their audit of the financial statements. If no unremediated material weaknesses are noted, the communication should so state.

(b) The insurer shall provide a description of remedial actions taken or proposed to correct unremediated material weaknesses, if the actions are not described in the accountant's communication.

"**§ 58-10-235. Accountant's letter of qualifications.**

The accountant shall furnish the insurer, in connection with, and for inclusion in, the filing of the annual audited financial report, a letter stating all of the following:

(1) That the accountant is independent with respect to the insurer and conforms to the standards of his or her profession as contained in the Code of Professional Ethics and pronouncements of the AICPA and the Rules of Professional Conduct of the North Carolina State Board of Certified Public Accountant Examiners Board of Public Accountancy, or similar code.

(2) The background and experience in general and the experience in audits of insurers of the staff assigned to the engagement and whether each is an independent certified public accountant. Nothing within this Part shall be construed as prohibiting the accountant from utilizing such staff as he or she deems appropriate where their use is consistent with the standards prescribed by generally accepted auditing standards.

(3) That the accountant understands the annual audited financial report and his opinion thereon will be filed in compliance with this Part and that the Commissioner will be relying on this information in the monitoring and regulation of the financial position of insurers.

(4) That the accountant consents to the requirements of G.S. 58-10-240 and that the accountant consents and agrees to make available for review by the Commissioner, or the Commissioner's designee or appointed agent, the work papers, as described in G.S. 58-10-240.

(5) A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the AICPA.

(6) A representation that the accountant is in compliance with the requirements of G.S. 58-10-210.

"**§ 58-10-240. Definition, availability, and maintenance of independent certified public accountants' work papers.**

(a) Work papers are the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the accountant's audit of the financial statements of an insurer. Work papers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents, and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of his or her audit of the financial statements of an insurer and which support the accountant's opinion.

(b) Every insurer required to file an audited financial report pursuant to this Part shall require the accountant to make available for review by the Commissioner all work papers prepared in the conduct of the accountant's audit and any communications related to the audit between the accountant and the insurer at the offices of the insurer, at the offices of the Commissioner, or at any other reasonable place designated by the Commissioner. The insurer shall require that the accountant retain the audit work papers and communications until the Commissioner has filed a report on examination covering the period of the audit but no longer than seven years after the date of the audit report.

(c) In the conduct of the periodic review by the Commissioner's examiners in subsection (b) of this section, copies of pertinent audit work papers may be made and retained by the Commissioner. Such reviews by the Commissioner's examiners shall be considered

investigations, and all working papers and communications obtained during the course of such investigations shall be confidential.

"**§ 58-10-245. Requirements for audit committees.**

(a) This section shall not apply to foreign or alien insurers licensed in this State or an insurer that is a SOX-compliant entity or a direct or indirect wholly owned subsidiary of a SOX-compliant entity.

(b) The audit committee shall be directly responsible for the appointment, compensation, and oversight of the work of any accountant, including resolution of disagreements between management and the accountant regarding financial reporting, for the purpose of preparing or issuing the audited financial report or related work. Each accountant shall report directly to the audit committee.

(c) Each member of the audit committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to subsection (f) of this section and G.S. 58-10-190(3).

(d) In order to be considered independent for purposes of this section, a member of the audit committee shall not, other than in his or her capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory, or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary of the entity. However, if North Carolina law requires board participation by otherwise nonindependent members, that law shall prevail and such members may participate in the audit committee and be designated as independent for audit committee purposes, unless they are an officer or employee of the insurer or one of its affiliates.

(e) If a member of the audit committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the Commissioner, may remain an audit committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one year from the occurrence of the event that caused the member to be no longer independent.

(f) To exercise the election of the controlling person to designate the audit committee, the ultimate controlling person shall provide written notice of the affected insurers to the Commissioner. Notification shall be made timely before the issuance of the statutory audit report and include a description of the basis for the election. The election can be changed through notice to the Commissioner by the insurer, which shall include a description of the basis for the change. The election shall remain in effect for perpetuity, until rescinded.

(g) Reports From Accountant.

(1) The audit committee shall require the accountant that performs for an insurer any audit required by this Part to timely report to the audit committee in accordance with the requirements of "Statement on Auditing Standards No. 61 of the AICPA Professional Standards, Communication with Audit Committees," or its replacement, including all of the following:

a. All significant accounting policies and material permitted practices.

b. All material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant.

c. Other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

(2) If an insurer is a member of an insurance holding company system, the reports required by subdivision (1) of subsection (g) of this section may be provided to the audit committee on an aggregate basis for insurers in the

holding company system, provided that any substantial differences among insurers in the system are identified to the audit committee.

(h) The proportion of independent audit committee members shall meet or exceed the following criteria:

Prior Calendar Year Direct Written and Assumed Premiums		
$0 – $300,000,000	Over $300,000,000 – $500,000,000	Over $500,000,000
No minimum requirements.	Majority (50% or more) of members shall be independent.	Supermajority of members (75% or more) shall be independent.

The Commissioner shall require the entity's board to enact improvements to the independence of the audit committee membership if the insurer is in a risk-based capital action level event, meets one or more of the standards of an insurer deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer. The Commissioner may order any insurer with less than five hundred million dollars ($500,000,000) in prior year direct written and assumed premiums to structure its audit committee with at least a supermajority of independent audit committee members. Prior calendar year direct written and assumed premiums shall be the combined total of direct premiums and assumed premiums from nonaffiliates for the reporting entities.

(i) An insurer with direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than five hundred million dollars ($500,000,000) may apply to the Commissioner for a waiver from the requirements in this section based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from this section with the states in which it is licensed or doing business and with the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format.

"**§ 58-10-250. Conduct of insurer in connection with the preparation of required reports and documents.**

(a) No director or officer of an insurer shall, directly or indirectly, do any of the following:

(1) Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review, or communication required under this Part.

(2) Omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review, or communication required under this Part.

(b) No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead, or fraudulently influence any accountant engaged in the performance of an audit pursuant to this Part if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading.

(c) For purposes of subsection (b) of this section, actions that, "if successful, could result in rendering the insurer's financial statements materially misleading" include, but are not limited to, actions taken at anytime with respect to the professional engagement period to coerce, manipulate, mislead, or fraudulently influence an accountant to do any of the following:

(1) Issue or reissue a report on an insurer's financial statements that is not warranted in the circumstances, due to material violations of statutory

accounting principles prescribed by the Commissioner, generally accepted auditing standards, or other professional or regulatory standards.

(2) Not perform audit, review, or other procedures required by generally accepted auditing standards or other professional standards.

(3) Not withdraw an issued report.

(4) Not communicate matters to an insurer's audit committee.

"**§ 58-10-255. Management's report of internal control over financial reporting.**

(a) Every insurer required to file an audited financial report pursuant to this Part that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of five hundred million dollars ($500,000,000) or more shall prepare a report of the insurer's or group of insurers' internal control over financial reporting, as these terms are defined in G.S. 58-10-190. The report shall be filed with the Commissioner along with the communication of internal control related matters noted in an audit described under G.S. 58-10-230. Management's report of internal control over financial reporting shall be as of December 31 immediately preceding.

(b) Notwithstanding the premium threshold in subsection (a) of this section, the Commissioner may require an insurer to file management's report of internal control over financial reporting if the insurer is in any risk-based capital level event, or meets any one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in G.S. 58-30-60(b).

(c) An insurer or a group of insurers that is:

(1) Directly subject to Section 404;

(2) Part of a holding company system whose parent is directly subject to Section 404;

(3) Not directly subject to Section 404 but is a SOX-compliant entity; or

(4) A member of a holding company system whose parent is not directly subject to Section 404 but is a SOX-compliant entity

may file its or its parent's Section 404 report and an addendum in satisfaction of this subsection's requirement provided that those internal controls of the insurer or group of insurers having a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements for items included in G.S. 58-10-200(b)(2) through G.S. 58-10-200(b)(6) were included in the scope of the Section 404 report. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurers' audited statutory financial statements for items included in G.S. 58-10-200(b)(2) through G.S. 58-10-200(b)(6) that were excluded from the Section 404 report. If there are internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements and those internal controls were not included in the scope of the Section 404 report, the insurer or group of insurers may either file (i) a G.S. 58-10-255 report, or (ii) the Section 404 report and a G.S. 58-10-255 report for those internal controls that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements not covered by the Section 404 report.

(d) Management's report of internal control over financial reporting shall include all of the following:

(1) A statement that management is responsible for establishing and maintaining adequate internal control over financial reporting.

(2) A statement that management has established internal control over financial reporting and an assertion, to the best of management's knowledge and belief, after diligent inquiry, as to whether its internal control over financial reporting is effective to provide reasonable assurance regarding the

reliability of financial statements in accordance with statutory accounting principles.

(3) A statement that briefly describes the approach or processes by which management evaluated the effectiveness of its internal control over financial reporting.

(4) A statement that briefly describes the scope of work that is included and whether any internal controls were excluded.

(5) Disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of December 31 immediately preceding. Management is not permitted to conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there are one or more unremediated material weaknesses in its internal control over financial reporting.

(6) A statement regarding the inherent limitations of internal control systems.

(7) Signatures of the chief executive officer and the chief financial officer, or equivalent position/title.

(e) Management shall document and make available upon a financial condition examination the basis upon which its assertions, required in subsection (d) of this section, are made. Management may base its assertions, in part, upon its review, monitoring, and testing of internal controls undertaken in the normal course of its activities. Management shall have discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost-effective manner and, as such, may include assembly of or reference to existing documentation. Management's report on internal control over financial reporting, required by subsection (a) of this section, and any documentation provided in support thereof during the course of a financial condition examination, shall be kept confidential by the Commissioner.

"**§ 58-10-260. Exemptions and effective dates.**

(a) Upon written application of any insurer, the Commissioner may grant an exemption from compliance with any and all provisions of this Part if the Commissioner finds, upon review of the application, that compliance with this Part would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at anytime and from time to time for a specified period or periods. Within 10 days after a denial of an insurer's written request for an exemption, the insurer may request in writing a hearing on its application for an exemption. The hearing shall be held in accordance with Article 3A of Chapter 150B of the General Statutes.

(b) Domestic insurers retaining a certified public accountant on the effective date of this Part who qualify as independent shall comply with this Part for the year ending December 31, 2010, and each year thereafter unless the Commissioner permits otherwise.

(c) Foreign insurers shall comply with this Part for the year ending December 31, 2010, and each year thereafter unless the Commissioner permits otherwise.

(d) The requirements of G.S. 58-10-210(d) shall become effective for audits of the year beginning January 1, 2010, and each year thereafter.

(e) The requirements of G.S. 58-10-245 shall become effective on January 1, 2010. An insurer or group of insurers that is not required to have independent audit committee members or only a majority of independent audit committee members, as opposed to a supermajority, because the total written and assumed premium is below the threshold and subsequently becomes subject to one of the independence requirements due to changes in premium shall have one year following the year the threshold is exceeded, but not earlier than January 1, 2010, to comply with the independence requirements. Likewise, an insurer that becomes subject to one of the independence requirements as a result of a business combination shall

have one calendar year following the date of acquisition or combination to comply with the independence requirements.

(f) The requirements of G.S. 58-10-255 become effective beginning with the reporting period ending December 31, 2010, and each year thereafter. An insurer or group of insurers that is not required to file a report because the total written premium is below the threshold and subsequently becomes subject to the reporting requirements shall have two years following the year the threshold is exceeded, but not earlier than December 31, 2010, to file a report. An insurer acquired in a business combination shall have two calendar years after the date of acquisition or combination to comply with the reporting requirements.

"**§ 58-10-265. Canadian and British companies.**

(a) In the case of Canadian and British insurers, the annual audited financial report shall be defined as the annual statement of total business on the form filed by such companies with their supervision authority duly audited by an independent chartered accountant.

(b) For such insurers, the letter required in G.S. 58-10-205(b) shall state that the accountant is aware of the requirements relating to the annual audited financial report filed with the Commissioner pursuant to G.S. 58-10-195 and shall affirm that the opinion expressed is in conformity with those requirements."

SECTION 2. G.S. 58-23-26(a) and (c) read as rewritten:

"(a) Each pool shall have an annual audit by an independent certified public ~~accountant,~~accountant, pursuant to Part 7 of Article 10 of this Chapter, at the expense of the pool, and shall make a copy of the audit available to the governing body or chief executive officer of each member of the pool. A copy of the audit shall be filed with the Commissioner within 130 days after the end of the pool's fiscal year, unless that time is extended by the Commissioner. The annual audit shall report the financial position of the pool in conformity with statutory accounting practices prescribed or permitted by the Commissioner.

...

(c) Each pool is subject to G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-165, 58-2-180, 58-2-185, 58-2-190, 58-2-200, 58-3-71, 58-3-75, 58-3-81, 58-3-105, 58-6-5, 58-7-21, 58-7-26, 58-7-30, 58-7-31, 58-7-50, 58-7-55, 58-7-140, 58-7-160, 58-7-162, 58-7-163, 58-7-165, 58-7-167, 58-7-168, 58-7-170, 58-7-172, 58-7-173, 58-7-175, 58-7-179, 58-7-180, 58-7-183, 58-7-185, 58-7-187, 58-7-188, 58-7-192, 58-7-193, 58-7-197, 58-7-200, Part 7 of Article 10, and Articles 13, 19, and 34 of this Chapter. Annual financial statements required by G.S. 58-2-165 shall be filed by each pool within 60 days after the end of the pool's fiscal year, subject to extension by the Commissioner."

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:

...

Part 7 of Article 10. Annual Financial Reporting."

SECTION 4. 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:

...

Part 7 of Article 10. Annual Financial Reporting."

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

HOUSE BILL 1314:
Annual Financial Reporting.-AB

2009-2010 General Assembly

Committee:	House Insurance	**Date:**	July 15, 2009
Introduced by:	Reps. Goforth, Wray	**Prepared by:**	Ben Popkin*
Analysis of:	Second Edition		Committee Counsel

SUMMARY: House Bill 1314 would add a new Part that requires the following: (i) an annual audit of insurers' financial statements by independent certified public accountants; (ii) communication of internal control related matters noted in the audit; and (iii) management's report of internal control over financial reporting.

BILL ANALYSIS: Section 1 adds a new Part 7 to Chapter 58, *Insurance*, of the General Statutes entitled "Annual Financial Reporting." This Part includes the following new sections:

- **G.S. 58-10-185 Purpose and Scope**

  This section adds language requiring the following: (i) an annual audit of insurers' financial statements by independent certified public accountants; (ii) communication of internal control related matters noted in the audit; and (iii) management's report of internal control over financial reporting.

  This section also provides that insurers having direct premiums written in the State of less than $1 million in a calendar year and fewer than 1,000 policyholders or certificate holders nationwide at the end of the calendar year are exempt from the Article unless the Commissioner finds that compliance is necessary.

  Foreign or alien insurers filing the financial report in another state are exempt from the audited financial reporting requirements if a copy of the audited financial report, communication of internal control related matters and the accountant's letter of qualifications filed in another state are filed with the Commissioner.

  Foreign or alien insurers required to file a substantially similar management's report of internal control in another state are exempt from filing the report in this State.

- **G.S. 58-10-190 Definitions**

- **G.S. 58-10-195 General requirements related to filing and extensions for filing of annual audited financial reports and audit committee appointment**

  Reports must be prepared by an independent certified public accountant and filed on or before June 1 for the year ending December 31 immediately preceding. Extensions may be granted for 30 day periods upon a showing by the insurer and its certified public accountant of the reasons for the extension and upon a determination of good cause by the Commissioner. If an extension is granted, then a similar extension of 30 days is granted to the filing of the management's report of internal control.

  Every insurer must designate a group of individuals as constituting its audit committee.

- **G.S. 58-10-200 Contents of annual audited financial report**

  The financial report must show the financial position of the insurer as of the end of the most recent calendar year and the results of its operation, cash flows, and changes in capital and surplus for the year then ended and must include similar language and groupings as information submitted in the

insurer's annual statement filed with the Commissioner. Data comparing the current year to the year immediately preceding must also be included.

The report must include the following: (1) report of an independent CPA; (2) balance sheet reporting admitted assets, liabilities, capital and surplus; (3) statement of operations; (4) statement of cash flows; (5) statement of changes in capital and surplus; and (6) notes to financial statements as required by the NAIC Annual Statement Instructions.

- **G.S. 58-10-210 Qualifications of independent certified public accountant**

The Commissioner shall not recognize a CPA if the CPA: (1) is not in good standing with the NC State Board of CPA Examiners and in all other states in which he or she is licensed to practice; (2) has directly or indirectly entered into an agreement of indemnity or release from liability with respect to the audit of the insurer.

Unless otherwise provided, the Commissioner shall recognize a CPA if he or she conforms to the specified ethical and professional standards of his or her profession. Mediation or arbitration agreements may be entered into with the insurer to settle disputes relating to the audit.

The lead or coordinating audit partner having primary responsibility for the audit must be subject to rotation and may not act as lead partner for more than 5 consecutive years, unless otherwise approved by the Commissioner.

The Commissioner may not accept audit reports prepared by a natural person who has been convicted of fraud, bribery, violation of insurance laws with respect to previous reports or has demonstrated a patter of failing to detect or disclose material information in previous reports.

The Commissioner may hold a hearing to determine whether a person is qualified.

A person is not an independent CPA if he or she provides the following non-audit services contemporaneously with the audit: (1) bookkeeping; (2) financial information systems design and implementation; (3) appraisal or valuation services; (4) actuarially-oriented services; (5) internal audit outsourcing; (6) management or human resources functions; (7) broker, dealer, investment adviser or investment banking services; legal or other expert services unrelated to the audit; (8) any other impermissible services as determined by the Commissioner. An insurer having direct premiums of less than $100,000,000 may request an exemption from these restrictions.

This section includes a basic statement of principles providing that, to be independent, the CPA may not function in the role of management, cannot audit his or her own work, and cannot serve in an advocacy role for the insurer. The CPA may engage in any other services not specifically listed or not in violation of this statement of principles only if the activity is approved in advance by the audit committee.

All audit and non-audit services provided by the CPA must be preapproved by the audit committee. Certain SOX-compliant entities are exempt from this requirement for non-audit services. An SOX-compliant entity is an insurer that is compliant with the auditor independence, audit committee, and internal control provisions of the federal Sarbanes-Oxley Act.

The audit committee may delegate preapproval of audit and non-audit services to one or more designated members of the committee.

- **G.S. 58-10-215 Consolidated or combined audits**

An insurer may seek approval from the Commissioner for approval to file a consolidated or combined financial statement if the insurer is part of a group of insurers that uses a pooling or 100% reinsurance agreement affecting solvency.

- **G.S. 58-10-220 Scope of audits**

  The audit must be conducted in accordance with generally accepted auditing standards, including those specifically referenced in this section.

- **G.S. 58-210-225 Notice of adverse financial condition**

  The insurer required to furnish the annual audited financial report shall require the independent CPA to report, in writing, within 5 business days to the board of directors or the auditing committee any determination by the independent CPA that the insurer has materially misstated its financial condition as reported to the Commissioner or that the insurer does not meet the minimum capital and surplus requirements under Chapter 58. The insurer must forward the report to the Commissioner within 5 business days of receipt and shall provide evidence to the CPA of the report being forwarded to the Commissioner. If the CPA fails to receive the evidence, he or she shall furnish a copy of the report to the Commissioner.

- **G.S. 58-10-230 Communication of internal control related matters noted in an audit**

  This section contains the requirement for insurer to file, in addition to the annual audit financial report, written communication as to any unremediated material weakness in its internal control over financial reporting noted during the audit. This communication is to be prepared by the CPA within 60 days of the filing of the annual audited financial report.

- **G.S. 58-10-235 Accountant's letter of qualifications**

  The CPA must furnish the insurer, for inclusion in the annual audited financial report, a letter stating the CPA's independence, background and experience, that the audit will be filed in accordance with this Part, that the CPA is licensed and in compliance with the qualifications section of this Part, and that the CPA understands the work papers requirements of G.S. 58-10-240.

- **G.S. 58-10-240 Definition, availability, and maintenance of independent certified public accountants' work papers**

  This section defines work papers and requires the CPA to make available for review by the Commissioner all work papers prepared in the conduct of the audit. The insurer must require that the accountant retain the work papers until the Commissioner has filed a report covering the audit period, but no longer than 7 years. The Commissioner may make copies of the work papers, but the papers shall remain confidential.

- **G.S. 58-10-245 Requirements for audit committees**

  This section does not apply to SOX-compliant entities or foreign or alien insurers. An SOX-compliant entity is an insurer that is compliant with the auditor independence, audit committee, and internal control provisions of the federal Sarbanes-Oxley Act.

  The audit committee is responsible for the appointment, compensation, and oversight of the work of any CPA under this Part. Each member of the committee must be a member of the board of directors of the insurer or of the board of directors of the entity controlling a group of insurers.

  To be considered independent, members of the audit committee may not accept any fee or compensation other than in his or her capacity as a member of the audit committee or board of directors, unless board participation is otherwise required by NC law. If a member is no longer

independent, then he or she may remain a member of the committee until the next annual meeting of the insurer or for one year, whichever is earlier.

The audit committee shall require the CPA to perform the audit in a timely manner and in accordance with specified auditing, professional standards.

The following independent membership requirements apply:

Direct written or assumed premiums

$0-$300,000,000	No minimum requirements
$300,000,000-$500,000,000	Majority must be independent
Over $500,000,000	Supermajority (75%) must be independent

The Commissioner may require improvements to the independence levels of the committee if the insurer is in a risk-based capital level event, meets one or more of the standards to be deemed in hazardous financial condition, or exhibits qualities of a troubled insurer.

Certain insurers may seek a waiver from these requirements in the case of hardship.

- **G.S. 58-10-250 Conduct of insurer in connection with the preparation of required reports and documents**

  No director or officer of an insurer shall directly or indirectly make or cause to be made materially false or misleading statements to the CPA or omit to state or cause another person to omit to state any material fact in order to make statements made not misleading to a CPA.

  No director or officer of an insurer or other person acting under the direction of an officer or director shall directly influence or indirectly influence take any action to coerce, manipulate, mislead, or fraudulently influence any CPA if that person knew or should have known that the action could result in rendering the CPA's financial statements materially misleading.

- **G.S. 58-10-255 Management's report of internal control over financial reporting**

  This section includes the requirement that insurers prepare a report on their internal control over financial reporting with the communication of internal control required under G.S. 58-10-230. Every insurer required to file an audited financial report is required to file the internal control report with certain exceptions. Notwithstanding the premium thresholds requiring the filing of an audited financial report, the Commissioner may require the report of internal control if the insurer is in a risk-based capital event or is in a hazardous financial condition.

  Statements and information to be included in the internal control report are outlined in this section.

- **G.S. 58-10-260 Exemptions and effective dates**

  The Commissioner may grant an exemption from any and all of the requirements of this Part if compliance would constitute a financial or organizational hardship upon the insurer.

Sections 2, 3 and 4 of the bill make technical and conforming changes.

EFFECTIVE DATE: House Bill 1314 is effective when it becomes law.

H1314-SMRD-182(e2) v1

**Tim Hovis and Kory Goldsmith, Counsels to House Insurance and Senate Commerce, contributed substantially to the drafting of this summary.*

VISITOR REGISTRATION SHEET

House Insurance — July 16, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sheria Reid	IOG
[illegible]	
Barbara Canales	BBGA

VISITOR REGISTRATION SHEET

House Insurance — July 16, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Bowy	MWC
Pat Porter	Hon. Assemb. Research

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

~~Senate~~ By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☑ Committee Substitute for

HB 1314 A BILL TO BE ENTITLED AN ACT TO IMPROVE THE INSURANCE COMMISSIONER'S ABILITY TO MONITOR THE FINANCIAL CONDITION OF INSURERS.

☒ 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 _____.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

Senate ☐ Committee Substitute for

HB 1183 A BILL TO BE ENTITLED AN ACT TO MAKE VARIOUS CHANGES IN THE LAWS GOVERNING HEALTH INSURANCE AND MANAGED CARE; TO CHANGE CERTAIN HEALTH INSURANCE LAWS TO COMPORT WITH RECENT CONGRESSIONAL ENACTMENTS; TO MAKE A TECHNICAL CORRECTION IN A CREDIT INSURANCE LAW; TO CONFORM MOTOR VEHICLE INSPECTION COMPLIANCE REQUIREMENT WITH DISCONTINUATION OF STICKERS; AND TO REPEAL THE EXPIRATION DATE OF THE INTERSTATE INSURANCE PRODUCT REGULATION COMPACT ACT.

☒ 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 _____.

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

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

DAY & DATE: **Thursday - July 16, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

*** For Concurrence**

HB 1183 – HEALTH AND OTHER INSURANCE LAW CHANGES – AB - Rep. Goforth and Wray

HB 1314 – ANNUAL FINANCIAL REPORTING - AB– Rep. Goforth and Wray

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at: **2:50 pm on July 15, 2009.**

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

HOUSE PAGES

NAME OF COMMITTEE INSURANCE DATE 7-16-09

1. Name: TROY MILLER
   County: DURHAM
   Sponsor: REP. HALL
2. Name: WILL PURCELL
   County: WAKE
   Sponsor: REP. ROSS
3. Name: MERCEDES BRYANT
   County: RICHMOND
   Sponsor: REP GOODWIN
4. Name: _____
   County: _____
   Sponsor: _____
5. Name: _____
   County: _____
   Sponsor: _____

SGT-AT-ARM

1. Name: JUDY TURNER
2. Name: MARVIN LEE
3. Name: CHARLES WILLIAMS
4. Name: _____

MINUTES

HOUSE COMMITTEE ON INSURANCE
August 4, 2009

The House Committee on Insurance met at 11:15 AM on Tuesday, August 4, 2009, in Room 1228. The following Representatives attended, Chairman Michael H. Wray; Vice Chairs: M. Dickson and M. Setzer. Members attending were Reps. Blust, Braxton, Brubaker, Cole, Faison, Holliman, Howard, Hughes and Pierce.

Chairman Wray called the meeting to order and welcomed visitors. He recognized Sgt-At-Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachment #1)

Chairman Wray recognized Rep. Holliman for a motion to bring a PCS for SB 563 before the committee. He called upon Sen. Don Davis to explain the PCS for SB 563-Pyrotechnics Safety Permitting Act. Sen. Davis shared the tremendous tragedy on Ocracoke Island that took the lives of four people from his district over the July 4th holiday, and he stated hopefully SB 563 will make us much safer. Sec. 1 in the bill would require supervision of those who transport, exhibit, use, handle or discharge pyrotechnics by a display operator. It would require those under supervision of a display operator attain training or be a current active member of any local fire or rescue department in good standing. Sec. 2 of the bill would require that the counties verify proof of insurance up to $500,000 and in some cases fireworks are displayed inside building. Sec. 3 would authorize the State Fire Marshall, working with the State Fire Rescue Commission, to set the standards for training and a fee up to $100 and the cost of examination. It also requires the display operator to receive a permit from the State Fire Marshall in order to be a display operator. You would have to be 21 years of age, participate in three authorized displays, complete minimum training, pass the examination and pay the fee. Bill is supported by the Department of Insurance, Fire Rescue Commission, Pyrotechnics Guild, American Pyrotechnics Association and many in the industry.

After several questions, Rep. Braxton sent forth an amendment and Mr. Ben Popkin explained the amendment (Attachment #2). The bill's sponsor supports the amendment. Rep. Braxton moved that we adopt the amendment before us and it carried. Rep. Cole moved for a favorable report on the PCS for SB 563, as amended, unfavorable to the original bill and referred to the Finance Committee, and the motion carried.

Chairman Wray adjourned the meeting at 11:25 AM.

Representative Michael H. Wray, Chair

Mary Capps, Committee Assistant

HOUSE INSURANCE COMMITTEE

August 4, 2009
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Margaret Dickson
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

SB 563 – PYROTECHNICS SAFETY PERMITTING ACT – Sen. Davis

Adjourn

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 563
State and Local Government Committee Substitute Adopted 7/22/09
Finance Committee Substitute Adopted 7/23/09
PROPOSED HOUSE COMMITTEE SUBSTITUTE S563-CSRDf-82 [v.1]

8/3/2009 6:27:17 PM

Short Title: Pyrotechnics Safety Permitting Act. (Public)

Sponsors:

Referred to:

March 12, 2009

A BILL TO BE ENTITLED

AN ACT TO IMPROVE PYROTECHNICS SAFETY IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 14-410 reads as rewritten:

"**§ 14-410. Manufacture, sale and use of pyrotechnics prohibited; exceptions; permit required; sale to persons under the age of 16 prohibited.**

(a) ~~It~~ Except as otherwise provided in this section, it shall be unlawful for any individual, firm, partnership or corporation to manufacture, purchase, sell, deal in, transport, possess, receive, advertise, ~~use~~ use, handle, exhibit, or ~~cause to be discharged~~discharge any pyrotechnics of any description whatsoever within the State of North ~~Carolina: provided, however, that it~~Carolina.

(a1) It shall be permissible for pyrotechnics to be exhibited, ~~used~~ used, handled, or discharged ~~at concerts or public exhibitions, such as fairs, carnivals, shows of all descriptions and public celebrations: provided, further, that the use of said pyrotechnics in connection with concerts or public exhibitions, such as fairs, carnivals, shows of all descriptions and public celebrations, shall be under supervision of experts~~ within the State, provided all of the following apply:

(1) The exhibition, use, or discharge is at a concert or public exhibition.

(2) All individuals who exhibit, use, handle, or discharge pyrotechnics in connection with a concert or public exhibition have completed the training required under G.S. 58-82A-2 and are under the direct supervision and control of a display operator who holds a display operator permit issued by the State Fire Marshal under G.S. 58-82A-3. The display operator must be present at the concert or public exhibition and must personally direct all aspects of exhibiting, using, handling, or discharging the pyrotechnics.

(3) The display operator has ~~who have previously~~ secured written authority under G.S. 14-413 from the board of county commissioners of the county, or the city if authorized under G.S. 14-413(a1), in which ~~said~~ the pyrotechnics are to be exhibited, used or discharged. Written authority from the board of commissioners or city is not ~~required, however,~~ required under this subdivision for a concert or public exhibition ~~authorized by~~provided the display operator has secured written authority from The University of North

Carolina or the University of North Carolina at Chapel Hill under G.S. 14-413, and pyrotechnics are exhibited ~~conducted~~ on lands or buildings in Orange County owned by The University of North Carolina or the University of North Carolina at ~~Chapel Hill, but such exhibition, use, or discharge of pyrotechnics shall be under supervision of experts who have previously secured written authority from The University of North Carolina or the University of North Carolina at~~ Chapel Hill.

(a2) Notwithstanding any provision of this section, it shall not be unlawful for a common carrier to receive, transport, and deliver pyrotechnics in the regular course of its business.

(a3) The requirements of this section apply to G.S. 14-413(b) and ~~G.S. 14-413(c) apply to this section~~ G.S. 14-413(c).

(b) Notwithstanding the provisions of G.S. 14-414, it shall be unlawful for any individual, firm, partnership, or corporation to sell pyrotechnics as defined in G.S. 14-414(2), (3), (4)c., (5), or (6) to persons under the age of 16.

(c) The following definitions apply in this Article:

(1) Concert or public exhibition. – A fair, carnival, show of any description, or public celebration.

(2) Display operator. – An individual issued a display operator permit under G.S. 58-82A-3.

(3) State Fire Marshal. – Defined in G.S. 58-80-1."

SECTION 2. G.S. 14-413 is amended by adding a new subsection to read:

"(d) A board of county commissioners or the governing board of a city shall not issue a permit under this section unless the display operator provides proof of insurance in the amount of at least five hundred thousand dollars ($500,000) or the minimum amount required under the North Carolina State Building Code pursuant to G.S. 143-138(e), whichever is greater. A board of county commissioners or the governing board of a city may require proof of insurance that exceeds these minimum requirements."

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

"Article 82A.

"Pyrotechnics Training and Permitting.

"**§ 58-82A-1. State Fire Marshal establish pyrotechnic safety guidelines.**

(a) Guidelines. – The State Fire Marshal, in consultation with the State Fire and Rescue Commission, must establish guidelines, testing, and training requirements for the following:

(1) Individuals who assist a display operator with the exhibition, use, handling, or discharge of pyrotechnics in connection with a concert or public exhibition authorized under Article 54 of Chapter 14 of the General Statutes.

(2) Individuals seeking to obtain a display operator permit under this Article.

(b) Definitions. – The definitions in G.S. 14-410 apply in this Article.

(c) Rule making. – The Commissioner may adopt rules to implement this Article.

"**§ 58-82A-2. Individual training requirements.**

An individual may not use, handle, exhibit, or discharge pyrotechnics in connection with a concert or public exhibition, as allowed under Article 54 of Chapter 14 of the General Statutes, unless the individual successfully completes the training approved or offered by the Commissioner of Insurance through the Office of State Fire Marshal or meets all of the following conditions:

(1) Is an active member in good standing with a local fire or rescue department that has experience in pyrotechnics or explosives, as verified by the State Fire Marshal.

(2) Possesses the professional qualifications required by the State Fire Marshal or the professional qualifications required by the jurisdiction where

permitting is being sought, whichever is greater. The professional qualifications set by the State Fire Marshal may not be less than the voluntary minimum professional qualifications for all levels of fire service and rescue service personnel established by the State Fire and Rescue Commission under G.S. 58-78-5.

"**§ 58-82A-3. Display operator permit.**

(a) Permit Required. – A display operator permit issued by the State Fire Marshal is required for an individual to obtain the necessary authorization under Article 54 of Chapter 14 of the General Statutes to exhibit, use, handle, or discharge pyrotechnics at a concert or public exhibition in this State. A permit issued under this section is valid for two years unless it is revoked by the State Fire Marshal.

(b) Requirements. – The State Fire Marshal may issue a display operator permit to an individual if all of the following conditions are met:

(1) The individual is at least 21 years of age.

(2) The individual has assisted with the exhibition, use, or display of pyrotechnics at a concert or public exhibition, as allowed under Article 54 of Chapter 14 of the General Statutes, on at least three occasions.

(3) The individual successfully completes the minimum training requirements established by the State Fire Marshal.

(4) The individual successfully passes an examination approved by the State Fire Marshal that demonstrates the individual has the knowledge to safely handle, store, and exhibit Class 1.3g and 1.4g pyrotechnics or provides satisfactory evidence of current certification by a third party acceptable to the State Fire Marshal.

(5) The individual pays an application fee not to exceed one hundred dollars ($100.00), and the cost of the examination.

(c) Reciprocity. – The State Fire Marshal may issue a display operator permit to an individual who holds a permit or certification issued by another state provided the minimum requirements of that state are at least equal to the minimum requirements under this section and the person pays the application fee required under subsection (b) of this section.

(d) Refusal and Revocation. – The State Fire Marshal may refuse to issue a permit or may revoke a permit issued under this section if any of the following apply:

(1) The display operator violates any provision of this Article.

(2) The display operator violates any requirement of a permit issued under G.S. 14-413.

(3) The display operator fails to provide direct supervision and control over individuals who assist the permit operator handle, use, exhibit, or display pyrotechnics.

(4) The display operator is convicted of a crime under Article 54 of Chapter 14 of the General Statutes.

(5) Another state revokes the permit or certification issued to that display operator by that state."

SECTION 4. The Commissioner of Insurance must report to the General Assembly by May 1, 2010, on the implementation of this act and may make recommendations regarding additional statutory changes and the need for additional personnel or other resources to implement the act.

SECTION 5. This act becomes effective February 1, 2010, and applies to offenses committed on or after that date.

SENATE BILL 563:
Pyrotechnics Safety Permitting Act

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Finance	**Date:**	August 3, 2009
Introduced by:	Sen. Davis	**Prepared by:**	Ben Popkin
Analysis of:	PCS to Third Edition S563-CSRDf-82		Committee Counsel

SUMMARY: ***Senate Bill 563 requires pyrotechnics at concerts and public displays to be exhibited under the supervision of a display operator who has a permit issued by the State Fire Marshal. It requires individuals exhibiting pyrotechnics to receive training developed by the State Fire Marshal. It also sets minimum insurance requirements that are verified at the local level.***

The PCS clarifies the fees associated with issuance of a display operator permit – individuals seeking a permit must pay an application fee not to exceed $100.00, and the cost of the examination; and shifts the effective date to February 1, 2010.

CURRENT LAW: Current law generally prohibits the manufacture, transportation (except by a common carrier), sale, or use of pyrotechnics, except in connection with approved concerts and public displays. The law requires that approved public displays of pyrotechnics be under the supervision of experts who have previously been issued permits by cities and counties to discharge pyrotechnics. Pursuant to G.S. 58-80-1, the Commissioner of Insurance is the State Fire Marshal.

BILL ANALYSIS:

Training, Display Operator Permit Required. Section 1 of the bill amends G.S. 14-410 to provide that pyrotechnics may only be exhibited, used, handled, or discharged if all the following criteria are met:

- The exhibition, use, or discharge is at a concert or public display.[1]
- All individuals who exhibit, use, handle or discharge pyrotechnics in connection with the concert or public display have completed the required training and are under the direct supervision and control of a permitted display operator, who is present and directs all aspects of the pyrotechnics.
- The display operator has written permission from the board of county commissioners or the city, as appropriate.

Insurance Requirements. Section 2 of the bill amends G.S. 14-413 to provide that the county commissioners or city council shall not issue a permit unless the display operator provides proof of insurance of $500,000, or the minimum required under the State Building Code, whichever is greater. The city or county may set a greater insurance requirement.

State Fire Marshall Sets Safety Guidelines. Section 3 of the bill adds a new Article 82A in Chapter 58 (Insurance), including G.S. 58-82A-1, directing the State Fire Marshal, in consultation with the State Fire and Rescue Commission, to set guidelines, testing, and training requirements for: 1) individuals who assist a display operator with the exhibition, use, handling, or discharge of pyrotechnics, and 2) individuals seeking a display operator permit. It also authorizes the Commissioner to adopt rules to implement Article 82A.

Training Requirements. Section 3 adds a new G.S. 58-82A-2 that prohibits individuals from using, handling, exhibiting, or discharging pyrotechnics for a concert or public exhibition unless they either: 1) complete the training approved or offered by the Commissioner through the Office of the State Fire Marshall, or 2) are an active member in good standing with a local fire or rescue department with experience in pyrotechnics or explosives, as verified by the State Fire Marshall, and possess the professional

[1] Defined as "A fair, carnival, show of any description, or public celebration."

qualifications required by the State Fire Marshall or the jurisdiction where permitting is sought, whichever is greater.

Display Operator Permit. Section 3 of the bill adds a new G.S. 58-82A-3, requiring individuals to have a display operator permit to be authorized to exhibit, use, handle, or discharge pyrotechnics at a concert or public exhibition in the State.

The State Fire Marshal may issue a display operator permit if the permit applicant satisfies the following: is at least 21 years old, has assisted with authorized displays at least 3 times, has completed the minimum training required, has passed an approved examination or has current certification by a third party acceptable to the State Fire Marshal, and pays the cost of the examination and an application fee of no more than $100.

This new section includes a reciprocity provision allowing the State Fire Marshal to issue a permit based on the applicant holding a permit in another state whose requirements meet or exceed those of this section. Permits are valid for two years unless revoked by the State Fire Marshal. The Fire Marshal may deny or revoke a permit for certain violations.

Section 4 of the bill directs the Commissioner to report to the General Assembly by May 1, 2010, on the implementation of the act, any recommendations for additional statutory changes, and the need for additional personnel or resources to implement the act.

EFFECTIVE DATE: The bill is effective February 1, 2010, and applies to offenses committee on or after that date.

Bill Gilkeson, counsel to Senate State and Local Government, and Heather Fennell, counsel to Senate Finance, substantially contributed to this summary.

S563-SMRD-196(CSRDf-82) v1

ATTACHMENT #2

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE 8/4/09

S. B. No. 563 Amendment No. _____

(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE X

Rep.) Brandon Brayton

Sen.)

1 moves to amend the bill on page 1, line 12

2 ( ) WHICH CHANGES THE TITLE

3 by inserting "Manufactured," after "handled,";

4

5 and on page 3, line 9 by

6 inserting the word "manufactured,"

after the word "handle,".

8

9 and on page 3, line 10, by

10 deleting the word "two" and

11 substituting "three".

12

13

14

15

16

17

18

19

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE

ATTACHMENT #1

VISITOR REGISTRATION SHEET

House Insurance — August 4, 2009

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robert Willson	Hale Artificial, Inc 545 New Bowers Road Lexington, NC 27292
Chris Noles	NCDOT
Richard Strickland	NCDOT
X	
John Bourdish	AstraZeneca
EWS	UNC

ATTACHMENT #1

HOUSE PAGES

NAME OF COMMITTEE INSURANCE DATE 8-4-09

1. Name: JULLIAN ABARCA
   County: FRANKLIN
   Sponsor: REP ALLEN
2. Name: DYLAN HAYNES
   County: JACKSON
   Sponsor: REP. HAIRE
3. Name: DEAN EATMAN
   County: HALIFAX
   Sponsor: REP. WRAY
4. Name: ANDY WILSON
   County: MECKLENBURG
   Sponsor: REP SAMUELSON
5. Name:
   County:
   Sponsor:

SGT-AT-ARM

1. Name: CHARLES WILLIAMS
2. Name: MARTHA GADISON
3. Name: DUSTY RHODES
4. Name: ROBERT ROSSI

Mary Capps (Rep. Wray)

ɔm: Ann Jordan (Rep. Goforth)
nt: Thursday, July 30, 2009 1:52 PM
To: Sen. Don Davis
Subject: Insurance Meeting Notice for August 4.doc

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
2009-2010 SESSION

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

DAY & DATE: **Tuesday – August 4, 2009**

TIME: **11:00 AM**

LOCATION: **Room 1228**

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

563 – PYROTECHNICS SAFETY PERMITTING ACT – Sen. Davis

Respectfully,

Representatives Goforth and Wray
Co-chairs

I hereby certify this notice was filed by the committee clerk at the following offices at: **1:45 pm on July 30, 2009.**

___Principal Clerk
___Reading Clerk - House Chamber

Ann Jordan (Committee Assistant)
Mary Capps (Committee Assistant)

HOUSE COMMITTEE ON INSURANCE

2010 SESSION

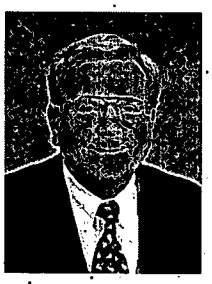
CHAIRS
REPRESENTATIVE BRUCE GOFORTH
REPRESENTATIVE MICHAEL H. WRAY

COMMITTEE ASSISTANTS
MARY CAPPS
MEREDITH MATNEY

STAFF
KORY GOLDSMITH
TIM HOVIS
BILL PATTERSON
BEN POPKIN

NORTH CAROLINA GENERAL ASSEMBLY

INSURANCE COMMITTEE
2009-2010 SESSION



Rep. Bruce Goforth
Chair

Rep. Michael H. Wray
Chair

Rep. Van Braxton
Vice-Chair

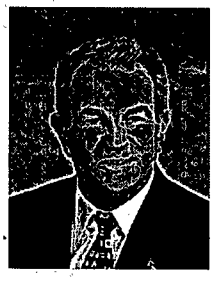
Rep. Jerry Dockham
Vice-Chair

Rep. Mitchell Setzer
Vice-Chair

Rep. Jeff Barnhart

Rep. John Blust

Rep. Harold Brubaker



Rep. Nelson Cole

Rep. Bill Current

Rep. Bill Faison

Rep. Pryor Gibson

Rep. Hugh Holliman

Rep. Julia Howard

Rep. Sandra Spaulding
Hughes

Rep. David Lewis

Rep. Garland Pierce

Rep. William Wainwright

HOUSE COMMITTEE ON INSURANCE

MEMBER	ASSISTANT	PHONE	OFFICE	SEAT
Chair Bruce Goforth	Meredith Matney	733-5746	1220	21
Chair Michael H. Wray	Mary Capps	733-5662	405	60
V-C Van Braxton	Barbara Hocutt	715-3017	2219	46
V-C Jerry Dockham	Regina Irwin	715-2526	1213	39
V-C Mitchell Setzer	Margaret Herring	733-4948	1204	49
Rep. Jeff Barnhart	Pamela Ahlin	715-2009	608	52
Rep. John Blust	Betty Childress	733-5781	1109	110
Rep. Harold Brubaker	Cindy Coley	715-4946	1229	2
Rep. Nelson Cole	Linda Layton	733-5779	1218	45
Rep. Bill Current	Wendy Miller	733-5809	418A	106
Rep. Bill Faison	Lavada Vitalis	715-3019	611	84
Rep. Pryor Gibson	Susanna Davis	715-3007	419A	96
Rep. Hugh Holliman	Carol Bowers	715-0873	2301	55
Rep. Julia Howard	Renee Weaver	733-5904	1106	3
Rep. Sandra S. Hughes	Marilyn Suitt	733-5754	537	89
Rep. David Lewis	Grace Rogers	715-3015	533	64
Rep. Garland Pierce	Mildred Alston	733-5803	301C	7
Rep. William Wainwright	Blinda Edwards	733-5995	301F	8

ATTENDANCE

House Committee on Insurance

(Name of Committee)

DATES	05-20-10	06-10-10	06-17-10	06-29-10	07-07-10	07-08-10									
GOFORTH, Bruce CHAIR	X	X	X		X	X									
WRAY, Michael H. CHAIR	X	X	X	X	X	X									
BRAXTON, Van VICE-CHAIR	X	X	X	ex	X	X									
DOCKHAM, Jerry VICE-CHAIR	X	X	X	X	X	X									
SETZER, Mitchell VICE-CHAIR	X	X	X	X	X	X									
BARNHART, Jeff			X		X										
BLUST, John	X	X	X	X											
BRUBAKER, Harold	X	X	X	X	X	X									
COLE, Nelson	X	X	X	X	X	X									
CURRENT, Bill		X	X	X	X										
FAISON, Bill	X	X	X	X	X										
GIBSON, Pryor		X	X	X											
HOLLIMAN, Hugh			X	X		X									
HOWARD, Julia	X	X	X	X	X										
HUGHES, Sandra Spaulding	X	X	X	X	X										
LEWIS, David	X		X												
PIERCE, Garland	X	X	X		X										
WAINWRIGHT, William						X									
Kory Goldsmith, Staff	X	X	X	X	X										
Tim Hovis, Staff	X	X	X	X	X										
Bill Patterson, Staff	X	X	X	X	X										
Ben Popkin, Staff	X	X	X	X	X										
Mary Capps, Committee Assistant	X	X	X	X	X										
Meredith Matney, Committee Assist.	X	X	X	X	X										

MINUTES

HOUSE COMMITTEE ON INSURANCE

May 20, 2010

The House Committee on Insurance met at 11:00 AM on Thursday, May 20, 2010 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael H. Wray; Vice Chairs: V. Braxton, J. Dockham and M. Setzer. Members attending were Reps. Blust, Brubaker, Cole, Faison, Howard, Hughes, Lewis, and Pierce.

Chairman Goforth called the meeting to order, welcomed visitors and introduced staff. He recognized Sgt-At Arms and Pages. Visitor Registration Sheets are attached and made part of the record (Attachment #1).

Chairman Goforth recognized Representative Holliman to explain HB 1707-SHP/Age-Out Dependents; Tobacco Use Testing. The bill allows two things. It allows children of members who are already enrolled on the State Health Plan to stay on the plan after they finish college if they are under age 26. It also allows the State Health Plan to not test for tobacco products in that the enrollment figures indicated a large percentage of people enrolling in the seventy-thirty plan and it was not felt benefits were worth the cost of testing. It does allow the State Health Plan to come back to the Committee on Employee Benefits if needed in the future. Chairman Goforth stated the bill is time sensitive and has to be passed by June 1, 2010 to continue services.

Chairman Goforth called upon Mark Trogdon, Fiscal Research, to discuss the Legislative Actuarial Note (Attachment #2). The estimated cost is $1.2 million and $3.4 million for 2010-11. Midpoint cost will be in the $2.5 million range.

Representative Howard asked why we should add costs to the State Health Plan a year early when we are cutting programs because of the budget shortfall. Representative Holliman stated we are trying to look after our State Employees and the cost will be met within the budget we have.

Chairman Goforth recognized Representative Braxton who moved for a favorable report for HB 1707 and re-referred bill to Appropriations Committee, and the motion passed.

Chairman Goforth adjourned the meeting at 11:16 AM.

Bruce Goforth

Representative Bruce Goforth, Chairman

Mary Capps

Mary Capps, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

1

HOUSE BILL 1707

Short Title:	SHP/ Age-Out Dependents; Tobacco Use Testing.	(Public)
Sponsors:	Representatives Holliman, Tarleton, Gill, Jackson (Primary Sponsors); M. Alexander, Cotham, Dockham, Dollar, Fisher, Glazier, Goforth, Harrison, Hughes, Insko, Parfitt, Ross, and Weiss.	
Referred to:	Insurance, if favorable, Appropriations.	

May 17, 2010

A BILL TO BE ENTITLED

AN ACT (1) TO ALLOW ALREADY ENROLLED DEPENDENT CHILDREN UNDER THE AGE OF TWENTY-SIX WHO ARE NOT ELIGIBLE FOR EMPLOYER-BASED HEALTH CARE TO REMAIN ON THE NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES FOR PLAN YEAR 2010-2011 AND (2) TO DIRECT THE STATE HEALTH PLAN TO CONSULT WITH THE COMMITTEE ON HOSPITAL AND MEDICAL BENEFITS BEFORE IMPLEMENTING ANY TOBACCO USE TESTING PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. Notwithstanding the requirement in G.S. 135-45.2(d)(1) that a dependent child less than 26 of age be a full-time student to be eligible for coverage, a dependent child enrolled in the North Carolina State ...h Plan for Teachers and State Employees as of May 1, 2010, may remain on the Plan through the end of the month following the dependent child's 26th birthday, regardless of the dependent child's status as a full-time student, provided that the dependent child is not eligible for other employer sponsored health benefit coverage as a primary beneficiary or spousal dependent.

SECTION 2. The Executive Administrator of the State Health Plan for Teachers and State Employees shall consult with the Committee on Employee and Hospital Medical Benefits prior to implementing any program to verify tobacco usage by members of the Plan.

SECTION 3. Section 1 of this act is effective June 1, 2010, and is repealed effective July 1, 2011. The remainder of the act is effective when it becomes law.

HOUSE BILL 1707:
SHP/ Age-Out Dependents; Tobacco Use Testing

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Appropriations	**Date:**	May 19, 2010
Introduced by:	Reps. Holliman, Tarleton, Gill, Jackson	**Prepared by:**	Ben Popkin Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***House Bill 1707 would allow dependent children who are already enrolled in the State Health Plan to remain enrolled in the plan through the end of the month following their 26th birthday. The bill would also direct the Executive Administrator of the State Health Plan to consult with the Committee on Employee and Hospital Medical Benefits before implementing an enrollee tobacco usage verification program.***

CURRENT LAW: G.S. 135-45.2 sets forth eligibility criteria for enrollees in the State Health Plan. G.S. 135-45.2(d)(1) allows for coverage to be offered to dependent children who are full-time students up until the end of the month following their 26th birthday. Standard dependent coverage terminates following the dependent's 19th birthday.

BILL ANALYSIS: **Section 1** of the bill would notwithstand the requirement that dependent children be full-time students to be eligible for coverage under the State Health Plan between the ages of 19 and 26. To be eligible for this coverage, the dependent must be enrolled in the State Health Plan as of May 1, 2010, and must not be eligible for other employer sponsored health benefit coverage as a primary beneficiary or spousal dependent. *Note that this section would be effective for a one year period, from June 1, 2010 until July 1, 2011.*

Section 2 of the bill would direct the Executive Administrator of the State Health Plan to consult with the Committee on Employee and Hospital Medical Benefits before implementing any program to verify tobacco usage by members of the State Health Plan.

EFFECTIVE DATE: Section 1 of the bill would be effective June 1, 2010 and repealed effective July 1, 2011. The remainder of the act would be effective when it becomes law.

BACKGROUND: The recently enacted Patient Protection and Affordable Care Act (Public Law 111-148) requires that health benefit plans that are entered into or renewed on or after September 23, 2010 (six months after enactment) provide dependent coverage for all dependents up to their 26th birthday. The State Health Plan plan year runs from July 1 of one year through June 30 of the following year, so absent the provision in Section 1 of this bill, this dependent coverage would become available to State Health Plan enrollees beginning in July 1, 2011 (the date at which Section 1 would be repealed).

H1707-SMRD-200(e1) v1

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: House Bill 1707 (First Edition)

SHORT TITLE: SHP/ Age-Out Dependents; Tobacco Use Testing.

SPONSOR(S): Representatives Holliman, Tarleton, Jackson, and Gill

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY:

Section 1: Effective June 1, 2010 and repealed July 1, 2011, the proposed bill removes the full-time student requirement for dependent children to remain eligible for benefit coverage under the Plan through the end of the month following their 26th birthday. The bill applies only to dependent children who were enrolled in the Plan as of May 1, 2010, and excludes certain dependent children from eligible coverage under the Plan if an otherwise eligible dependent child is eligible for other employer-sponsored health benefit coverage

Section 2: Requires the Plan's Executive Administrator to consult with the General Assembly's Committee on Employee and Hospital Medical Benefits before implementing a plan to verify tobacco use by plan members.

EFFECTIVE DATE: Section 1 of the act is effective June 1, 2010 and is repealed effective July 1, 2011. The remainder of the act is effective when it becomes law.

ESTIMATED IMPACT ON STATE:

Aon Consulting, the consulting actuary for the State Health Plan for Teachers and State Employees, estimates that Section 1 of the bill's requirements will increase the Plan's total claims cost by a range of $1.2 million to $3.4 million for the 2010-2011 fiscal year.

Hartman & Associates, the consulting actuary for the General Assembly's Fiscal Research Division, estimates that Section 1 of the bill's requirements will increase the Plan's total claims cost by a range of $2.1 million to $3.6 million for the 2010-2011 fiscal year.

The additional cost impact of the requirements in Section 1 of the bill, projected by either consulting actuary, would be expected to impact total claims growth by approximately fourteen tenths of one percent (0.14%) for the 2010-2011 fiscal year based on the highest estimate of additional cost (i.e., $3.6 million).
ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2009, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total *revised* requirements for the Plan are estimated to be $2.55 billion for FY 2009-10 and $2.74 billion for FY 2010-11. The Plan's PPO benefit design includes two alternative benefit levels listed below:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums; and

2) The "Standard" 80/20 plan.

The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under both plans is offered on a fully contributory basis.

Financial Condition

Revised Financial Projection 2009-11 Biennium – The following summarizes a revised financial projection conducted by the Plan's consulting actuary, Aon Consulting, for the 2009-11biennium. The information is provided by fiscal year based on year-to-date financial experience (through March 2010) and other updated factors.

For the fiscal year beginning July 1, 2009, the Plan began its operations with a beginning cash balance of $189.9 million. Receipts for the year are projected to be $2.41 billion from net premium collections, $74.4 million from Medicare Part D subsidies, and $3.4 million from investment earnings for a total of approximately $2.49 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.39 billion in net claim-payment expenses and $164.1 million in administration and claims-processing expenses for projected total expenses of nearly $2.55 billion for FY 2009-10. The Plan's net operating loss is projected to be approximately $66.3 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan is projected to begin its operations with a beginning cash balance of $123.6 million. Receipts for the year are projected to be $2.68 billion from net premium collections, $56.1 million from Medicare Part D subsidies, and $2.7 million from investment earnings for a total of approximately $2.73 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.55 billion in net claim-payment expenses and $191.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.74 billion for FY 2010-11. The Plan's net operating loss is projected to be approximately $7.1 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Based on the revised financial projection (May 2010), the Plan's estimated ending cash balance on June 30, 2011 is projected to be $116.5 million. This amount is approximately $75.7 million less than the originally projected (April 2009) ending cash balance of $192.2 million.

Original Financial Projection 2009-11 Biennium (April 2009) – Session Law 2009-16 (Senate Bill 287) appropriated funds from various sources, authorized annual premium rate increases, made various benefit and provider related changes to achieve financial savings, and directed other various changes to the Plan. The enacted law also appropriated the sum of $250 million from the Savings Reserve Account ("Rainy Day Fund") of the General Fund for the 2008-09 fiscal year. The following summarizes the original financial projection by conducted by the Plan's consulting actuary, Aon Consulting, for the 2009-11 biennium. The following summarizes the original financial projection by fiscal year for the 2009-11 biennium and assumes the changes enacted in Session Law 2009-16 (Senate Bill 287).

For the fiscal year beginning July 1, 2009, the Plan was projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year were projected to be $2.4 billion from net premium collections, $56.3 million from Medicare Part D subsidies, and $8.0 million from investment earnings for a total of approximately $2.5 billion in receipt income for the year. Projected disbursements from the Plan were expected to be $2.3 billion in net claim-payment expenses and $185.6 million in administration and claims-processing expenses for projected total expenses of nearly $2.5 billion for FY 2009-10. The Plan's net operating income was projected to be approximately $14.8 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan was projected to begin its operations with a beginning cash balance of $161.6 million. Receipts for the year were projected to be $2.7 billion from net premium collections, $50.4 million from Medicare Part D subsidies, and $8.8 million from investment earnings for a total of approximately $2.7 billion in receipt income for the year. Projected disbursements from the Plan were expected to be $2.5 billion in net claim-payment expenses and $191.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.7 billion for FY 2010-11. The Plan's net operating income was projected to be approximately $30.6 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Other Information

Historically, the Plan has applied a premium increase in October of the first fiscal year of a biennium. However, the annual premium increases authorized in Session Law 2009-16 (Senate Bill 287) changes that methodology to an annual increase at the beginning of each fiscal year of the 2009-11 biennium.

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with

other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment as of December 31, 2009

I. No. of Participants	Basic	Standard	Total	Percent of Total
Actives				
Employees	30	6	36	0.0%
Dependents	49	10	59	0.0%
Sub-total	79	16	95	0.1%
Retired				
Employees	2,074	151,395	153,469	85.3%
Dependents	1,313	18,075	19,388	10.8%
Sub-total	3,387	169,470	172,857	96.1%
Former Employees with Continuation Coverage				
Employees	121	3,120	3,241	1.8%
Dependents	87	749	836	0.5%
Sub-total	208	3,869	4,077	2.3%
Firefighters, Rescue Squad & National Guard				
Employees	-	5	5	0.0%
Dependents	-	3	3	0.0%
Sub-total	-	8	8	0.0%
Local Governments				
Employees	91	1,829	1,920	1.1%
Dependents	174	777	951	0.5%
Sub-total	265	2,606	2,871	1.6%
Total				
Employees	2,316	156,355	158,671	88.2%
Dependents	1,623	19,614	21,237	11.8%
Grand Total	**3,939**	**175,969**	**179,908**	**100%**
Percent of Total	**2.2%**	**97.8%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Total
Employee Only	3,252	378,539	381,791
Employee Child(ren)	6,026	43,820	49,846
Employee Spouse	2,550	21,785	24,335
Employee Family	4,288	19,741	24,029
Total	**16,116**	**463,885**	**480,001**

Percent Enrollment by Contract	Basic	Standard	Total
Employee Only	20.2%	81.6%	79.5%
Employee Child(ren)	37.4%	9.4%	10.4%
Employee Spouse	15.8%	4.7%	5.1%
Employee Family	26.6%	4.3%	5.0%
Total	**100.0%**	**100.0%**	**100.0%**

III. Enrollment by Sex	Basic	Standard	Total
Female	22,479	390,209	412,688
Male	19,804	228,840	248,644
Total	**42,283**	**619,049**	**661,332**

Percent Enrollment by Sex	Basic	Standard	Total
Female	53.2%	63.0%	62.4%
Male	46.8%	37.0%	37.6%
Total	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Total
19 & Under	17,315	95,431	112,746
20 to 29	3,311	57,142	60,453
30 to 44	9,555	120,292	129,847
45 to 54	6,455	108,447	114,902
55 to 64	4,090	128,933	133,023
65 & Over	1,557	108,804	110,361
Total	**42,283**	**619,049**	**661,332**

Percent Enrollment by Age	Basic	Standard	Total
19 & Under	41.0%	15.4%	17.0%
20 to 29	7.8%	9.2%	9.1%
30 to 44	22.6%	19.4%	19.6%
45 to 54	15.3%	17.5%	17.4%
55 to 64	9.7%	20.8%	20.1%
65 & Over	3.7%	17.6%	16.7%
Total	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	51,747	11,879	63,626
Medicare Eligible	101,722	7,509	109,231
Total	**153,469**	**19,388**	**172,857**

III. Enrollment by Sex	Basic	Standard	Total
Female	-	-	-
Male	-	1	1
Total	**-**	**1**	**1**

VI. Enrollment By Major Employer Groups	Employees	Dependents	Total
State Agencies	75,367	34,645	110,012
UNC System	50,106	29,726	79,832
Local Public Schools	181,270	88,258	269,528
Local Community Colleges	14,623	7,524	22,147
Other			
Local Governments	1,920	951	2,871
COBRA	3,241	836	4,077
Nat. Guard, Fire & Rescue	5	3	8
Sub-total	5,166	1,790	6,956
Retirement System	153,469	19,388	172,857
Total	**480,001**	**181,331**	**661,332**

Percent Enrollment by Major Employer Groups	Employees	Dependents	Total
State Agencies	15.7%	19.1%	16.6%
UNC System	10.4%	16.4%	12.1%
Local Public Schools	37.8%	48.7%	40.8%
Local Community Colleges	3.0%	4.1%	3.3%
Other			
Local Governments	0.4%	0.5%	0.4%
COBRA	0.7%	0.5%	0.6%
Nat. Guard, Fire & Rescue	0.0%	0.0%	0.0%
Sub-total	1.1%	1.0%	1.1%
Retirement System	32.0%	10.7%	26.1%
Total	100.0%	100.0%	100.0%

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, House Bill 1707 (First Edition), "Proposed House Bill: An Act to Allow Already Enrolled Dependent Children to Remain in the Teachers and State Employees Until Age 26 and to Direct the Plan to Consult with the Committee on Hospital and Medical Benefits Before Implementing any Tobacco Testing Program", May 18, 2010, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, House Bill 1707 (First edition), 'House DRH80523-91 Age-Out Dependents; Tobacco Use Testing", May 14, 2010, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Marilyn Chism, Director
Fiscal Research Division

DATE: May 19, 2010

Official
Fiscal Research Division
Publication

Signed Copy Located in the NCGA Principal Clerk's Offices

House Bill 1707 / S.L. 2010-3

2009-2010 Session

SHP/ Age-Out Dependents; Tobacco Use Testing.

View Bill Digest	
Text	**Fiscal Note**
Filed [HTML]	-
Edition 1 [HTML]	HAH1707v1
Ratified [HTML]	-
SL2010-3 [HTML]	-

Status: Ch. SL 2010-3 on 06/08/2010

Sponsors

Primary: Holliman; Tarleton; Gill; Jackson;

Co: M. Alexander; Cotham; Dockham; Dollar; Fisher; Glazier; Goforth; Harrison; Hughes; Insko; Parfitt; Ross; Weiss;

Attributes: Public;

Vote History

Date	Subject	RCS #	Aye	No	N/V	Exc. Abs.	Exc. Vote	Total	Result
05/26/2010 3:48PM	Second Reading	[H] - 1403	79	34	1	6	0	113	PASSED
06/02/2010 3:22PM	Second Reading	[S] - 1258	29	20	0	1	0	49	PASSED

Viewing Last 2 Vote(s) *View All Votes*

History

Date	Chamber	Action
05/13/2010	House	Filed
/17/2010	House	Passed 1st Reading
/17/2010	House	Ref to the Com on Insurance, if favorable, Appropriations
/20/2010	House	Reptd Fav
05/20/2010	House	Re-ref Com On Appropriations
05/25/2010	House	Assigned To Appropriations Subcommittee on Health and Human Services
05/25/2010	House	Reptd Fav
05/25/2010	House	Cal Pursuant Rule 36(b)
05/25/2010	House	Placed On Cal For 5/26/2010
05/26/2010	House	Passed 2nd & 3rd Reading
05/26/2010	Senate	Rec From House
05/26/2010	Senate	Ref To Com On Rules and Operations of the Senate
06/01/2010	Senate	Withdrawn From Com
06/01/2010	Senate	Re-ref Com On Select Committee on Employee Hospital and Medical Benefits
06/01/2010	Senate	Reptd Fav
06/02/2010	Senate	Passed 2nd & 3rd Reading
06/02/2010		Ratified
06/03/2010		Pres. To Gov. 6/2/2010
06/08/2010		Signed By Gov. 6/7/2010
06/08/2010		Ch. SL 2010-3

Note: a bill listed on this website is not law until passed by the House and the Senate, ratified, and, if required, signed by the Governor.

2009-2010 Session

Bill Number: enter bill # (i.e., S Look-Up

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2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 1707 A BILL TO BE ENTITLED AN ACT (1) TO ALLOW ALREADY ENROLLED DEPENDENT CHILDREN UNDER THE AGE OF TWENTY-SIX WHO ARE NOT ELIGIBLE FOR EMPLOYER-BASED HEALTH CARE TO REMAIN ON THE NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES FOR PLAN YEAR 2010-2011 AND (2) TO DIRECT THE STATE HEALTH PLAN TO CONSULT WITH THE COMMITTEE ON HOSPITAL AND MEDICAL BENEFITS BEFORE IMPLEMENTING ANY TOBACCO USE TESTING PROGRAM.

☒ With a favorable report and recommendation that the 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 _____.

_____ The bill/resolution is re-referred to the Committee on _____.

Attachment 1

VISITOR REGISTRATION SHEET

House Committee on Insurance — 05-20-10

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
George DeVane	CWA
Tom Coley	CWA
[signature]	JD, M, PA
Amy Whited	NCMedSoc.
Jeff Smith	~~[illegible]~~ UNC-TV
Zane Stilwell	NCGA
Sarah Corbett	NCAOC
Russ Eubanks	NC AOC
Maria Salerno	American Heart Assoc.
Elizabeth Robison	NCRMA
[signature]	MLC

VISITOR REGISTRATION SHEET

House Committee on Insurance — 05-20-10

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	NCRGEA
Jim Stegall	U.C.P.S.
Katherine Joyce	NCASA
Mark Flory	BCBSNC
Robin Miller	BCBSNC
Adri Maisonet	BCBSNC
Dipti Patil-Misra	BCBSNC
Barbara Conklin	BCBSNC
Carol Durrell	StateHealthPlan
Lacey Barnes	SHP
Suzanne Beasley	SEANC

VISITOR REGISTRATION SHEET

House Committee on Insurance — 05-20-10

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DAVID BARNES	Pacific Spirits

VISITOR REGISTRATION SHEET

House Committee on Insurance — **Name of Committee**

May 20, 2010 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chuck Stone	SEANC / NCAHC
Cam Cuver	Brooks Pierce
Sam Sanders	William Mueller
Brian Dempsey	NNWC
Carl Dean	DSD
Jay D. Roberts	AP
KW Hut	BCBSNC

Mary Capps (Rep. Wray)

From: Meredith Matney (Rep. Goforth)
Sent: Tuesday, May 18, 2010 4:19 PM
To: @House/Insurance; @HouseCommitteeNotice; Mary Capps (Rep. Wray); Rep. Bill Current; Rep. Bill Faison; Rep. D. Bruce Goforth; Rep. David Lewis; Rep. Garland Pierce; Rep. Harold "Bru" Brubaker; Rep. Hugh Holliman; Rep. Jeff Barnhart; Rep. Jerry Dockham; Rep. John M. Blust; Rep. Julia Howard; Rep. Michael Wray; Rep. Mitchell Setzer; Rep. Nelson Cole; Rep. Pryor Gibson; Rep. R. Van Braxton; Rep. Sandra Spaulding Hughes; Rep. Wainwright's Office
Subject: <NCGA> House Insurance Committee Meeting Notice for Thursday, May 20, 2010

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2009-2010 SESSION

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

DAY & DATE: Thursday, May 20, 2010
TIME: 11:00 am
LOCATION: 1228 LB
COMMENTS:

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 1707	SHP/ Age-Out Dependents; Tobacco Use Testing.	Representative Holliman Representative Tarleton Representative Gill Representative Jackson

Respectfully,
Representative Goforth, Chair
Representative Wray, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **15** o'clock on **May 18, 2009.**

Principal Clerk
Reading Clerk – House Chamber

Meredith Matney (Committee Assistant)

HOUSE INSURANCE COMMITTEE

May 20, 2010
11:00 a.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Van Braxton
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

HB 1707- SHP/ Age-Out Dependents; Tobacco Use Testing – Reps. Holliman, Tarleton, Gill & Jackson

Adjourn

MINUTES

HOUSE COMMITTEE ON INSURANCE
June 10, 2010

The House Committee on Insurance met at 11:00 AM on Thursday, June 10, 2010 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael H. Wray; Vice Chairs: V. Braxton, J. Dockham and M. Setzer. Members attending were Reps. Blust, Brubaker, Cole, Current, Faison, Gibson, Howard, Hughes and Pierce

Chairman Wray called the meeting to order and welcomed visitors. He recognized House Pages and Sgt-at-Arms. Visitor Registration Sheets are attached and made part of the record (Attachment #1).

Chairman Wray recognized Representative Faison to explain HB 766-Annuity Insolvency Coverage/Ins. Guar. Assn. The bill is to correct a drafting error having to do with annuities. The bill drafters were looking to protect the beneficiary of the annuity – the payee. The phrase used in the bill was "contract holder" so this bill is merely a correction of the name. After a few questions, Chairman Wray recognized Rep. Cole who moved that the House concur with the Senate Committee Substitute, and the motion carried.

Chairman Wray called upon Rep. Insko to present HB1905-Fire Safe Cigarettes. Rep. Insko explained that this bill is a clarification of the fire safe cigarette bill from a few years ago. All of the manufacturers have agreed to this bill. Rep. Insko then suggested that Ms. Rose Vaughn Williams, Department of Insurance, speak on the bill. Ms. Williams said the bill clarifies a confusion of whether cigarette companies should put all of brand styles into one form and pay one time $250 or pay $250 per brand style. The latter was the intent. Chairman Wray then asked the committee for questions. Rep. Dockham wanted specification on the term "brand style." Research staff clarified that within a brand name of a cigarette, there are a variety of different types such as menthol, non-menthol, etc. Rep. Braxton moved for a favorable report on HB 1905 and that the bill is re-referred to Finance, and the motion carried.

Chairman Wray adjourned the meeting at 11:15 AM.

Representative Michael H. Wray, Chairman

Mary Capps, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H 3

HOUSE BILL 766*

Committee Substitute Favorable 4/15/09
Senate Commerce Committee Substitute Adopted 6/1/10

Short Title: Annuity Insolvency Coverage/Ins. Guar. Assn. (Public)

Sponsors:

Referred to:

March 25, 2009

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE PROTECTION PROVIDED BY THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION AGAINST FAILURE IN THE PERFORMANCE OF CONTRACTUAL OBLIGATIONS UNDER ANNUITY CONTRACTS BECAUSE OF THE DELINQUENCY OF THE MEMBER INSURER THAT ISSUED THE POLICIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-62-21(d)(5) reads as rewritten:

"(d) The benefits for which the Association is liable do not, in any event, exceed the lesser of:

...

(5) With respect to any one ~~contract holder~~ payee (or beneficiaries of one payee if the payee is deceased) of a structured settlement annuity, one million dollars ($1,000,000) for all benefits, including cash values."

SECTION 2. G.S. 58-62-21(e) is repealed.

SECTION 3. This act is effective when it becomes law and applies to claims submitted to the North Carolina Life and Health Insurance Guaranty Association on or after August 7, 2009.

HOUSE BILL 766:
Annuity Insolvency Coverage/Ins. Guar. Assn

2009-2010 General Assembly

Committee:	House Insurance	**Date:**	June 9, 2010
Introduced by:	Reps. Womble, Parmon, Mobley, Jones	**Prepared by:**	Bill Patterson
Analysis of:	Third Edition		Committee Counsel

SUMMARY: ***For insolvencies involving issuers of structured settlement annuities covered by the North Carolina Life and Health Insurance Guaranty Association, House Bill 766 makes the existing $1,000,000 coverage limit applicable on a "per payee" rather "per contract holder" basis.***

For insolvencies involving issuers of all other annuities covered by the Association, the bill repeals the current aggregate coverage limit of $500,000 per individual.

CURRENT LAW: The North Carolina Life and Health Insurance Guaranty Association ("the Association") is a statutory entity comprising all insurers licensed to sell life insurance, accident and health insurance, and annuities in the state of North Carolina. By statute,[1] the Association provides specified limits of coverage for North Carolina residents who are holders of individual annuities issued by an insurer that subsequently becomes insolvent.

S.L. 2009-448 extended the Association's coverage to insolvencies involving issuers of structured settlement annuities,[2] subject to a limit of $1,000,000 "per contract holder." In addition, for insolvencies involving issuers of other types of annuities, the 2009 amendments increased the aggregate lifetime limit of coverage from $300,000 to $500,000 for each covered individual.

BILL ANALYSIS:

Section 1. For insolvencies involving issuers of structured settlement annuities, the bill rewords the $1,000,000 coverage limit in G.S. 58-62-21(d)(5) so that it applies on a "per payee" basis rather than on the existing "per contract holder" basis.

Section 2. For insolvencies involving issuers of all other annuities, the bill deletes the aggregate limit on coverage under G.S. 58-62-21(e). With this change, a North Carolina resident owning annuity contracts issued by more than one company will remain subject to the $300,000 coverage limit per insolvency under G.S. 58-62-21(d)(2),[3] but will not be subject to an aggregate lifetime coverage limit in the event that the individual is the holder of annuities issued by more than one insolvent insurer.

EFFECTIVE DATE: The act is effective when it becomes law and applies to any claims submitted to the Association on or after August 7, 2009, the effective date of the 2009 amendments to the statute.

BACKGROUND:

Section 1. Under ordinary annuity contracts, the holder of the contract is the payee who will receive payments under the annuity. By contrast, for tax reasons,[4] the holder of a structured settlement annuity is not the payee, but is instead usually a subsidiary of the issuing company that holds thousands of other

[1] Article 62 of Chapter 58 of the General Statutes.

[2] Structured settlement annuities are used to fund structured settlements of claims involving personal injury or illness, including claims under the Workers Compensation Act. Structured settlements are

[3] Although this limit is stated as applying "with respect to any one individual," the Association interprets it as applying "per insolvency," according to information provided by the Association to Staff.

[4] Payments received under a structured settlement lose their tax-free status if the taxpayer is the owner of the annuity. Treas. Reg. § 1.451-2(a).

contracts issued by the same insurer. As a result, if a coverage limit for structured settlement annuities is applied on a "per contract holder" basis, it must be divided among all of the contracts held by the contract holder, thereby providing only a small fraction of the total coverage limit to any single individual entitled to annuity payments. The bill addresses this problem by applying the Association's $1,000,000 coverage limit on a "per payee" rather "per contract holder" basis for structured settlement annuities.

Section 2. The Insurance Guaranty Association supports repeal of the aggregate lifetime limit of coverage set forth in G.S. 58-62-21(e) because as a practical matter, the limit cannot be enforced. The Association does not track the aggregate amount recovered by any individual payee as a result of separate insolvencies, and therefore is unable to determine when such a coverage limit has been reached.

H766-SMTG-81(e3) v2

House Bill 766 / S.L. 2010-11 (= S411)

2009-2010 Session

Annuity Insolvency Coverage/Ins. Guar. Assn.

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Text	**Fiscal Note**
Filed [HTML]	-
Edition 1 [HTML]	HAR0766v1
Edition 2 [HTML]	-
Edition 3 [HTML]	-
Ratified [HTML]	-
SL2010-11 [HTML]	-

Status: Ch. SL 2010-11 on 06/23/2010

Sponsors

Primary: Womble; Parmon; Mobley; Jones;

Co: Adams; K. Alexander; M. Alexander; Blue; Brown; Bryant; Dollar; Faison; Farmer-Butterfield; E. Floyd; Glazier; Hall; Harrison; Luebke; Mackey; McGee; Spear; Tarleton; Wainwright; Weiss; Wray;

Attributes: Public; Text has changed;

Vote History

Date	Subject	RCS #	Aye	No	N/V	Exc. Abs.	Exc. Vote	Total	Result
06/02/2010 3:02PM	Second Reading	[S] - 1256	49	0	0	1	0	49	PASSED
06/14/2010 7:10PM	M11 Concur	[H] - 1486	109	0	3	8	0	109	PASSED

Viewing Last 2 Vote(s) *View All Votes*

History RSS

Date	Chamber	Action
03/24/2009	House	Filed
03/25/2009	House	Passed 1st Reading
03/25/2009	House	Ref to the Com on Homeland Security, Military, and Veterans Affairs, if favorable, Pensions and Retirement
04/15/2009	House	Reptd Fav Com Substitute
04/15/2009	House	Re-ref Com On Pensions and Retirement
04/29/2009	House	Reptd Fav
04/29/2009	House	Cal Pursuant Rule 36(b)
04/29/2009	House	Placed On Cal For 4/30/2009
04/30/2009	House	Passed 2nd & 3rd Reading
05/04/2009	Senate	Rec From House
05/04/2009	Senate	Ref To Com On Rules and Operations of the Senate
05/26/2010	Senate	Withdrawn From Com
05/26/2010	Senate	Re-ref Com On Commerce
06/01/2010	Senate	Reptd Fav Com Substitute
06/01/2010	Senate	Com Substitute Adopted
06/02/2010	Senate	Passed 2nd & 3rd Reading
06/07/2010	House	Rec To Concur S Com Sub
06/07/2010	House	Ref To Com On Insurance
06/10/2010	House	Reptd Fav To Concur
06/10/2010	House	Cal Pursuant Rule 36(b)
06/10/2010	House	Placed On Cal For 6/14/2010
06/14/2010	House	Concurred In S/Com Sub
06/15/2010		Ratified
06/16/2010		Pres. To Gov. 6/16/2010
06/23/2010		Signed By Gov. 6/23/2010
06/23/2010		Ch. SL 2010-11

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2009-2010 Session

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2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☒ Senate Committee Substitute # ___ for

HB 766 A BILL TO BE ENTITLED AN ACT TO CLARIFY THE PROTECTION PROVIDED BY THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION AGAINST FAILURE IN THE PERFORMANCE OF CONTRACTUAL OBLIGATIONS UNDER ANNUITY CONTRACTS BECAUSE OF THE DELINQUENCY OF THE MEMBER INSURER THAT ISSUED THE POLICIES.

☒ 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 _____.

HOUSE BILL 1905*

Short Title:	Fire Safe Cigarettes.	(Public)
Sponsors:	Representatives Insko, England (Primary Sponsors); M. Alexander, Glazier, Harrison, Hughes, Luebke, and Martin.	
Referred to:	Insurance, if favorable, Finance.	

May 20, 2010

A BILL TO BE ENTITLED

AN ACT TO AMEND THE FIRE-SAFETY STANDARD AND FIREFIGHTER PROTECTION ACT, AS RECOMMENDED BY THE PUBLIC HEALTH STUDY COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-92-10 reads as rewritten:

"**§ 58-92-10. Definitions.**

For the purposes of this Article:

(1) "Agent" means any person authorized by the Department of Revenue to pay the excise tax on packages of cigarettes.

(1a) "Brand style" means a variety of cigarettes distinguished by the tobacco used, tar and nicotine content, flavoring used, size of the cigarette, filtration on the cigarette, or packaging.

(2) "Cigarette" means any roll for smoking, whether made wholly or in part of tobacco or any other substance, irrespective of size or shape, and whether or not such tobacco or substance is flavored, adulterated, or mixed with any other ingredient, the wrapper or cover of which is made of paper or any other substance or material, other than leaf tobacco.

(3) "Commissioner" means the Commissioner of Insurance.

(4) "Consumer testing" means an assessment of cigarettes that is conducted by a manufacturer (or under the control and direction of a manufacturer), for the purpose of evaluating consumer acceptance of such cigarettes.

(5) "Distributor" means any person other than a manufacturer who sells cigarettes or tobacco products to retail dealers or other persons for purposes of resale, any person who owns, operates, or maintains one or more cigarette or tobacco product vending machines in, at, or upon premises owned or occupied by any other person, or a distributor as defined in G.S. 105-113.4(3)a.

(6) "Manufacturer" means:

a. Any entity ~~which~~ that manufactures or otherwise produces cigarettes or causes cigarettes to be manufactured or produced anywhere that ~~such~~ the manufacturer intends to be sold in this State, including cigarettes intended to be sold in the United States through an importer;

b. The first purchaser anywhere that intends to resell in the United States cigarettes manufactured anywhere that the original

manufacturer or maker does not intend to be sold in the United States; or

c. Any entity that becomes a successor of an entity described in sub-subdivision a. or b. of this subdivision.

(7) "Quality control and quality assurance program" means the laboratory procedures implemented to ensure that operator bias, systematic and nonsystematic methodological errors, and equipment-related problems do not affect the results of the testing. Such a program ensures that the testing repeatability remains within the required repeatability values stated in G.S. 58-92-15(g) for all test trials used to certify cigarettes in accordance with this Article.

(8) "Repeatability" means the range of values within which the repeat results of cigarette test trials from a single laboratory will fall ninety-five percent (95%) of the time.

(9) "Retail dealer" means any person, other than a manufacturer or distributor, engaged in selling cigarettes or tobacco products.

(10) "Sale" means any transfer of title or possession or both, exchange or barter, conditional or otherwise, in any manner or by any means whatever or any agreement therefor. In addition to cash and credit sales, the giving of cigarettes as samples, prizes, or gifts, and the exchanging of cigarettes for any consideration other than money, are considered sales.

(11) "Sell" means to sell, or to offer or agree to do the same."

SECTION 2. G.S. 58-92-20 reads as rewritten:

"**§ 58-92-20. Certification and product change.**

(a) Each manufacturer shall submit to the Commissioner a written certification attesting both of the following:

(1) Each cigarette listed in the certification has been tested in accordance with G.S. 58-92-15.

(2) Each cigarette listed in the certification meets the performance standard set forth in G.S. 58-92-15.

(b) Each cigarette listed in the certification shall be described with the following information:

(1) Brand or trade name on the package.

(2) ~~Style, such as light or ultralight.~~ Brand style, as defined in G.S. 58-92-10(1a).

(3) Length in millimeters.

(4) Circumference in millimeters.

(5) Flavor, such as menthol or chocolate, if applicable.

(6) Filter or nonfilter.

(7) Package description, such as soft pack or box.

(8) Marking pursuant to G.S. 58-92-25.

(9) The name, address, and telephone number of the laboratory, if different than the manufacturer that conducted the test.

(10) The date that the testing occurred.

(c) Certifications shall be made available to the Attorney General for purposes consistent with this Article and the Commissioner for the purposes of ensuring compliance with this section.

(d) Each cigarette certified under this section shall be recertified every three years.

(e) For each ~~certification form,~~ brand style listed in a certification, a manufacturer shall pay to the Commissioner a fee of two hundred fifty dollars ($250.00). The Commissioner may

annually adjust this fee to ensure it defrays the actual costs of the processing, testing, enforcement, and oversight activities required by this Article.

(f) There is established in the State treasury a separate, nonreverting fund to be known as the "Fire Safety Standard and Firefighter Protection Act Enforcement Fund." The fund shall consist of all certification fees submitted by manufacturers and shall, in addition to any other monies made available for such purpose, be available to the Commissioner solely to support processing, testing, enforcement, and oversight activities under this Article.

(g) If a manufacturer has certified a cigarette pursuant to this section, and thereafter makes any change to such cigarette that is likely to alter its compliance with the reduced cigarette ignition propensity standards required by this Article, that cigarette shall not be sold or offered for sale in this State until the manufacturer retests the cigarette in accordance with the testing standards set forth in G.S. 58-92-15 and maintains records of that retesting as required by G.S. 58-92-15. Any altered cigarette ~~which~~ that does not meet the performance standard set forth in G.S. 58-92-15 ~~may~~ shall not be sold in this State."

SECTION 3. This act becomes effective July 1, 2010.

PRINTABLE VERSION

<< Previous: H1904 Next: H1906 >>

House Bill 1905 / S.L. 2010-101 (= S1338)

2009-2010 Session

Fire Safe Cigarettes.

View Bill Digest	
Text	**Fiscal Note**
Filed [HTML]	-
Edition 1 [HTML]	HFN1905v1
Ratified [HTML]	-
SL2010-101 [HTML]	-

Status: Ch. SL 2010-101 on 07/20/2010

Sponsors

Primary: Insko; England;

Co: M. Alexander; Glazier; Harrison; Hughes; Luebke; Martin;

Attributes: Public;

Vote History

Date	Subject	RCS #	Aye	No	N/V	Exc. Abs.	Exc. Vote	Total	Result
07/07/2010 5:45PM	Second Reading	[S] - 1523	48	0	0	2	0	48	PASSED
07/08/2010 10:15AM	Third Reading	[S] - 1534	48	0	1	1	0	48	PASSED

Viewing Last 2 Vote(s) *View All Votes*

History RSS

Date	Chamber	Action
05/19/2010	House	Filed
05/20/2010	House	Passed 1st Reading
20/2010	House	Ref to the Com on Insurance, if favorable, Finance
10/2010	House	Reptd Fav
10/2010	House	Re-ref Com On Finance
06/30/2010	House	Reptd Fav
06/30/2010	House	Cal Pursuant Rule 36(b)
06/30/2010	House	Placed On Cal For 7/1/2010
07/01/2010	House	Passed 2nd Reading
07/06/2010	House	Passed 3rd Reading
07/06/2010	Senate	Rec From House
07/06/2010	Senate	Ref To Com On Finance
07/07/2010	Senate	Reptd Fav
07/07/2010	Senate	Placed On Cal For 7/7/2010
07/07/2010	Senate	Passed 2nd Reading
07/08/2010	Senate	Passed 3rd Reading
07/09/2010		Ratified
07/09/2010		Pres. To Gov. 7/9/2010
07/20/2010		Signed By Gov. 7/20/2010
07/20/2010		Ch. SL 2010-101

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2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☒ Committee Substitute for

HB 1905 A BILL TO BE ENTITLED AN ACT TO AMEND THE FIRE-SAFETY STANDARD AND FIREFIGHTER PROTECTION ACT, AS RECOMMENDED BY THE PUBLIC HEALTH STUDY COMMISSION.

☒ With a favorable report and recommendation that the 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 _____.

_____ The bill/resolution is re-referred to the Committee on _____.

Attachment 1

VISITOR REGISTRATION SHEET

House Committee on Insurance — June 10, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Canales	BCBR
Joyce Peters	JP Assoc
Gene Ainsworth	A & A
[illegible]	Bone: Assoc
Whitney Campbell	Jordan Price
Penny Griffin	School of Gov.
Gary Salamido	GSK
Elizabeth Robinson	NCPCA
Christine Weason	American Cancer Society
Maria Salerno	American Heart Assoc.
Betsy Vetter	American Heart Assoc.

VISITOR REGISTRATION SHEET

House Committee on Insurance — June 10, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robert Paschal	Young, Moore
[illegible]	NMRS
Bill Patterson	Hunton & Williams
Gerald Arnold	1206 Ballyhack Pl., Raleigh
Edward LeCarpentier	3210 Burns Place, Raleigh 27609
Lori Ann Harris	CAHA
Stephanie Klass	Rep Ins Co's of Mid-Co
Tara Stilwell	NCGA
Pat O'Connell	NCAH
John Hatcher	NFS

VISITOR REGISTRATION SHEET

House Committee on Insurance — June 10, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DAVID BARNES	PS

HOUSE INSURANCE COMMITTEE

June 10, 2010
11:00 AM
Room 1228 – LB

Rep. Michael H. Wray, Chairman
Rep. Bruce Goforth, Chairman

Vice-Chairs
Rep. Van Braxton
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

HB 766 - Annuity Insolvency Coverage/Ins. Guar. Assn.
Reps. Womble, Parmon, Mobley & Jones

HB 1905 – Fire Safe Cigarettes
Reps. Insko & England

Adjourn

Mary Capps (Rep. Wray)

From: Mary Capps (Rep. Wray)
Sent: Thursday, June 10, 2010 10:15 AM
To: Rep. Larry Womble; Rep. Earline W. Parmon; Rep. Annie Mobley; Rep. Earl Jones; Rep. Verla Insko; Rep. Bob England
Cc: Dorothy McLean (Rep. Womble); Pat Christmas (Rep. Parmon); Veronica Green (Rep. Mobley); Gina Insko (Rep. Insko); Lisa Brown (Rep. England)
Subject: <NCGA> House Insurance Committee Meeting Notice for Thursday, June 10, 2010

Corrected Notice
Remove HB 1730
Add HB 1905

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2009-2010 SESSION

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

DAY & DATE: Thursday, June 10, 2010
TIME: 11:00 am
LOCATION: 1228 LB
COMMENTS:

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 766	Annuity Insolvency Coverage/Ins. Guar. Assn.	Representative Womble Representative Parmon Representative Mobley Representative Jones
~~HB 1730~~	~~Auth. State Risk Pool to Admin. Fed Risk Pool.~~	~~Representative Insko~~ ~~Representative Holliman~~ ~~Representative Martha B. Alexander~~ ~~Representative England, M.D.~~
HB 1905	Fire Safe Cigarettes	Representative Insko Representative England, M.D.

Respectfully,
Representative Goforth, Chair
Representative Wray, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 10:00 o'clock on **June 10, 2010.**

Principal Clerk
Reading Clerk – House Chamber

Mary Capps (Committee Assistant)

06/10/2010

Mary Capps (Rep. Wray)

From: Mary Capps (Rep. Wray)
Sent: Wednesday, June 09, 2010 1:00 PM
To: Rep. Larry Womble; Rep. Earline W. Parmon; Rep. Annie Mobley; Rep. Earl Jones; Rep. Verla Insko; Rep. Hugh Holliman; Rep. Martha Alexander; Rep. Bob England
Cc: Dorothy McLean (Rep. Womble); Pat Christmas (Rep. Parmon); Veronica Green (Rep. Mobley); Kenneth McKoy (Rep. Jones); Gina Insko (Rep. Insko); Carol Bowers (Rep. Holliman); Ann Faust (Rep. Alexander); Lisa Brown (Rep. England)
Subject: <NCGA> House Insurance Committee Meeting Notice for Thursday, June 10, 2010

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2009-2010 SESSION

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HB 1730	Auth. State Risk Pool to Admin. Fed Risk Pool.	Representative Insko Representative Holliman Representative Martha B. Alexander Representative England, M.D.
HB 2055	State Health Plan/ Local Govt Retiree Contrib.	Representative England, M.D.

Respectfully,
Representative Goforth, Chair
Representative Wray, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 1:15 PM **12** o'clock on **June 09, 2009.**

Principal Clerk
Reading Clerk – House Chamber

Mary Capps (Committee Assistant)

06/09/2010

MINUTES
HOUSE COMMITTEE ON INSURANCE
June 17, 2010

The House Committee on Insurance met at 11:00 AM on Thursday, June 17, 2010 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael Wray; Vice Chairs: M. Dickson, J. Dockham and M. Setzer. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Cole, Current, Faison, Gibson, Holliman, Howard, Spaulding Hughes, Lewis Pierce, and Wainwright.

Chairman Goforth called the meeting to order and welcomed visitors. He recognized Sgt-At Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachments).

Chairman Goforth called on Rep. Braxton to explain SB 1193- Implement LTC Partnership Program. After discussion on the bill, questions were raised from Representative Dockham that were answered by Rep. Braxton. Following discussion Rep. Dockham moved a favorable report to the PCS and then it would be heard on the floor. Motion passed unanimously.

Chairman Goforth called on Representative England to discuss HB 2055- State Health Plan/Local Govt Retiree Contrib. Once Rep. England was finished explaining the bill, Chairman Goforth asked Mark Trogdon from Fiscal Research to explain the fiscal part of the bill. After much discussion and questioned from Rep. Howard, Brubaker, Gibson and Lewis; that were answered by Mark Trogdon. Rep. Lewis moved for favorable report of PCS and to send it to Pensions and Retirements. Motion passed unanimously.

Chairman Goforth introduces and discusses HB 2037- State Health Plan/Transfer to Dept Insurance. Chairman Goforth says that there will be no vote only discussion of the bill. Rep. Holliman made motion to accept the PCS. Rep. Dollar talked on the bill. Discussion ensued and Mark Trogdon talked about the fiscal note. Chairman Goforth asked if it would cost money for the Department of Insurance. Chief Legislative Council for the Department of Insurance Rose Vaughn Williams answered, as well as Rep. Dollar. Chairman Wray asked a question about what Blue Ribbon was since people kept bringing it up. Rep. Holliman and Braxton answered. Artis Blacks from State Employees Union said that Blue Ribbon was a lot of talk but no action. Rep. Blust said that it was not a legislative function. Rep. Holliman said that Blue Ribbon has only been meeting for six months. Rep. Current asked Rep. Braxton a question. When there was no further discussion Chairman Goforth adjourned the meeting.

Representative Bruce Goforth, Chairman

Meredith Matney – Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1853*
PROPOSED COMMITTEE SUBSTITUTE H1853-CSTG-49 [v.1]

6/16/2010 1:48:02 PM

Short Title: State Health Plan/Treat Teachers Equitably. (Public)

Sponsors:

Referred to:

May 20, 2010

A BILL TO BE ENTITLED

AN ACT TO GRANT THE SAME HEALTH BENEFIT COVERAGE CURRENTLY PROVIDED TO OTHER STATE EMPLOYEES TO TEACHERS WHO HAVE WORKED A FULL SCHOOL YEAR.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-45.2(a)(8) reads as rewritten:

"**§ 135-45.2. Eligibility.**

(a) Noncontributory Coverage. – The following persons are eligible for coverage under the Plan, on a noncontributory basis, subject to the provisions of G.S. 135-45.4:

...

(8) Notwithstanding the provisions of G.S. G.S. 135-45.12 employees formerly covered by the provisions of this section, other than retired employees, who have been employed for 12 or more months by an employing ~~unit~~ unit, or who have completed a contract term of employment of 10 or 11 months and whose employing unit is a local school administrative unit, and whose jobs are eliminated because of a reduction, in total or in part, in the funds used to support the job or its responsibilities, provided the employees were covered by the Plan at the time of separation from service resulting from a job elimination. Employees covered by this subsection shall be covered for a period of up to 12 months following a separation from service because of a job elimination."

SECTION 2. This act becomes effective July 1, 2010.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

REVISED

BILL NUMBER: House Bill 1853 (First Edition)

SHORT TITLE: State Health Plan/Treat Teachers Equitably.

SPONSOR(S): Representatives Glazier, Cotham, Parmon, and Whilden

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY: Amends a section of the Plan's governing statute under G.S. 135-45.2, entitled "Eligibility", to allow a local school administrative unit employee enrolled in the Plan, who has been employed a minimum period of 10 or 11 months, to be eligible for one-year of non contributory coverage under the Plan if the employee subsequently has their job eliminated because of a reduction, in total or part, in the funds to support the job.

EFFECTIVE DATE: July 1, 2010

ESTIMATED IMPACT ON STATE:

Aon Consulting, the consulting actuary for the State Health Plan for Teachers and State Employees, estimates that the bill's requirements will not have a fiscal impact on the Plan.

Hartman & Associates, the consulting actuary for the General Assembly's Fiscal Research Division, estimates that the bill will not have a material impact on the Plan.

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Additional Information Provided to Each Consulting Actuary

According to the Department of Public Instruction, there were 4,283 employees of local public schools subject to reduction-in-force for the current FY 2009-2010 school year. Of this total, the Department estimates that 3,726 employees were 10-month employees.

Of the 3,726 10-month employees subject to RIF, 2,271 were teachers and instructional support with the balance being teacher assistants. Of the 2,271 teachers/instructional support, the Department estimates that 10% of the RIF'd employees were first year 10-month teachers/instructional support employees.

As a basis for estimating the future affected population for any potential reductions-in-force effective for the FY 2010-2011, data from the Retirement Systems' Division of the Department of State Treasurer indicates that, there were 4,525 first year 10-month local public school employees hired in the months of August 2009 and September 2009 who became contributing members of the retirement system. The months of August 2009 and September 2009 were selected to reflect the possible population of first year 10-month employees assuming the school year ends in late May 2010 and early June 2010. The data count reflects the enrollees under Job Classification code "100" which includes "Teachers, Teacher Aides, Coaches, Guidance Counselors, and Librarians", and were assumed to be 10-month employees.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2009, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total *revised* requirements for the Plan are estimated to be $2.55 billion for FY 2009-10 and $2.74 billion for FY 2010-11. The Plan's PPO benefit design includes two alternative benefit levels listed below:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums; and

2) The "Standard" 80/20 plan.

The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under both plans is offered on a fully contributory basis.

Financial Condition

Revised Financial Projection 2009-11 Biennium – The following summarizes a revised financial projection be conducted by the Plan's consulting actuary, Aon Consulting, for the 2009-11 biennium. The information is provided by fiscal year based on year-to-date financial experience (through March 2010) and other updated factors.

For the fiscal year beginning July 1, 2009, the Plan began its operations with a beginning cash balance of $189.9 million. Receipts for the year are projected to be $2.41 billion from net premium collections, $74.4 million from Medicare Part D subsidies, and $3.4 million from investment earnings for a total of

approximately $2.49 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.39 billion in net claim-payment expenses and $164.1 million in administration and claims-processing expenses for projected total expenses of nearly $2.55 billion for FY 2009-10. The Plan's net operating loss is projected to be approximately $66.3 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan is projected to begin its operations with a beginning cash balance of $123.6 million. Receipts for the year are projected to be $2.68 billion from net premium collections, $56.1 million from Medicare Part D subsidies, and $2.7 million from investment earnings for a total of approximately $2.73 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.55 billion in net claim-payment expenses and $191.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.74 billion for FY 2010-11. The Plan's net operating loss is projected to be approximately $7.1 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Based on the revised financial projection (May 2010), the Plan's estimated ending cash balance on June 30, 2011 is projected to be $116.5 million. This amount is approximately $75.7 million less than the originally projected (April 2009) ending cash balance of $192.2 million.

Original Financial Projection 2009-11 Biennium (April 2009) – Session Law 2009-16 (Senate Bill 287) appropriated funds from various sources, authorized annual premium rate increases, made various benefit and provider related changes to achieve financial savings, and directed other various changes to the Plan. The enacted law also appropriated the sum of $250 million from the Savings Reserve Account ("Rainy Day Fund") of the General Fund for the 2008-09 fiscal year. The following summarizes the original financial projection by fiscal year for the 2009-11 biennium and assumes the changes enacted in Session Law 2009-16 (Senate Bill 287).

For the fiscal year beginning July 1, 2009, the Plan was projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year were projected to be $2.4 billion from net premium collections, $56.3 million from Medicare Part D subsidies, and $8.0 million from investment earnings for a total of approximately $2.5 billion in receipt income for the year. Projected disbursements from the Plan were expected to be $2.3 billion in net claim-payment expenses and $185.6 million in administration and claims-processing expenses for projected total expenses of nearly $2.5 billion for FY 2009-10. The Plan's net operating income was projected to be approximately $14.8 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan was projected to begin its operations with a beginning cash balance of $161.6 million. Receipts for the year were projected to be $2.7 billion from net premium collections, $50.4 million from Medicare Part D subsidies, and $8.8 million from investment earnings for a total of approximately $2.7 billion in receipt income for the year. Projected disbursements from the Plan were expected to be $2.5 billion in net claim-payment expenses and $191.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.7 billion for FY 2010-11. The Plan's net operating income was projected to be approximately $30.6 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Other Information

Historically, the Plan has applied a premium increase in October of the first fiscal year of a biennium. However, the annual premium increases authorized in Session Law 2009-16 (Senate Bill 287) changes that methodology to an annual increase at the beginning of each fiscal year of the 2009-11 biennium.

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment as of December 31, 2009

I. No. of Participants	Basic	Standard	Total	Percent of Total
Actives				
Employees	13,830	307,541	321,371	48.6%
Dependents	24,593	135,563	160,156	24.2%
Sub-total	38,423	443,104	481,527	72.8%
Retired				
Employees	2,074	151,395	153,469	23.2%
Dependents	1,313	18,075	19,388	2.9%
Sub-total	3,387	169,470	172,857	26.1%
Former Employees with Continuation Coverage				
Employees	121	3,120	3,241	0.5%
Dependents	87	749	836	0.1%
Sub-total	208	3,869	4,077	0.6%
Firefighters, Rescue Squad & National Guard				
Employees	-	5	5	0.0%
Dependents	-	3	3	0.0%
Sub-total	-	8	8	0.0%
Local Governments				
Employees	91	1,829	1,920	0.3%
Dependents	174	777	951	0.1%
Sub-total	265	2,606	2,871	0.4%
Total				
Employees	16,116	463,885	480,001	72.6%
Dependents	26,167	155,164	181,331	27.4%
Grand Total	**42,283**	**619,049**	**661,332**	**100%**
Percent of Total	**6.4%**	**93.6%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Total
Employee Only	3,252	378,539	381,791
Employee Child(ren)	6,026	43,820	49,846
Employee Spouse	2,550	21,785	24,335
Employee Family	4,288	19,741	24,029
Total	**16,116**	**463,885**	**480,001**

Percent Enrollment by Contract	Basic	Standard	Total
Employee Only	20.2%	81.6%	79.5%
Employee Child(ren)	37.4%	9.4%	10.4%
Employee Spouse	15.8%	4.7%	5.1%
Employee Family	26.6%	4.3%	5.0%
Total	**100.0%**	**100.0%**	**100.0%**

III. Enrollment by Sex	Basic	Standard	Total
Female	22,479	390,209	412,688
Male	19,804	228,840	248,644
Total	**42,283**	**619,049**	**661,332**

Percent Enrollment by Sex	Basic	Standard	Total
Female	53.2%	63.0%	62.4%
Male	46.8%	37.0%	37.6%
Total	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Total
19 & Under	17,315	95,431	112,746
20 to 29	3,311	57,142	60,453
30 to 44	9,555	120,292	129,847
45 to 54	6,455	108,447	114,902
55 to 64	4,090	128,933	133,023
65 & Over	1,557	108,804	110,361
Total	**42,283**	**619,049**	**661,332**

Percent Enrollment by Age	Basic	Standard	Total
19 & Under	41.0%	15.4%	17.0%
20 to 29	7.8%	9.2%	9.1%
30 to 44	22.6%	19.4%	19.6%
45 to 54	15.3%	17.5%	17.4%
55 to 64	9.7%	20.8%	20.1%
65 & Over	3.7%	17.6%	16.7%
Total	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	51,747	11,879	63,626
Medicare Eligible	101,722	7,509	109,231
Total	**153,469**	**19,388**	**172,857**

VI. Enrollment By Major Employer Groups	Employees	Dependents	Total
State Agencies	75,367	34,645	110,012
UNC System	50,106	29,726	79,832
Local Public Schools	181,270	88,258	269,528
Local Community Colleges	14,623	7,524	22,147
Other			
Local Governments	1,920	951	2,871
COBRA	3,241	836	4,077
Nat. Guard, Fire & Rescue	5	3	8
Sub-total	5,166	1,790	6,956
Retirement System	153,469	19,388	172,857
Total	**480,001**	**181,331**	**661,332**

Percent Enrollment by Major Employer Groups	Employees	Dependents	Total
State Agencies	15.7%	19.1%	16.6%
UNC System	10.4%	16.4%	12.1%
Local Public Schools	37.8%	48.7%	40.8%
Local Community Colleges	3.0%	4.1%	3.3%
Other			
Local Governments	0.4%	0.5%	0.4%
COBRA	0.7%	0.5%	0.6%
Nat. Guard, Fire & Rescue	0.0%	0.0%	0.0%
Sub-total	1.1%	1.0%	1.1%
Retirement System	32.0%	10.7%	26.1%
Total	100.0%	100.0%	100.0%

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, "House Bill 1853: An Act to Grant the Same Health Benefit Coverage Currently Available to Other State Employees to Teachers Who Have Worked a Full School Year", June 4, 2010, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "House Bill 1853 State Health Plan/Treat Teachers Equitably", June 4, 2010, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Marilyn Chism, Director
Fiscal Research Division

Signed Copy Located in the NCGA Principal Clerk's Offices

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 2037
PROPOSED COMMITTEE SUBSTITUTE H2037-CSRD-90 [v.2]

6/17/2010 10:08:20 AM

Short Title: State Health Plan/ Transfer to Dept Insurance. (Public)

Sponsors:

Referred to:

May 26, 2010

A BILL TO BE ENTITLED

AN ACT TO TRANSFER THE NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES TO THE DEPARTMENT OF INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. The North Carolina State Health Plan for Teachers and State Employees is transferred to the Department of Insurance. This transfer shall have all the elements of a Type II transfer, as defined by G.S. 143A-6.

SECTION 2. G.S. 135-43(b) reads as rewritten:

"**§ 135-43. Confidentiality of information and medical records; provider contracts.**

(b) Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees may contract with providers of institutional and professional medical care and services to establish preferred provider networks.

The terms of a contract between the Plan and its third party administrator or between the Plan and its pharmacy benefit manager are a public record except that the terms in those contracts that contain trade secrets or proprietary or competitive information are not a public record under Chapter 132 of the General Statutes, and any such proprietary or competitive information and trade secrets contained in the contract shall be redacted by the Plan prior to making it available to the public. This subsection shall not be construed to prevent or restrict the release of any information made not a public record under this subsection to the Commissioner of Insurance, the State Auditor, the Attorney General, the Director of the State Budget, the Plan's Board of Trustees, and the Plan's Executive ~~Administrator, and the Committee on Employee Hospital and Medical Benefits~~ Administrator solely and exclusively for their use in the furtherance of their duties and responsibilities, and to the Department of Health and Human Services solely for the purpose of implementing the transition of NC Health Choice from the Plan to the Department of Health and Human Services. The design, adoption, and implementation of the preferred provider contracts, networks, and optional alternative comprehensive health benefit plans, and programs available under the optional alternative plans, as authorized under G.S. 135-45 are not subject to the requirements of Article 3 of Chapter 143 of the General Statutes. The Executive Administrator and Board of Trustees shall make reports as requested to the President of the Senate, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the ~~Committee on Employee Hospital and Medical Benefits.~~ Commissioner of Insurance."

SECTION 3. G.S. 135-43.1 is repealed.

SECTION 4. G.S. 135-43.2 is repealed.

SECTION 5. G.S. 135-43.3 reads as rewritten:

"**§ 135-43.3. ~~Oversight team.~~ Oversight.**

(a) ~~The Committee on Employee Hospital and Medical Benefits may use employees of the Legislative Services Office and may employ contractual services as approved by the Legislative Services Commission to monitor the Executive Administrator and Board of Trustees, the Claims Processor, and the Comprehensive Major Medical Plan [State Health Plan for Teachers and State Employees].~~ The Director of the Budget may use employees of the Office of State Budget and Management to monitor the Executive Administrator and Board of Trustees, the Claims Processor, and the Comprehensive Major Medical Plan [State Health Plan for Teachers and State Employees]. ~~Employees authorized by the Legislative Services Commission and the Director of the Budget to provide assistance to the Committee on Employee Hospital and Medical Benefits and to the Director of the Budget shall comprise an oversight team.~~

(b) The ~~oversight team shall, jointly or individually,~~ Director of the Budget and Commissioner of Insurance or their designees shall have access to all records of the Board of Trustees, the Executive Administrator, the Claims Processor, and the Plan. The ~~oversight team shall, jointly or individually,~~ Director of the Budget and Commissioner of Insurance or their designees shall be entitled to attend all meetings of the Board of Trustees.

~~(c) The oversight team shall report to the Committee on Employee Hospital and Medical Benefits when requested by the Committee.~~"

SECTION 6. G.S. 135-43.6 reads as rewritten:

"**§ 135-43.6. Reports to the General Assembly.**

The Executive Administrator and Board of Trustees shall report to the General Assembly at such times and in such forms as shall be designated by ~~the Committee on Employee Hospital and Medical Benefits.~~ the President of the Senate, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives."

SECTION 7. G.S. 135-44.2(b) reads as rewritten:

"**§ 135-44.2. Executive Administrator.**

(b) The Executive Administrator shall be appointed by the ~~State Health Plan Administrative Commission.~~ Commissioner of Insurance. The term of employment and salary of the Executive Administrator shall be set by the ~~State Health Plan Administrative Commission~~ Commissioner of Insurance. ~~upon the advice of an executive committee of the Committee on Employee Hospital and Medical Benefits.~~

The Executive Administrator may be removed from office by the ~~State Health Plan Administrative Commission,~~ Commissioner of Insurance, ~~upon the advice of an executive committee of the Committee on Employee Hospital and Medical Benefits,~~ and any vacancy in the office of Executive Administrator may be filled by the ~~State Health Plan Administrative Commission~~ Commissioner of Insurance. ~~with the term of employment and salary set upon the advice of an executive committee of the Committee on Employee Hospital and Medical Benefits.~~"

SECTION 8. G.S. 135-44.7(a) reads as rewritten:

"**§ 135-44.7. Administrative review.**

(a) If, after exhaustion of internal appeal handling as outlined in the contract with the Claims Processor any person is aggrieved, the Claims Processor shall bring the matter to the attention of the Executive Administrator and Board of Trustees, which shall promptly decide whether the subject matter of the appeal is a determination subject to external review under Part 4 of Article 50 of Chapter 58 of the General Statutes. The Executive Administrator and Board of Trustees shall inform the aggrieved person and the aggrieved person's provider of the decision and shall provide the aggrieved person notice of the aggrieved person's right to appeal that decision as provided in this subsection. If the Executive Administrator and Board of

Trustees decide that the subject matter of the appeal is not a determination subject to external review, then the Executive Administrator and Board of Trustees may make a binding decision on the matter in accordance with procedures established by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written summary of the decisions made pursuant to this section to all employing units, all health benefit representatives, the oversight ~~team~~ agencies provided for in G.S. 135-43.3, all relevant health care providers affected by a decision, and to any other parties requesting a written summary and approved by the Executive Administrator and Board of Trustees to receive a summary immediately following the issuance of a decision. A decision by the Executive Administrator and Board of Trustees that a matter raised on internal appeal is a determination subject to external review as provided in subsection (b) of this section may be contested by the aggrieved person under Chapter 150B of the General Statutes. The person contesting the decision may proceed with external review pending a decision in the contested case under Chapter 150B of the General Statutes."

SECTION 9. G.S. 135-44.8 reads as rewritten:

"**§ 135-44.8. Rules.**

The Executive Administrator and Board of Trustees may adopt rules to implement Parts 2, 3, 4, and 5 of this Article. The Executive Administrator and Board of Trustees shall provide to all employing units, all health benefit representatives, the oversight ~~team~~ agencies provided for in G.S. 135-43.3, all relevant health care providers affected by a rule, and to any other persons requesting a written description and approved by the Executive Administrator and Board of Trustees written notice and an opportunity to comment not later than 30 days prior to adopting, amending, or rescinding a rule, unless immediate adoption of the rule without notice is necessary in order to fully effectuate the purpose of the rule. Rules of the Board of Trustees shall remain in effect until amended or repealed by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written description of the rules adopted under this section to all employing units, all health benefit representatives, the oversight ~~team~~ agencies provided for in G.S. 135-43.3, all relevant health care providers affected by a rule, and to any other persons requesting a written description and approved by the Executive Administrator and Board of Trustees on a timely basis. Rules adopted by the Executive Administrator and Board of Trustees to implement this Article are not subject to Article 2A of Chapter 150B of the General Statutes."

SECTION 10. This act becomes effective July 1, 2011.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: Proposed Committee Substitute to HB 2055 (H2055-CSME-15 [v.3])

SHORT TITLE: State Health Plan/ Local Govt Retiree Contrib.

SPONSOR(S): Representative England

SYSTEM OR PROGRAM AFFECTED: Retiree Health Benefit Fund, a trust fund authorized under G.S. 135-7(f). The Retiree Health Benefit fund receives payroll contributions from employing units and uses those contributions, plus investment earnings, to pay for non-contributory health benefit coverage of eligible retired employees.

BILL SUMMARY: The Proposed Committee Substitute to House Bill 2055 forgives a liability owed by Rutherford County, a local government authorized to be an employing unit under the State Health Plan, to the State's Retiree Health Benefit Fund. The amount of the liability to be forgiven is equal to the net of the total payroll contributions owed by the County to the Fund for the period July 1, 2005 through June 30, 2008 minus the aggregate premium contributions paid by the County to the State Health Plan for its covered retirees during the same period of time.

EFFECTIVE DATE: July 1, 2010

ESTIMATED IMPACT ON STATE:

Aon Consulting, consulting actuary for the State Health Plan for Teachers and State Employees, and Hartman and Associates, consulting actuary for the General Assembly's Fiscal Research Division, each estimate the bill will have no impact on the State Health Plan, but would result in the State's Retiree Health Benefit Fund not collecting an estimated $1.09 million in net payroll contributions and lost investment earnings.

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Each consulting actuary, based on data provided by the Retirement Systems Division of the Department of State Treasurer, assumed the amount of payroll contributions owed by Rutherford County for the period equaled $1,501,953. Payroll contributions deposited to the Retiree Health Benefit Fund are invested in the State's Short-term Investment Fund. Therefore, each actuary then estimated the lost investment earnings on the funds owed by Rutherford County from July 1, 2005 through June 30, 2009 based on actual earnings in the Short-term Investment Fund, and then a projected return through June 30, 2010 based on actual returns under the Fund through March 30, 2010. The amount of lost investment earnings is projected to be $122, 410 by Hartman and Associates, and $126,975. The difference is due to a slightly different projected investment return for the period July 1, 2009 through June 30, 2010.

As an offset to the payroll contributions and interest owed, each consulting actuary credited the amount paid by the County in premium contributions to the State Health Plan during the affected period by $539,363 as reported by the Plan.

Retiree Health Benefit Fund: Through May 31, 2010, the Retiree Health Benefit Fund had an ending cash balance of $556.7 million. Year-to-date average monthly payroll contributions have equaled $56.1 million with average monthly investment earnings of $708,955. Total monthly contributions plus investment earnings have averaged $56.8 million through May 31, 2010. Average monthly disbursements from the Fund for the same period were $47.7 million with average monthly administrative charges of $24,055. On average, through May 31, 2010, the Fund has averaged a net monthly gain of $9.1 million.

Other Post Employment Benefits: The amount of annual payroll contributions to the Fund is projected to be $673.2 million based on actual results through May 31, 2010 and a payroll contribution rate of 4.5% of payroll. According to the most recent Other Post Employment Benefit actuarial valuation of retiree health care liabilities for the State as of December 2008, the State's Unfunded Actuarial Accrued Liability for retiree healthcare obligations is projected to be $27.9 billion over a 30-year period. The Annual Required Contribution for the State to fund this obligation on an actuarial basis over a 30-year period is projected to be $2.7 billion, or 17.5% of payroll.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2009, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total *revised* requirements for the Plan are estimated to be $2.55 billion for FY 2009-10 and $2.74 billion for FY 2010-11. The Plan's PPO benefit design includes two alternative benefit levels listed below:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums; and

2) The "Standard" 80/20 plan.

The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under both plans is offered on a fully contributory basis.

Financial Condition

Revised Financial Projection 2009-11 Biennium – The following summarizes a revised financial projection by conducted by the Plan's consulting actuary, Aon Consulting, for the 2009-11 biennium. The

information is provided by fiscal year based on year-to-date financial experience (through March 2010) and other updated factors.

For the fiscal year beginning July 1, 2009, the Plan began its operations with a beginning cash balance of $189.9 million. Receipts for the year are projected to be $2.41 billion from net premium collections, $74.4 million from Medicare Part D subsidies, and $3.4 million from investment earnings for a total of approximately $2.49 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.39 billion in net claim-payment expenses and $164.1 million in administration and claims-processing expenses for projected total expenses of nearly $2.55 billion for FY 2009-10. The Plan's net operating loss is projected to be approximately $66.3 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan is projected to begin its operations with a beginning cash balance of $123.6 million. Receipts for the year are projected to be $2.68 billion from net premium collections, $56.1 million from Medicare Part D subsidies, and $2.7 million from investment earnings for a total of approximately $2.73 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.55 billion in net claim-payment expenses and $191.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.74 billion for FY 2010-11. The Plan's net operating loss is projected to be approximately $7.1 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Based on the revised financial projection (May 2010), the Plan's estimated ending cash balance on June 30, 2011 is projected to be $116.5 million. This amount is approximately $75.7 million less than the originally projected (April 2009) ending cash balance of $192.2 million.

Original Financial Projection 2009-11 Biennium (April 2009) – Session Law 2009-16 (Senate Bill 287) appropriated funds from various sources, authorized annual premium rate increases, made various benefit and provider related changes to achieve financial savings, and directed other various changes to the Plan. The enacted law also appropriated the sum of $250 million from the Savings Reserve Account ("Rainy Day Fund") of the General Fund for the 2008-09 fiscal year. The following summarizes the original financial projection by fiscal year for the 2009-11 biennium and assumes the changes enacted in Session Law 2009-16 (Senate Bill 287).

For the fiscal year beginning July 1, 2009, the Plan was projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year were projected to be $2.4 billion from net premium collections, $56.3 million from Medicare Part D subsidies, and $8.0 million from investment earnings for a total of approximately $2.5 billion in receipt income for the year. Projected disbursements from the Plan were expected to be $2.3 billion in net claim-payment expenses and $185.6 million in administration and claims-processing expenses for projected total expenses of nearly $2.5 billion for FY 2009-10. The Plan's net operating income was projected to be approximately $14.8 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan was projected to begin its operations with a beginning cash balance of $161.6 million. Receipts for the year were projected to be $2.7 billion from net premium collections, $50.4 million from Medicare Part D subsidies, and $8.8 million from investment earnings for a total of approximately $2.7 billion in receipt income for the year. Projected disbursements from the Plan were expected to be $2.5 billion in net claim-payment expenses and $191.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.7 billion for FY 2010-11. The Plan's net operating income was projected to be approximately $30.6 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Other Information

Historically, the Plan has applied a premium increase in October of the first fiscal year of a biennium. However, the annual premium increases authorized in Session Law 2009-16 (Senate Bill 287) changes that methodology to an annual increase at the beginning of each fiscal year of the 2009-11 biennium.

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment as of December 31, 2009

I. No. of Participants	Basic	Standard	Total	Percent of Total
Actives				
Employees	13,830	307,541	321,371	48.6%
Dependents	24,593	135,563	160,156	24.2%
Sub-total	38,423	443,104	481,527	72.8%
Retired				
Employees	2,074	151,395	153,469	23.2%
Dependents	1,313	18,075	19,388	2.9%
Sub-total	3,387	169,470	172,857	26.1%
Former Employees with Continuation Coverage				
Employees	121	3,120	3,241	0.5%
Dependents	87	749	836	0.1%
Sub-total	208	3,869	4,077	0.6%
Firefighters, Rescue Squad & National Guard				
Employees	-	5	5	0.0%
Dependents	-	3	3	0.0%
Sub-total	-	8	8	0.0%
Local Governments				
Employees	91	1,829	1,920	0.3%
Dependents	174	777	951	0.1%
Sub-total	265	2,606	2,871	0.4%
Total				
Employees	16,116	463,885	480,001	72.6%
Dependents	26,167	155,164	181,331	27.4%
Grand Total	**42,283**	**619,049**	**661,332**	**100%**
Percent of Total	**6.4%**	**93.6%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Total
Employee Only	3,252	378,539	381,791
Employee Child(ren)	6,026	43,820	49,846
Employee Spouse	2,550	21,785	24,335
Employee Family	4,288	19,741	24,029
Total	**16,116**	**463,885**	**480,001**

Percent Enrollment by Contract	Basic	Standard	Total
Employee Only	20.2%	81.6%	79.5%
Employee Child(ren)	37.4%	9.4%	10.4%
Employee Spouse	15.8%	4.7%	5.1%
Employee Family	26.6%	4.3%	5.0%
Total	**100.0%**	**100.0%**	**100.0%**

III. Enrollment by Sex	Basic	Standard	Total
Female	22,479	390,209	412,688
Male	19,804	228,840	248,644
Total	**42,283**	**619,049**	**661,332**

Percent Enrollment by Sex	Basic	Standard	Total
Female	53.2%	63.0%	62.4%
Male	46.8%	37.0%	37.6%
Total	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Total
19 & Under	17,315	95,431	112,746
20 to 29	3,311	57,142	60,453
30 to 44	9,555	120,292	129,847
45 to 54	6,455	108,447	114,902
55 to 64	4,090	128,933	133,023
65 & Over	1,557	108,804	110,361
Total	**42,283**	**619,049**	**661,332**

Percent Enrollment by Age	Basic	Standard	Total
19 & Under	41.0%	15.4%	17.0%
20 to 29	7.8%	9.2%	9.1%
30 to 44	22.6%	19.4%	19.6%
45 to 54	15.3%	17.5%	17.4%
55 to 64	9.7%	20.8%	20.1%
65 & Over	3.7%	17.6%	16.7%
Total	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	51,747	11,879	63,626
Medicare Eligible	101,722	7,509	109,231
Total	**153,469**	**19,388**	**172,857**

VI. Enrollment By Major Employer Groups	Employees	Dependents	Total
State Agencies	75,367	34,645	110,012
UNC System	50,106	29,726	79,832
Local Public Schools	181,270	88,258	269,528
Local Community Colleges	14,623	7,524	22,147
Other			
Local Goverments	1,920	951	2,871
COBRA	3,241	836	4,077
Nat. Guard, Fire & Rescue	5	3	8
Sub-total	5,166	1,790	6,956
Retirement System	153,469	19,388	172,857
Total	**480,001**	**181,331**	**661,332**

Percent Enrollment by Major Employer Groups	Employees	Dependents	Total
State Agencies	15.7%	19.1%	16.6%
UNC System	10.4%	16.4%	12.1%
Local Public Schools	37.8%	48.7%	40.8%
Local Community Colleges	3.0%	4.1%	3.3%
Other			
Local Goverments	0.4%	0.5%	0.4%
COBRA	0.7%	0.5%	0.6%
Nat. Guard, Fire & Rescue	0.0%	0.0%	0.0%
Sub-total	1.1%	1.0%	1.1%
Retirement System	32.0%	10.7%	26.1%
Total	100.0%	100.0%	100.0%

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, "House Bill 2055 Proposed Committee Substitute H2055-CSME-15 [v.3]; An Act to Provide That a Local Government That Has Been Submitting Premium Payments For Its Employees to the State Health Plan Is Not Liable For Contributions Owed to the Retiree Health Benefit Fund for a Specified Period", June 14, 2010, an original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "House Bill 2055 Proposed Committee Substitute H2055-CSME-15 [v.3]",June 16, 2010, an original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Marilyn Chism, Director
Fiscal Research Division

DATE: June 17, 2010

NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

HOUSE BILL 2055
PROPOSED COMMITTEE SUBSTITUTE H2055-CSME-15 [V.3]

STATE HEALTH PLAN / LOCAL GOVERNMENT RETIREE CONTRIBUTIONS

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30305

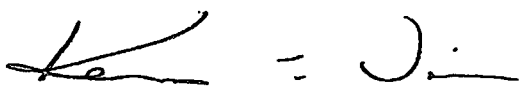
June 2010

ACTUARIAL STATEMENT

The North Carolina State Health Plan for Teachers and State Employees has requested that Aon Consulting prepare an Actuarial Note in response to House Bill 2055 Proposed Committee Substitute H2055-CSME-15 [v.3] entitled "An Act To Provide That A Local Government That Has Been Submitting Premium Payments For Its Employees To The State Health Plan For Teachers And State Employees Is Not Liable For Contributions Owed To The Retiree Health Benefit Fund For A Specified Period."

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and the Retirement System.



June 16, 2010

Kenneth C. Vieira, F.S.A., M.A.A.A.
Senior Vice President

Date

June 16, 2010

Kirsten R. Schatten, A.S.A., M.A.A.A.
Assistant Vice President

Date

STATE HEALTH PLAN / LOCAL GOVERNMENT RETIREE CONTRIBUTIONS

PLAN CHANGES

The proposed legislation discharges the liability for contributions owed to the Retiree Health Benefit Fund for a local government. This proposed legislation has no impact on the State Health Plan, but provides for a loss to the Retiree Health Benefit Fund. The full text of the bill is attached to this actuarial note.

PROJECTED COSTS

Change to Retiree Health Benefit Fund	Liability As of July 1, 2010
Discharge liability for contributions owed	$1,089,565

PRICING APPROACH AND COMMENTS

The following information was compiled and utilized in determining the projected costs associated with the component addressed in this actuarial note:

- The proposed legislation has no impact on the State Health Plan.
- Aon has quantified the loss to the Retiree Health Benefit Fund, owned by the Retirement System, based on the proposed legislation.
- Payroll contributions owed for the time period July 2005 through June 2008 by month were provided to Aon by the Retirement Systems Division.
- Premiums Paid to State Health Plan for the time period July 2005 through June 2008 by month were provided to Aon by the State Health Plan.
- Investment returns that would have accrued on payroll contributions owed were provided in The State Treasurer's Annual Report for the Treasurer's Short-Term Investment Fund for fiscal years 2006 through 2009.
- Year-to-date investment returns for the Treasurer's Short-Term Investment Fund for fiscal year 2010 were provided in the Treasurer's quarterly report for the period ended March 31, 2010. Aon annualized this return to estimate a fiscal year return as of July 1, 2010.
- Aon calculated the net difference between contributions owed and premiums paid by month and accumulated with interest to July 1, 2010.
- We assumed all contributions owed and premiums paid occurred at the beginning of each month.
- The resulting liability for the period July 1, 2005 through June 30, 2008 as of July 1, 2010 is $1,089,565.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 2055*
PROPOSED COMMITTEE SUBSTITUTE H2055-CSME-15 [v.3]

6/10/2010 10:42:47 AM

Short Title: State Health Plan/ Local Govt Retiree Contrib. (Local)

Sponsors:

Referred to:

May 27, 2010

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT A LOCAL GOVERNMENT THAT HAS BEEN SUBMITTING PREMIUM PAYMENTS FOR ITS EMPLOYEES TO THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES IS NOT LIABLE FOR CONTRIBUTIONS OWED TO THE RETIREE HEALTH BENEFIT FUND FOR A SPECIFIED PERIOD.

The General Assembly of North Carolina enacts:

SECTION 1. This act applies to Rutherford County only.

SECTION 2. Notwithstanding Section 31.26(b) of S.L. 2004-124, a local government that was approved to participate in the Teachers' and State Employees' Comprehensive Major Medical Plan ("Plan") (predecessor plan to the State Health Plan for Teachers and State Employees) effective July 1, 2004, and that has been making contributions to the Plan for its active and retired employees based on active employee contribution rates, is not liable for the amount of contributions owed to the Retiree Health Benefit Fund under GS 135-7(f) that represents the difference between the contribution rate owed under S.L. 2004-124 and the amount actually paid to the Plan for local government retiree coverage.

SECTION 3. This act becomes effective July 1, 2010, and applies only to retirement contributions owing for the period July 1, 2005, through June 30, 2008.

HARTMAN & ASSOCIATES, LLC

ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

hartman@triad.rr.com

Phone: (336) 731-4038
Fax: (336) 731-2583

668 Link Road
Lexington, NC 27295

June 14, 2010

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: House Bill 2055 Proposed Committee Substitute H2055-CSME-15 [v.3]: An Act to Provide That a Local Government That Has Been Submitting Premium Payments For Its Employees to the State Health Plan Is Not Liable For Contributions Owed to the Retiree Health Benefit Fund for a Specified Period

Dear Mr. Trogdon:

The proposed committee substitute to this bill provides that notwithstanding Section 31.26(b) of S.L. 2004-124, a local government that was approved to participate in the State Health Plan and that has been making contributions to the Plan for its retired members, is not liable for contributions owed to the Retiree Health Benefit Fund under G.S. 135-7(f). This act applies only to Rutherford County. This act is effective July 1, 2010 and applies to retirement contributions owing for the period July 1, 2005 through June 30, 2008.

This bill will have no impact on the Plan since the Plan received the actual premium payments. The bill will create a loss to the Retiree Health Benefit Fund for the difference in the amount of required contributions to the Fund and the premiums paid to the Plan. Including loss of investment income, I have calculated the loss to the Retiree Health Benefit Fund at $1,085,000.

This calculation is based on data from the Plan showing total premiums paid by the County for retirees of $539,363, data from the Retirement Systems Division showing required payroll contributions to the Fund of $1,501,953, and investment returns from the State Treasurer's Annual Report for the Short Term Investment Fund.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, FCA, EA
Consulting Actuary

MVH/mt

HOUSE BILL 2055:
State Health Plan/ Local Govt Retiree Contrib

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Pensions and Retiremcnt	**Date:**	June 16, 2010
Introduced by:	Rep. England	**Prepared by:**	Tim Hovis Committee Counsel
Analysis of:	PCS to First Edition H2055-CSME-15		

SUMMARY: The Proposed Committee Substitute for House Bill 2055 provides that a local government that elects to participate and make contributions to the State Health Plan for its active and retired employees is not liable for the difference between required contributions to the Retiree Health Benefit Fund and the amount actually paid for retiree coverage.

House Bill 2055 applies to Rutherford County only.

[As introduced, this bill was identical to S1423, as introduced by Sen. Clary, which is currently in Senate Pensions & Retirement & Aging.]

BACKGROUND: S.L. 2004-124, Section 31.26(b) requires a local government electing to cover its retired employees in the State Health Plan to make contributions on account of its retired employees, including contributions to the Retiree Health Benefit Fund. The Fund, established under G.S. 135-7, consists of accumulated contributions from employers to provide health benefits to retired and disabled employees. The Board of Trustees Teachers' and State Employees' Retirement System is trustee of the Fund.

EFFECTIVE DATE: House Bill 2055 becomes effective July 1, 2010 and applies only to contributions owing for the period July 1, 2005 through June 30, 2008.

H2055-SMRG-112(CSME-15) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 2055*
PROPOSED COMMITTEE SUBSTITUTE H2055-CSME-15 [v.3]

6/10/2010 10:42:47 AM

Short Title: State Health Plan/ Local Govt Retiree Contrib. (Local)

Sponsors:

Referred to:

May 27, 2010

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT A LOCAL GOVERNMENT THAT HAS BEEN SUBMITTING PREMIUM PAYMENTS FOR ITS EMPLOYEES TO THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES IS NOT LIABLE FOR CONTRIBUTIONS OWED TO THE RETIREE HEALTH BENEFIT FUND FOR A SPECIFIED PERIOD.

The General Assembly of North Carolina enacts:

SECTION 1. This act applies to Rutherford County only.

SECTION 2. Notwithstanding Section 31.26(b) of S.L. 2004-124, a local government that was approved to participate in the Teachers' and State Employees' Comprehensive Major Medical Plan ("Plan") (predecessor plan to the State Health Plan for Teachers and State Employees) effective July 1, 2004, and that has been making contributions to the Plan for its active and retired employees based on active employee contribution rates, is not liable for the amount of contributions owed to the Retiree Health Benefit Fund under GS 135-7(f) that represents the difference between the contribution rate owed under S.L. 2004-124 and the amount actually paid to the Plan for local government retiree coverage. only change

SECTION 3. This act becomes effective July 1, 2010, and applies only to retirement contributions owing for the period July 1, 2005, through June 30, 2008.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 2055 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT A LOCAL GOVERNMENT THAT HAS BEEN SUBMITTING PREMIUM PAYMENTS FOR ITS EMPLOYEES TO THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES IS NOT LIABLE FOR CONTRIBUTIONS OWED TO THE STATE RETIREMENT SYSTEM FOR A SPECIFIED PERIOD.

☒ With a favorable report as to the committee substitute bill, which changes the title, unfavorable as to the original bill, and recommendation that the committee substitute bill be re-referred to the Committee on PENSIONS AND RETIREMENT.

(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.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 1193*
Health Care Committee Substitute Adopted 6/3/10
PROPOSED HOUSE COMMITTEE SUBSTITUTE S1193-CSRC-71 [v.2]

6/17/2010 9:10:30 AM

Short Title: Implement LTC Partnership Program. (Public)

Sponsors:

Referred to:

May 18, 2010

A BILL TO BE ENTITLED

AN ACT TO IMPLEMENT THE LONG-TERM CARE PARTNERSHIP PROGRAM, TO ENSURE THAT NORTH CAROLINA'S LONG-TERM CARE INSURANCE LAWS COMPORT WITH THE LONG-TERM CARE PARTNERSHIP PROVISIONS IN THE FEDERAL DEFICIT REDUCTION ACT OF 2005, AND TO AUTHORIZE THE SHARING OF CONFIDENTIAL INFORMATION BETWEEN THE NORTH CAROLINA DEPARTMENT OF INSURANCE, ENTITIES THAT CONTRACT WITH THE FEDERAL GOVERNMENT, AND OTHER GOVERNMENTAL AGENCIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. Part 6, Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-70.4. Long-Term Care Partnership Program.**

(a) The following definitions apply in this section:

(1) Asset. – Resources and income.

(2) Department. – The Department of Health and Human Services.

(3) Division. – The Division of Medical Assistance.

(4) Estate recovery. – The placing of a statutory claim on the estate of a deceased Medicaid recipient, as provided by G.S. 108A-70.5.

(5) Medicaid. – The federal medical assistance program established under Title XIX of the Social Security Act.

(6) Qualified long-term care partnership policy or qualified policy. – A long-term care insurance policy approved for use in North Carolina and that meets all the requirements of the federal Deficit Reduction Act of 2005, P.L. 109-171.

(7) Resource. – Cash or its equivalent and real or personal property that is available to an applicant or recipient.

(8) Resource disregard. – The amount of resources of an applicant for long-term care Medicaid that is equal to the amount of benefits paid to the applicant under a qualified long-term care partnership policy.

(9) Resource protection. – An amount equal to the resource disregard given to a Medicaid recipient during the long-term care Medicaid eligibility determination process.

(b) There is established the North Carolina Long-Term Care Partnership Program (Partnership Program) to be administered by the Division with assistance from the Department of Insurance. The Partnership Program shall:

(1) Provide a mechanism for individuals to qualify for coverage of the cost of their long-term care needs under Medicaid without first being required to substantially exhaust their resources.

(2) Provide counseling services to individuals planning for their long-term care needs.

(3) Reduce the financial burden on the State medical assistance program by encouraging individuals to obtain private long-term care insurance.

(c) Under the Partnership Program, the Department shall:

(1) Provide resource disregard to an applicant for long term-care Medicaid who has received benefits under a qualified long-term care partnership policy. The amount of the resource disregard shall be equal to the total insurance benefits paid to the individual under a qualified policy after the implementation of the Partnership Program and prior to the individual's first application for long-term care Medicaid.

(2) Provide resource protection by reducing any subsequent recovery by the State under G.S. 108A-70.5 from a deceased recipient's estate for payment of Medicaid paid services by the amount of resource disregard given under subdivision (1) of this subsection.

(d) The Department shall adopt rules and amendments to the State Plan to allow for resource disregard at long-term care Medicaid eligibility determination and resource protection at estate recovery. The Department and the Department of Insurance shall adopt rules to implement the provisions of the Partnership Program and to provide for its administration.

(e) Effective January 1, 2011, or 60 days after approval of the Medicaid State Plan amendment, whichever is later, a qualified long-term care partnership policy shall be accompanied by a Partnership Disclosure Notice detailing in plain language the current law pertaining to the Partnership Program, resource disregard, and resource protection.

(f) The Department may enter into a reciprocal agreement with other states that enter into a national reciprocity agreement to extend the resource disregard and resource protection to residents of the State who purchased, or purchased and used, a qualified long-term care policy in another state.

(g) G.S. 108A-70.5 applies to the estate of an individual who received benefits under a qualified long-term care partnership policy."

SECTION 2. G.S. 108A-70.5 reads as rewritten:

"**§ 108A-70.5. Medicaid Estate Recovery Plan.**

(a) There is established in the Department of Health and Human Services, the Medicaid Estate Recovery Plan, as required by the Omnibus Budget Reconciliation Act of 1993, to recover from the estates of recipients of medical assistance an equitable amount of the State and federal shares of the cost paid for the recipient. The Department shall administer the program in accordance with applicable federal law and regulations, including those under Title XIX of the Social Security Act, 42 U.S.C. § 1396(p).

(b) ~~As used in this section:~~The following definitions apply in this section:

(1) ~~"Medical assistance" means medical~~ Medical assistance. – Medical care services paid for by the North Carolina Medicaid Program on behalf of the recipient:

a. If the recipient of any age is receiving medical care services as an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and cannot reasonably be expected to be discharged to return home; or

b. If the recipient is 55 years of age or older and is receiving one or more of the following medical care services:
1. Nursing facility services.
2. Home and community-based services.
3. Hospital care.
3a. Prescription drugs.
4. Personal care services.
5 through 9. Repealed by Session Laws 2007-442, s. 1, effective August 23, 2007.

(2) ~~"Estate" means all~~ Estate. – All the real and personal property considered assets of the estate available for the discharge of debt pursuant to G.S. 28A-15-1. For individuals who have received benefits under a qualified long-term care partnership policy as described in G.S. 108A-70.4, "estate" also includes any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(3) Repealed by Session Laws 2007-442, s. 1, effective August 23, 2007.

(c) The amount the Department recovers from the estate of any recipient shall not exceed the amount of medical assistance made on behalf of the recipient and shall be recoverable only for medical care services prescribed in subsection (b) of this section. The Department is a fifth-class creditor, as prescribed in G.S. 28A-19-6, for purposes of determining the order of claims against an estate; provided, however, that judgments in favor of other fifth-class creditors docketed and in force before the Department seeks recovery for medical assistance shall be paid prior to recovery by the Department.

(d) The Department of Health and Human Services shall adopt rules pursuant to Chapter 150B of the General Statutes to implement the Plan, including rules to waive whole or partial recovery when this recovery would be inequitable because it would work an undue hardship or because it would not be administratively cost-effective and rules to ensure that all recipients are notified that their estates are subject to recovery at the time they become eligible to receive medical assistance.

(e) Repealed by Session Laws 2007-442, s. 1, effective August 23, 2007."

SECTION 3. Article 55 of Chapter 58 of the General Statutes is amended by designating G.S. 58-55-1 through G.S. 58-55-50 as "Part 1. General Provisions."

SECTION 4. Article 55 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 2. Long-Term Care Partnership.

"**§ 58-55-55. Definitions.**

The following definitions apply in this section:

(1) Asset. – Resources and income.

(2) Department. – The Department of Health and Human Services.

(3) Division. – The Division of Medical Assistance.

(4) Estate recovery. – The placing of a statutory claim on the estate of a deceased Medicaid recipient, as provided by G.S. 108A-70.5.

(5) Medicaid. – The federal medical assistance program established under Title XIX of the Social Security Act.

(6) Qualified long-term care partnership policy or qualified policy. – A long-term care insurance policy approved for use in North Carolina and that meets all the requirements of the federal Deficit Reduction Act of 2005, P.L. 109-171.

(7) Resource. – Cash or its equivalent and real or personal property that is available to an applicant or recipient.

(8) Resource disregard. – The amount of resources of an applicant for long-term care Medicaid that is equal to the amount of benefits paid to the applicant under a qualified long-term care partnership policy.

(9) Resource protection. – An amount equal to the resource disregard given to a Medicaid recipient during the long-term care Medicaid eligibility determination process.

"**§ 58-55-60. Qualified long-term care partnership policy.**

A qualified long-term care partnership policy is a long-term care insurance policy or a certificate issued under a group long-term care insurance policy that satisfies all of the following requirements:

(1) The policy meets the requirements for a qualified long-term care insurance contract, as defined in section 7702B of the Internal Revenue Code of 1986 (26 U.S.C. § 7702B(b)).

(2) The effective date of the coverage is on or after January 1, 2011, or 60 days after approval of the Medicaid State Plan amendment, whichever is later.

(3) The policy covers an insured who was a resident of North Carolina or another reciprocal partnership state when coverage first became effective under the policy.

(4) The policy meets the federal consumer protection requirements of section 1917(b) of the Social Security Act as amended by section 6021(a) of the Deficit Reduction Act of 2005, P.L. 109-171 of the Social Security Act (42 U.S.C. § 1396p(b)(5)(A)).

(5) The policy is issued with and retains inflation protection coverage which meets the inflation standards based on the insured's then attained age as defined in sub-subdivisions a., b., and c. below:

a. Policies or certificates issued to an individual who is under 61 years old must provide compound annual inflation protection.

b. Policies or certificates issued to an individual who is 61 to 76 years old must provide some level of inflation protection. This may include simple interest or compound inflation protection.

c. For purchasers 76 years old or older, inflation protection may be offered but is not required.

Notwithstanding the above, purchasers of qualified long-term care insurance policies may adjust their inflation protection as they age. However, their policies shall continue to be qualified long-term care insurance policies as long as the inflation protection in the qualified policies continues to meet the minimum requirements for the insured's attained age.

(6) The policy states that it is intended to be a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.

(7) A qualified policy issued, executed, and delivered in North Carolina shall be accompanied by a Partnership Disclosure Notice explaining the benefits associated with a qualified policy and indicating that at the time issued, the policy is a qualified long-term care insurance partnership policy in North Carolina. The Partnership Disclosure Notice shall also include a statement indicating that by purchasing this partnership policy, the insured does not automatically qualify for Medicaid. Notices providing additional information may be used in conjunction with the Partnership Disclosure Notice described in this section if filed and approved by the Commissioner. The Notice shall state the following in at least 12-point font:

"Partnership Policy Status: Your long-term care insurance policy is intended to qualify as a Partnership Policy under the North Carolina Long-Term Care Partnership Program as of your policy's effective date. For Medicaid applicants applying for help with the cost of long-term care, this means that an amount of your resources equal to the dollar amount of long-term care insurance benefits paid to you or on your behalf under this policy may be disregarded for purposes of determining your eligibility for long-term care Medicaid and from any subsequent recovery by the State from your estate for payment of Medicaid paid services. The amount that may be disregarded at eligibility will be equal to the amount of the long-term care partnership benefits paid out prior to the time you apply for long-term care Medicaid. As a result, you may qualify for coverage of the cost of your long-term care needs under Medicaid without first being required to substantially exhaust your personal resources. The amount that may be protected from recover by the State from your estate will be equal to the amount disregarded for purposed of eligibility for long-term care Medicaid. If you are already a recipient of long-term care Medicaid, this policy will not allow a resource disregard or estate recovery resource protection. The purchase of a Partnership Policy does not automatically qualify you for Medicaid.

Please note that this policy may lose long-term care partnership program status if you move to a different state that does not recognize North Carolina's Long-Term Care.Partnership Program or you modify this policy after issuance. This policy may also lose long-term care partnership program status due to changes in federal or state laws.

If you have questions regarding long-term care insurance and the North Carolina Long-Term Care Partnership Program, you may contact the Seniors' Health Insurance Information Program of the Department of Insurance at 1-800-443-9354."

In the case of a group insurance contract, this Partnership Disclosure Notice shall be provided to the insured upon the issuance of the certificate. The insurer shall include in that Notice that the amount of the insured's resources that may be disregarded at eligibility will be equal to the amount of qualified long-term care partnership policy benefits paid prior to the time the insured applied for long-term care Medicaid. The insurer shall also include in the notice a warning to the insured that the policy may lose long-term care partnership program status if the insured moves to another state that does not recognize North Carolina's Long-Term Care Partnership Program, or if the policy is modified after issuance.

(8) When the insured's remaining lifetime maximum benefit is equal to 90 times the current daily benefit, or three times the current monthly benefit, the insurer shall notify the insured in writing advising the insured to go to the local department of social services to apply for Medicaid if the insured had not already done so.

"**§ 58-55-65. Compliance with federal regulations.**

(a) The Commissioner may adopt rules to conform long-term care policies and certificates to the requirements of federal law and regulations, including any changes required by Congress or the U.S. Department of Health and Human Services, or any successor agencies.

(b) The tax-qualified long-term care provisions required of the Health Insurance Portability and Accountability Act of 1996, including subsequent amendments and editions, are hereby incorporated into Article 55 of Chapter 58 of the General Statutes.

(c) The long-term care partnership provisions required of the Deficit Reduction Act of 2005, including subsequent amendments and editions, are hereby incorporated into Article 55 of Chapter 58 of the General Statutes.

"**§ 58-55-70. Disclosure notices.**

(a) Prior to making a change requested by the policyholder to a qualified long-term care partnership policy that would result in the loss to the policy of qualified policy status, the insurer shall provide to the policyholder a written explanation within 30 calendar days of how this action would affect the insured and shall obtain the insured's signature indicating consent to the change.

(b) If a qualified long-term care partnership policy subsequently loses qualified policy status, the insurer shall explain in writing within 30 calendar days to the policyholders the reason for the loss of status.

(c) The disclosures required in this section shall be provided to any insured who exchanges a policy for a qualified long-term care partnership policy.

"**§ 58-55-75. Exchange of long-term care policies for long-term care partnership policies.**

An insurer shall offer, on a onetime basis, in writing, to all existing policyholders that were issued a long-term care policy on or after February 8, 2006, the option to exchange their existing long-term care coverage for coverage that is intended to qualify under North Carolina's Long-Term Care Partnership Program. The insurer shall provide notification of this onetime offer within 180 days from the date on which the company begins to offer partnership coverage in the State. The mandatory offer of an exchange shall only apply to products issued by the insurer that are comparable to the type of policy form, such as group policies and individual policies, and on the policy series that the company has certified as partnership qualified. This exchange may be subject to underwriting and premium adjustment. A policy received in an exchange after the effective date of North Carolina's Long-Term Care Partnership Program is treated as newly issued and is eligible for qualified policy status. For purposes of applying the Medicaid rules relating to qualified long-term care partnership policies, the addition of a rider, endorsement, or change in schedule page for a policy may be treated as giving rise to an exchange. The effective date of the long-term care partnership policy shall be the date the policy was exchanged."

"**§ 58-55-80. Information sharing.**

(a) In order to assist in the performance of the Commissioner's duties under the long-term care partnership program specified in the federal Deficit Reduction Act of 2005, the Commissioner may:

(1) Share information, including identifying information, related to the long-term care partnership program with other state and federal agencies, the National Association of Insurance Commissioners, and any entity contracting with the federal government under the program.

(2) Receive information, including identifying information, related to the long-term care partnership program from other state and federal agencies, the National Association of Insurance Commissioners, and any entity contracting with the federal government under the program, and shall maintain as confidential or privileged any identifying information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information. Information received under this subdivision of this subsection is not a "public record" as defined in G.S. 132-1.

(3) Enter into agreements governing sharing and use of information consistent with this section.

(b) No waiver of an existing privilege or claim of confidentiality in the identifying information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (a) of this section.

(c) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this section shall be available and enforced in any proceeding in, and in any court of, this State.

(d) As used in this section, "identifying information" has the same meaning as in G.S. 14-113.20(b)."

SECTION 5. This act becomes effective January 1, 2011, or 60 days after approval of the Medicaid State Plan amendment, whichever is later.

SENATE BILL 1193:
Implement LTC Partnership Program

2009-2010 General Assembly

Committee:	House Insurance	**Date:**	June 17, 2010
Introduced by:	Sen. Swindell	**Prepared by:**	Kory Goldsmith Committee Counsel
Analysis of:	PCS to Third Edition S1193-CSRC-71		

SUMMARY: ***Senate Bill 1193 would create the Long-Term Care Partnership Program which would allow policyholders of certain long-term care insurance policies set aside for purposed of Medicaid long-term care eligibility and Medicaid estate recovery determinations an amount of assets equal to the amount of policy benefits received under a long-term care insurance policy prior to applying for Medicaid.***

The PCS for the Second Edition of Senate Bill 1193 makes technical changes to the bill.

[As introduced, this bill was identical to H1704, as introduced by Reps. Weiss, Farmer-Butterfield, Pierce, England, which is currently in House Aging, if favorable, Insurance.]

BILL ANALYSIS: **Section 1** creates G.S. 108A-70.4 to establish the North Carolina Long-Term Care Partnership Program (Program), which would allow an individual who applies for long-term care Medicaid and who has a qualified long-term care partnership policy ("qualified policy") to protect a portion of the individual's assets from consideration for the purposes of 1) determining eligibility for enrollment into long-term care Medicaid (resource disregard), and 2) estate recovery actions for payment of care provided to the enrollee, once they are deceased (resource protection). The amount protected under both resource disregard and resource protection would be equal to the dollar amount of benefits actually paid to or on behalf of the individual under the qualified policy from the date the qualified policy was issued to the date the individual applied for long-term care Medicaid.

The Program would be administered by the Division of Medical Assistance with assistance from the Department of Insurance (DOI). The Department of Health and Human Services (DHHS) would be authorized to adopt rules and amendments to the State Medicaid Plan to allow for resource disregard and protection, DHHS would be authorized to enter into reciprocal agreements with other states, and DHHS and DOI will adopt rules to implement the provisions of the Program.

Section 2 – would broaden the definition of "estate" under the existing Medicaid Estate Recovery Plan provision (G.S. 108A-70.5). For persons who receive benefits under a qualified policy, "estate" would also include any real or personal property or other assets in which the person had any legal title or interest at the time of death (to the extent of that interest) including assets conveyed to a survivor, heir, or assign of the deceased individual thorough joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. .

Section 3 & 4 – would restructure Article 55 (Long-Term Care Insurance) of Chapter 58 (Insurance), and add a new Part 2 "Long-Term Care Partnership",

G.S. 58-55-55 restates the definitions used in G.S. 108A-70.4.

G.S. 58-55-60 lists the requirements a long-term care insurance policy must contain in order to be considered a qualified long-term care partnership policy. These include that the policy is issued on or after the effective date of the Act, the policy covers an insured who is a resident of North Carolina a resident of another state that has a similar long-term care partnership program in place, the policy meets multiple federal requirement, the policy includes specified inflation protection coverage, and includes certain notices to the policy holder or insured describing the resource disregard and resource protection that applies to the policy.

G.S. 58-55-65 authorizes the Commissioner of Insurance to adopt rules to conform State long-term care policies and certificates to the requirements of federal law and regulations.

G.S. 58-55-70 requires insurers to provide policy holders with certain disclosure notices relating to loss of qualified policy status

G.S. 58-55-75 provides that within 180 days of the date when an insurance company starts to offer qualified policies, the insurer must offer to holders of existing long-term care insurance policies issued on or after February 8, 2006, a onetime offer to exchange the existing policy for a qualified policy. A qualified policy issued as a result of this exchange is to be treated as newly issued and is eligible for qualified policy status.

G.S. 58-55-80 allows the Commissioner to share "identifying information" related to the long-term care partnership program with other state and federal agencies, the National Association of Insurance Commissioners, and any entity contracting with the federal government under the partnership program. Identifying information that is received as a result of the partnership program would be privileged and confidential and would not be considered a public record as defined in G.S. 132-1.

EFFECTIVE DATE: The act would become effective the later of January 1, 2011, or 60 days after approval of the Medicaid State Plan amendment.

BACKGROUND: After the passage of the federal Deficit Reduction Act of 2005, 33 states have decided to offer a long-term care insurance partnership program. The Department of Health and Human Services (DHHS) was directed in 2006 (S.L. 2006-66, Sec. 10.10) to develop a N.C. Long-Term Care Partnership Program to reduce future Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid. The goal of the program is to offer incentives to individuals to plan for their long-term care needs with private insurance so they don't have to deplete all of their resources to pay for care. DHHS was required to report to the General Assembly.

The Department convened a workgroup consisting of the Divisions of Medical Assistance, Division of Aging and Adult Services, DHHS; Department of Insurance; Department of Justice, county department of social services staff; and representatives of the N.C. Health Care Facilities Association, American Association of Retired Persons, insurance companies, and the N.C. Bar Association to develop a Long-Term Care Partnership (LTCP) program and report to the General Assembly.

The report explained that a LTCP program allows a special resource disregard and resource protection at Estate Recovery for an individual who: 1) purchases a LTCP policy, 2) utilizes the benefits of the policy, and 3) applies for Medicaid. The amount of resource disregard and the Estate Recovery resource protection is equal to the amount of benefits paid out by the LTCP policy prior to the application for Medicaid.

The Study Commission on Aging recommended this bill in response to the Department of Health and Human Services and the Department of Insurance recommendation to proceed with the establishment of a Long-Term Care Partnership program and the submission of the State Plan amendment to allow the operation of the program.

**Ben Popkin, Committee Counsel for Senate Health Care Committee, and Sara Kamprath, Committee Staff to House Aging contributed significantly to this summary.*

S1193-SMRC-80(CSRC-71) v1

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

House ☒Committee Substitute for
SB 1193 A BILL TO BE ENTITLED AN ACT TO IMPLEMENT THE LONG-TERM CARE PARTNERSHIP PROGRAM, TO ENSURE THAT NORTH CAROLINA'S LONG-TERM CARE INSURANCE LAWS COMPORT WITH THE LONG-TERM CARE PARTNERSHIP PROVISIONS IN THE FEDERAL DEFICIT REDUCTION ACT OF 2005, AND TO AUTHORIZE THE SHARING OF CONFIDENTIAL INFORMATION BETWEEN THE NORTH CAROLINA DEPARTMENT OF INSURANCE, ENTITIES THAT CONTRACT WITH THE FEDERAL GOVERNMENT, AND OTHER GOVERNMENTAL AGENCIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

☒ With a favorable report as to House committee substitute bill #2, unfavorable as to House 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.

HOUSE BILL 2037:
State Health Plan/ Transfer to Dept Insurance

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Appropriations	**Date:**	June 17, 2010
Introduced by:	Reps. Dollar, Blackwell, Hurley	**Prepared by:**	Ben Popkin
Analysis of:	PCS to First Edition H2037-CSRD-90		Committee Counsel

SUMMARY: House Bill 2037 would transfer the North Carolina State Health Plan for Teachers and State Employees to the Department of Insurance and dissolve the Committee on Employee Hospital and Medical Benefits and the State Health Plan Administrative Commission.

BILL ANALYSIS: **Section 1** would transfer the State Health Plan (Plan) to the Department of Insurance, as a Type II transfer.

Section 2 would substitute the Commissioner of Insurance (Commissioner) for the Committee on Employee Hospital and Medical Benefits and add the Plan's Board of Trustees as being among those who may access information that is not public record, "...for their use in the furtherance of their duties and responsibilities."

Section 3 would dissolve the Committee on Employee Hospital and Medical Benefits by repealing its authorizing provision (G.S. 135-43.1).

Section 4 would dissolve the State Health Plan Administrative Commission by repealing its authorizing provision (G.S. 135-43.2).

Section 5 would remove reference to an oversight team and to the Committee on Employee Hospital and Medical Benefits from the Plan oversight process, and provide that the Director of the Budget (who may use employees of the OSBM) and the Commissioner would provide oversight of the Plan that is currently provided by an oversight team (which currently consists of employees authorized by the Legislative Services Commission and the Director of the Budget). This section would also grant the Director of the Budget and the Commissioner (or their designees) access to Plan records and allow them to attend the Plan's Board of Trustee meetings.

Section 6 would remove reference to the Committee on Employee Hospital and Medical Benefits in the Plan reporting provision, providing that the Executive Administrator and Board of Trustees of the Plan would report to the General Assembly "...at such times and in such forms as shall be designated by the President of the Senate, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives."

Section 7 would authorize the Commissioner to do the following: appoint the Executive Administrator of the Plan, set the term of employment and salary of the Executive Administrator, remove the Executive Administrator from office, and fill any vacancy in the office of the Executive Administrator.

Sections 8 and 9 would remove reference to the oversight team (deleted in section 6 of this bill) in the administrative review and rulemaking provisions of the Plan.

EFFECTIVE DATE: This act becomes effective July 1, 2011.

H2037-SMRD-212(CSRD-90) v2

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

REVISED

BILL NUMBER: House Bill 2037 (First Edition)

SHORT TITLE: State Health Plan/ Transfer to Dept Insurance.

SPONSOR(S): Representatives Dollar, Blackwell, and Hurley

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY: House Bill 2037 (First Edition) transfers the Plan to be under the purview of the Department of Insurance via a Type I transfer as defined by G.S. 143A-6. The bill also adds to the powers and duties of the Commissioner of Insurance the requirement to administer the Plan as set forth in Article 3A of Chapter 135 of the General Statutes. The bill also repeals the statutory authorization for the General Assembly's Committee on Employee Hospital and Medical Benefits and the accompanying assignment of legislative staff to the Committee including staff access to the Plan's records for the purpose of oversight by the Committee.

EFFECTIVE DATE: July 1, 2011

ESTIMATED IMPACT ON STATE:

Aon Consulting, the consulting actuary for the State Health Plan for Teachers and State Employees, estimates that the bill's requirements will not have a fiscal impact on the Plan.

Hartman & Associates, the consulting actuary for the General Assembly's Fiscal Research Division, estimates that the bill will not have a financial impact on the Plan.

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Note: For HB 2037 (First Edition), each actuary's analysis was based on information provided by the Plan's staff evaluation of the potential administrative and legal impact to the Plan. The bill does not impact the Plan's level of claims expenditures or premium contributions received; thus, no actuarial estimate of impact was conducted.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2009, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total *revised* requirements for the Plan are estimated to be $2.55 billion for FY 2009-10 and $2.74 billion for FY 2010-11. The Plan's PPO benefit design includes two alternative benefit levels listed below:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums; and

2) The "Standard" 80/20 plan.

The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under both plans is offered on a fully contributory basis.

Financial Condition

Revised Financial Projection 2009-11 Biennium – The following summarizes a revised financial projection by conducted by the Plan's consulting actuary, Aon Consulting, for the 2009-11 biennium. The information is provided by fiscal year based on year-to-date financial experience (through March 2010) and other updated factors.

For the fiscal year beginning July 1, 2009, the Plan began its operations with a beginning cash balance of $189.9 million. Receipts for the year are projected to be $2.41 billion from net premium collections, $74.4 million from Medicare Part D subsidies, and $3.4 million from investment earnings for a total of approximately $2.49 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.39 billion in net claim-payment expenses and $164.1 million in administration and claims-processing expenses for projected total expenses of nearly $2.55 billion for FY 2009-10. The Plan's net operating loss is projected to be approximately $66.3 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan is projected to begin its operations with a beginning cash balance of $123.6 million. Receipts for the year are projected to be $2.68 billion from net premium collections, $56.1 million from Medicare Part D subsidies, and $2.7 million from investment earnings for a total of approximately $2.73 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.55 billion in net claim-payment expenses and $191.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.74 billion for FY 2010-11. The

Plan's net operating loss is projected to be approximately $7.1 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Based on the revised financial projection (May 2010), the Plan's estimated ending cash balance on June 30, 2011 is projected to be $116.5 million. This amount is approximately $75.7 million less than the originally projected (April 2009) ending cash balance of $192.2 million.

Original Financial Projection 2009-11 Biennium (April 2009) – Session Law 2009-16 (Senate Bill 287) appropriated funds from various sources, authorized annual premium rate increases, made various benefit and provider related changes to achieve financial savings, and directed other various changes to the Plan. The enacted law also appropriated the sum of $250 million from the Savings Reserve Account ("Rainy Day Fund") of the General Fund for the 2008-09 fiscal year. The following summarizes the original financial projection by conducted by the Plan's consulting actuary, Aon Consulting, for the 2009-11 biennium The following summarizes the original financial projection by fiscal year for the 2009-11 biennium and assumes the changes enacted in Session Law 2009-16 (Senate Bill 287).

For the fiscal year beginning July 1, 2009, the Plan was projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year were projected to be $2.4 billion from net premium collections, $56.3 million from Medicare Part D subsidies, and $8.0 million from investment earnings for a total of approximately $2.5 billion in receipt income for the year. Projected disbursements from the Plan were expected to be $2.3 billion in net claim-payment expenses and $185.6 million in administration and claims-processing expenses for projected total expenses of nearly $2.5 billion for FY 2009-10. The Plan's net operating income was projected to be approximately $14.8 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan was projected to begin its operations with a beginning cash balance of $161.6 million. Receipts for the year were projected to be $2.7 billion from net premium collections, $50.4 million from Medicare Part D subsidies, and $8.8 million from investment earnings for a total of approximately $2.7 billion in receipt income for the year. Projected disbursements from the Plan were expected to be $2.5 billion in net claim-payment expenses and $191.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.7 billion for FY 2010-11. The Plan's net operating income was projected to be approximately $30.6 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Other Information

Historically, the Plan has applied a premium increase in October of the first fiscal year of a biennium. However, the annual premium increases authorized in Session Law 2009-16 (Senate Bill 287) changes that methodology to an annual increase at the beginning of each fiscal year of the 2009-11 biennium.

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment as of December 31, 2009

I. No. of Participants	Basic	Standard	Total	Percent of Total
Actives				
Employees	13,830	307,541	321,371	48.6%
Dependents	24,593	135,563	160,156	24.2%
Sub-total	38,423	443,104	481,527	72.8%
Retired				
Employees	2,074	151,395	153,469	23.2%
Dependents	1,313	18,075	19,388	2.9%
Sub-total	3,387	169,470	172,857	26.1%
Former Employees with Continuation Coverage				
Employees	121	3,120	3,241	0.5%
Dependents	87	749	836	0.1%
Sub-total	208	3,869	4,077	0.6%
Firefighters, Rescue Squad & National Guard				
Employees	-	5	5	0.0%
Dependents	-	3	3	0.0%
Sub-total	-	8	8	0.0%
Local Governments				
Employees	91	1,829	1,920	0.3%
Dependents	174	777	951	0.1%
Sub-total	265	2,606	2,871	0.4%
Total				
Employees	16,116	463,885	480,001	72.6%
Dependents	26,167	155,164	181,331	27.4%
Grand Total	**42,283**	**619,049**	**661,332**	**100%**
Percent of Total	**6.4%**	**93.6%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Total
Employee Only	3,252	378,539	381,791
Employee Child(ren)	6,026	43,820	49,846
Employee Spouse	2,550	21,785	24,335
Employee Family	4,288	19,741	24,029
Total	**16,116**	**463,885**	**480,001**

Percent Enrollment by Contract	Basic	Standard	Total
Employee Only	20.2%	81.6%	79.5%
Employee Child(ren)	37.4%	9.4%	10.4%
Employee Spouse	15.8%	4.7%	5.1%
Employee Family	26.6%	4.3%	5.0%
Total	**100.0%**	**100.0%**	**100.0%**

III. Enrollment by Sex	Basic	Standard	Total
Female	22,479	390,209	412,688
Male	19,804	228,840	248,644
Total	**42,283**	**619,049**	**661,332**

Percent Enrollment by Sex	Basic	Standard	Total
Female	53.2%	63.0%	62.4%
Male	46.8%	37.0%	37.6%
Total	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Total
19 & Under	17,315	95,431	112,746
20 to 29	3,311	57,142	60,453
30 to 44	9,555	120,292	129,847
45 to 54	6,455	108,447	114,902
55 to 64	4,090	128,933	133,023
65 & Over	1,557	108,804	110,361
Total	**42,283**	**619,049**	**661,332**

Percent Enrollment by Age	Basic	Standard	Total
19 & Under	41.0%	15.4%	17.0%
20 to 29	7.8%	9.2%	9.1%
30 to 44	22.6%	19.4%	19.6%
45 to 54	15.3%	17.5%	17.4%
55 to 64	9.7%	20.8%	20.1%
65 & Over	3.7%	17.6%	16.7%
Total	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	51,747	11,879	63,626
Medicare Eligible	101,722	7,509	109,231
Total	**153,469**	**19,388**	**172,857**

VI. Enrollment By Major Employer Groups	Employees	Dependents	Total
State Agencies	75,367	34,645	110,012
UNC System	50,106	29,726	79,832
Local Public Schools	181,270	88,258	269,528
Local Community Colleges	14,623	7,524	22,147
Other			
Local Goverments	1,920	951	2,871
COBRA	3,241	836	4,077
Nat. Guard, Fire & Rescue	5	3	8
Sub-total	5,166	1,790	6,956
Retirement System	153,469	19,388	172,857
Total	**480,001**	**181,331**	**661,332**

Percent Enrollment by Major Employer Groups	Employees	Dependents	Total
State Agencies	15.7%	19.1%	16.6%
UNC System	10.4%	16.4%	12.1%
Local Public Schools	37.8%	48.7%	40.8%
Local Community Colleges	3.0%	4.1%	3.3%
Other			
Local Goverments	0.4%	0.5%	0.4%
COBRA	0.7%	0.5%	0.6%
Nat. Guard, Fire & Rescue	0.0%	0.0%	0.0%
Sub-total	1.1%	1.0%	1.1%
Retirement System	32.0%	10.7%	26.1%
Total	100.0%	100.0%	100.0%

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, "House Bill 2037: An Act to Transfer the State Health Plan to the Department of Insurance", June 4, 2010, an original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "House Bill 2037 State Health Plan/Transfer to Department of Insurance, June 4, 2010, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Marilyn Chism, Director
Fiscal Research Division

DATE: June 15, 2010

Signed Copy Located in the NCGA Principal Clerk's Offices

NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

HOUSE BILL 2037

STATE HEALTH PLAN / TRANSFER TO DEPARTMENT OF INSURANCE

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30305

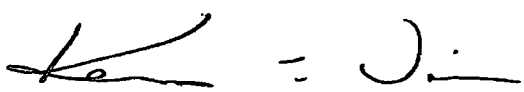
June 2010

ACTUARIAL STATEMENT

The North Carolina State Health Plan for Teachers and State Employees has requested that Aon Consulting prepare an Actuarial Note in response to House Bill 2037 entitled "An Act To Transfer The North Carolina State Health Plan For Teachers And State Employees to The Department Of Insurance."

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.



June 4, 2010

Kenneth C. Vieira, F.S.A., M.A.A.A.
Senior Vice President

Date

June 4, 2010

Kirsten R. Schatten, A.S.A., M.A.A.A.
Assistant Vice President

Date

STATE HEALTH PLAN / TRANSFER TO DEPARTMENT OF INSURANCE

PLAN CHANGES

The proposed legislation transfers the North Carolina State Health Plan to the Department of Insurance effective July 1, 2011. The full text of the bill is attached to this actuarial note.

PROJECTED COSTS

	Based on Midpoint Increase (in millions)		
Plan Design Change	2010-2011 Fiscal Year Cost	2011-2012 Fiscal Year Cost	Total Biennium Cost
Transfer NCSHP to Department of Insurance	No fiscal impact		

PRICING APPROACH AND COMMENTS

The following information was compiled and utilized in determining the projected costs or savings of each benefit component addressed in this actuarial note:

- Fiscal impact considerations related to the proposed changes outlined in this bill were provided to Aon by State Health Plan.
- Aon expects the bill will have no fiscal impact on the Plan's cost.

HOUSE BILL 2037

Short Title:	State Health Plan/ Transfer to Dept Insurance.	(Public)
Sponsors:	Representatives Dollar, Blackwell, Hurley (Primary Sponsors); Hilton, Jackson, Moore, Randleman, Ross, Setzer, Starnes, and Weiss.	
Referred to:	Insurance, if favorable, Appropriations.	

May 26, 2010

A BILL TO BE ENTITLED

AN ACT TO TRANSFER THE NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES TO THE DEPARTMENT OF INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. The North Carolina State Health Plan for Teachers and State Employees is transferred to the Department of Insurance. This transfer shall have all the elements of a Type I transfer, as defined by G.S. 143A-6.

SECTION 2. G.S. 58-2-40 is amended by adding a new subdivision to read:

"**§ 58-2-40. Powers and duties of Commissioner.**

The Commissioner shall:

...

(10) Administer the North Carolina State Health Plan for Teachers and State Employees, as provided in Article 3A of Chapter 135 of the General Statutes."

SECTION 3. G.S. 135-43(b) reads as rewritten:

"**§ 135-43. Confidentiality of information and medical records; provider contracts.**

(b) Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees may contract with providers of institutional and professional medical care and services to establish preferred provider networks.

The terms of a contract between the Plan and its third party administrator or between the Plan and its pharmacy benefit manager are a public record except that the terms in those contracts that contain trade secrets or proprietary or competitive information are not a public record under Chapter 132 of the General Statutes, and any such proprietary or competitive information and trade secrets contained in the contract shall be redacted by the Plan prior to making it available to the public. This subsection shall not be construed to prevent or restrict the release of any information made not a public record under this subsection to the Commissioner of Insurance, the State Auditor, the Attorney General, the Director of the State Budget, and the Plan's Executive ~~Administrator, and the Committee on Employee Hospital and Medical Benefits~~ Administrator solely and exclusively for their use in the furtherance of their duties and responsibilities, and to the Department of Health and Human Services solely for the purpose of implementing the transition of NC Health Choice from the Plan to the Department of Health and Human Services. The design, adoption, and implementation of the preferred provider contracts, networks, and optional alternative comprehensive health benefit plans, and programs available under the optional alternative plans, as authorized under G.S. 135-45 are not subject to the requirements of Article 3 of Chapter 143 of the General Statutes. The

Executive Administrator and Board of Trustees shall make reports as requested to the President of the Senate, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the ~~Committee on Employee Hospital and Medical Benefits.~~ Commissioner of Insurance."

SECTION 4. G.S. 135-43.1 is repealed.

SECTION 5. G.S. 135-43.2(h) reads as rewritten:

"**§ 135-43.2. State Health Plan Administrative Commission.**

(h) The Commission shall be located administratively within the Department of Insurance ~~but~~ and shall exercise all of its prescribed statutory powers ~~independently of~~ in conjunction with the Commissioner of Insurance."

SECTION 6. G.S. 135-43.3 reads as rewritten:

"**§ 135-43.3. ~~Oversight team.~~ Oversight.**

(a) ~~The Committee on Employee Hospital and Medical Benefits may use employees of the Legislative Services Office and may employ contractual services as approved by the Legislative Services Commission to monitor the Executive Administrator and Board of Trustees, the Claims Processor, and the Comprehensive Major Medical Plan [State Health Plan for Teachers and State Employees].~~ The Director of the Budget may use employees of the Office of State Budget and Management to monitor the Executive Administrator and Board of Trustees, the Claims Processor, and the Comprehensive Major Medical Plan [State Health Plan for Teachers and State Employees]. ~~Employees authorized by the Legislative Services Commission and the Director of the Budget to provide assistance to the Committee on Employee Hospital and Medical Benefits and to the Director of the Budget shall comprise an oversight team.~~

(b) The ~~oversight team shall, jointly or individually,~~ Director of the Budget and Commissioner of Insurance shall have access to all records of the Board of Trustees, the Executive Administrator, the Claims Processor, and the Plan. The ~~oversight team shall, jointly or individually,~~ Director of the Budget and Commissioner of Insurance shall be entitled to attend all meetings of the Board of Trustees.

~~(c) The oversight team shall report to the Committee on Employee Hospital and Medical Benefits when requested by the Committee.~~"

SECTION 7. G.S. 135-43.6 reads as rewritten:

"**§ 135-43.6. Reports to the General Assembly.**

The Executive Administrator and Board of Trustees shall report to the General Assembly at such times and in such forms as shall be designated by ~~the Committee on Employee Hospital and Medical Benefits.~~ the President of the Senate, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives."

SECTION 8. G.S. 135-44.2(b) reads as rewritten:

"**§ 135-44.2. Executive Administrator.**

(b) The Executive Administrator shall be appointed by the ~~State Health Plan Administrative Commission.~~ Commissioner of Insurance. The term of employment and salary of the Executive Administrator shall be set by the ~~State Health Plan Administrative Commission~~ Commissioner of Insurance upon the advice of ~~an executive committee of the Committee on Employee Hospital and Medical Benefits.~~ State Health Plan Administrative Commission.

The Executive Administrator may be removed from office by the ~~State Health Plan Administrative Commission,~~ Commissioner of Insurance, upon the advice of ~~an executive committee of the Committee on Employee Hospital and Medical Benefits,~~ the State Health Plan Administrative Commission, and any vacancy in the office of Executive Administrator may be filled by the ~~State Health Pla n Administrative Commission~~ Commissioner of Insurance with the term of employment and salary set upon the advice of ~~an executive committee of the~~

~~Committee on Employee Hospital and Medical Benefits.~~ the State Health Plan Administrative Commission."

SECTION 9. G.S. 135-44.7(a) reads as rewritten:

"**§ 135-44.7. Administrative review.**

(a) If, after exhaustion of internal appeal handling as outlined in the contract with the Claims Processor any person is aggrieved, the Claims Processor shall bring the matter to the attention of the Executive Administrator and Board of Trustees, which shall promptly decide whether the subject matter of the appeal is a determination subject to external review under Part 4 of Article 50 of Chapter 58 of the General Statutes. The Executive Administrator and Board of Trustees shall inform the aggrieved person and the aggrieved person's provider of the decision and shall provide the aggrieved person notice of the aggrieved person's right to appeal that decision as provided in this subsection. If the Executive Administrator and Board of Trustees decide that the subject matter of the appeal is not a determination subject to external review, then the Executive Administrator and Board of Trustees may make a binding decision on the matter in accordance with procedures established by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written summary of the decisions made pursuant to this section to all employing units, all health benefit representatives, the oversight ~~team~~ agencies provided for in G.S. 135-43.3, all relevant health care providers affected by a decision, and to any other parties requesting a written summary and approved by the Executive Administrator and Board of Trustees to receive a summary immediately following the issuance of a decision. A decision by the Executive Administrator and Board of Trustees that a matter raised on internal appeal is a determination subject to external review as provided in subsection (b) of this section may be contested by the aggrieved person under Chapter 150B of the General Statutes. The person contesting the decision may proceed with external review pending a decision in the contested case under Chapter 150B of the General Statutes."

SECTION 10. G.S. 135-44.8 reads as rewritten:

"**§ 135-44.8. Rules.**

The Executive Administrator and Board of Trustees may adopt rules in consultation with the Commissioner of Insurance to implement Parts 2, 3, 4, and 5 of this Article. The Executive Administrator and Board of Trustees shall provide to all employing units, all health benefit representatives, the oversight ~~team~~ agencies provided for in G.S. 135-43.3, all relevant health care providers affected by a rule, and to any other persons requesting a written description and approved by the Executive Administrator and Board of Trustees written notice and an opportunity to comment not later than 30 days prior to adopting, amending, or rescinding a rule, unless immediate adoption of the rule without notice is necessary in order to fully effectuate the purpose of the rule. Rules of the Board of Trustees shall remain in effect until amended or repealed by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written description of the rules adopted under this section to all employing units, all health benefit representatives, the oversight ~~team~~ agencies provided for in G.S. 135-43.3, all relevant health care providers affected by a rule, and to any other persons requesting a written description and approved by the Executive Administrator and Board of Trustees on a timely basis. Rules adopted by the Executive Administrator and Board of Trustees to implement this Article are not subject to Article 2A of Chapter 150B of the General Statutes."

SECTION 11. This act becomes effective July 1, 2011.

HARTMAN & ASSOCIATES, LLC
ACTUARIAL CONSULTING

ARK V. HARTMAN, FSA, MAAA, MCA, EA
hartman@triad.rr.com

Phone: (336) 731-4038
Fax: (336) 731-2583

668 Link Road
Lexington, NC 27295

June 4, 2010

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: House Bill 2037: An Act to Transfer the State Health Plan to the Department of Insurance

Dear Mr. Trogdon:

This bill amends various sections of the General Statutes to transfer the North Carolina State Health Plan for Teachers and State Employees to the Department of Insurance. The bill moves certain responsibilities and oversight of the Plan from the Committee on Employee Hospital and Medical Benefits to the Commissioner of Insurance and provides that the State Health Plan Administrative Commission shall exercise its statutory powers in conjunction with the Commissioner of Insurance. This bill is effective July 1, 2011.

The bill does not appear to have an actuarial effect on the Plan, and the Plan's staff has stated that they have found no cost impact to the Plan. Thus, this bill is not expected to have a financial impact on the Plan.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, FCA, EA
Consulting Actuary

MVH/mt

VISITOR REGISTRATION SHEET

Insurance — 6-17-10

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tom Harris	SEANC
Chuck Stone	SEANC
Linda Watkins	SEANC
Suzanne Beasley	SEANC
Robert Pasch	Young Moore
[illegible]	NCSC
Lee-Ann Creighton	NCANPHA
John Bowdish	Astra Zeneca
[illegible]	
[illegible]	McGuireWoods
Larry Barnes	State Health Plan

VISITOR REGISTRATION SHEET

House Committee on Insurance — June 17, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Vanderweide	NCDST
Michael Williamson	
Penny Burtner	School of Gov.
BILL RUSSO	ACP
Roz Sawitt	NCCCN
Carl Dean	OSP
Paula A. Wolf	Friends of Residents in Long Term Care
MIKE JAMES	ACP
Amy Whited	NC Med Soc
TED HAMBY	NC DOI
Adam Linker	NC Justice

VISITOR REGISTRATION SHEET

House Committee on Insurance — June 17, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ed Sudbury	Brooks Pierce
Robert W Wilson	SOS
Gary Salamido	GSK
Rob Black	Teamsters
Allison Stolte	
Sim Stegall	UCPS.
Lindsay Clifton	Gov's office
Rep Dale Folwell	NCGA
Alex Phillips	NCGA
Johnna Tant	NCAAE

VISITOR REGISTRATION SHEET

House Committee on Insurance — June 17, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jeff Drozda	United Health Care
Jackson Barnes	
David Barnes	Reynolds
John Roos	Blue Cross Blue Shield of NC
Gary Bolt	Blue Cross Blue Shield of NC
Mark Henry	BCBSNC
Jeff Horton	NAHU
Jim Harris	WCPSS
Katherine Joyce	NCASA
Lane Stilwell	NCGA
David Starling	NC DST

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carol Durrell	State Health Plan.
Toni Davis	SEANC
Amber Ernst	SEANC
Erica Baldwin	SEANC
Ronnie Londrey	DOT
Louis Belo	NCDOT
Brenda Hooker	SEANC
Michelle Thrower	SEANC
Sophie Brauns	SEANC
Cam Cline	BPMHL
Carolyn McClanahan	DHHS-DMA
Mary Bathe	AARP-NC

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ernest L. Nickerson	NCDOI
Rose Williams	NCDOI
Joey Nichols	Medco
Jim Blackburn	NC Association of County Commissioners
Daniel Blum	Troutman Sanders

HOUSE INSURANCE COMMITTEE

June 17, 2010
11:00 AM
Room 1228 – LB

Rep. Bruce Goforth, Chairman
Rep. Michael H. Wray, Chairman

Vice-Chairs
Rep. Van Braxton
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

HB 1853 – State Health Plan/Treat Teachers Equitably
Reps. Glazier, Cotham, Parmon, Whilden

HB 2055 – State Health Plan/Local Govt Retiree Contrib
Rep. England

SB 1193 – Implement LTC Partnership Program
Sen. Swindell

HB 2037 – State Health Plan/Transfer to Dept Insurance
Reps. Dollar, Blackwell, Hurley

Adjourn

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2009-2010 SESSION

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

DAY & DATE: Thursday, June 17, 2010
TIME: 11:00 am
LOCATION: 1228 LB
COMMENTS:

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 1853	State Health Plan/ Treat Teachers Equitably.	Representative Glazier Representative Cotham Representative Parmon Representative Whilden
~~HB 1991~~	~~State Health Plan/Court-Ordered Guardianships.~~	~~Representative Farmer-Butterfield~~ ~~Representative Bryant~~ ~~Representative Goodwin~~ ~~Representative Hurley~~
HB 2037	State Health Plan/ Transfer to Dept Insurance.	Representative Dollar Representative Blackwell Representative Hurley
HB 2055	State Health Plan/ Local Govt Retiree Contrib.	Representative England, M.D.
SB 1193	Implement LTC Partnership Program.	Senator Swindell IV

Respectfully,
Representative Goforth, Chair
Representative Wray, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **4:45** o'clock on **June 16, 2010**.

☐ Principal Clerk
☐ Reading Clerk – House Chamber

Meredith Matney (Committee Assistant)

MINUTES

HOUSE COMMITTEE ON INSURANCE
June 29, 2010

The House Committee on Insurance met at 11:00AM on Tuesday, June 29, 2010 in Room 1228. The following Representatives attended, Chairman Michael H. Wray; Vice Chairs: V. Braxton (excused), J. Dockham and M. Setzer. Members attending were Reps. Blust, Brubaker, Cole, Current, Faison, Gibson, Holliman, Howard and Hughes.

Chairman Wray called the meeting to order and welcomed visitors. He recognized House Pages and Sgt-at-Arms. Visitor Registration Sheets are attached and made part of the record (Attachment #1).

Chairman Wray recognized Senator McKissick to present Senate Bill 1392-State Health Plan/Court Ordered Guardianships. Senator McKissick explained that the bill includes, within a definition of dependent children, those who might be covered by a court ordered guardianship. If you had a child and you were a state employee and you did in fact have a court ordered guardianship, you could pay for this child to have health insurance coverage the same way that you would if it were your natural child. There are only about 54-56 children who are affected by this statewide and the implementation would be financially minimal. He told the committee that he had received no objections to the bill. Chairman Wray recognized Representative Faison who moved for a favorable report for SB 1392 and that the bill is re-referred to the Appropriations Committee, and the motion passed.

Chairman Wray called upon Senator Kinnaird to present SB 354-Continuing Care Retire. Community/Home Care. Representative Dockham made a motion for a PCS to be heard. Senator Kinnaird explained that this bill refers to continuing care retirement communities that are privately paid. These retirement communities are nonprofit and are regulated by the Department of Insurance. Because of changing demographics and situations that arise at some of these continuing care communities, people are starting to want to stay in their own homes but still belong to a continuing care retirement community. She compared this situation to a college campus, where some students live on campus and others live off. People who are members of the retirement community will have access to all of the resources and facilities of the retirement community but will continue to live in their own homes. The services will include an infirmary, assisted living, and a nursing home. People want to continue living in their own homes as long as they are independently able to do so. Some retirement homes are overcrowded and have waiting lists, thus making it next to impossible for them to live in the retirement facility. Some people are unable to sell their homes and want to continue living in them. The retirement communities are supporting these options and no opposition is known. Staff members recommended that the committee add some more clarifying language to the bill. The clarifying language was added. Chairman Wray then asked for a motion on an amendment to the bill offered by Representative Faison who then moved that the amendment pass and it did. He moved for a favorable report on SB-354, bill rolled into a committee substitute, as amended, with referral to the Finance Committee, and the motion passed.

Chairman Wray then recognized staff to present SB-1251 State Health Plan/Treat Teachers Equitably in Representative Glazier's absence. Staff explained that under current law, state employees who have been employed for at least twelve months are covered under the state

health plan and are permitted to continue to participate in the state health plan after their position has been eliminated for up to twelve months. This bill is intended to allow the same continuation right to public education employees who have been contracted for 10 or 11 month terms of employment and whose positions have been terminated due to a lack of funding. After a few questions, Chairman Wray recognized Representative Gibson to stand in the well in the absence of Rep. Glazier. Rep. Gibson recommended that the committee move the bill forward. Chairman Wray recognized Representative Holliman who moved for a favorable report for SB-1251 and that bill is re-referred to Appropriations Committee, and the motion passed.

Chairman Wray adjourned the meeting at 11:15 AM.

Representative Michael H. Wray, Chairman

Mary Capps, Committee Assistant

SENATE BILL 1392*

Short Title:	State Health Plan/Court-Ordered Guardianships.	(Public)
Sponsors:	Senator McKissick.	
Referred to:	Pensions & Retirement & Aging.	

May 26, 2010

A BILL TO BE ENTITLED

AN ACT TO ALLOW STATE EMPLOYEES TO ENROLL CHILDREN FOR WHICH THEY ARE COURT-APPOINTED GUARDIANS AS DEPENDENTS IN THE NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-45.1(10) reads as rewritten:

"**§ 135-45.1. General definitions.**

As used in this Article unless the context clearly requires otherwise, the following definitions apply:

...

(10) Dependent child. – A natural, legally adopted, or foster child or children of the employee and or spouse, unmarried, up to the first of the month following his or her 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for such child's maintenance and support. Dependent child also includes a child for which an employee is a court-appointed guardian, as long as the employee is legally responsible for the child's maintenance and support. Dependent child also includes a stepchild of the member who is married to the stepchild's natural parent. To be eligible, the stepchild must have his or her primary residence with the member. Dependent child shall also include any child under age 19 who has reached his or her 18th birthday, provided the employee was legally responsible for such child's maintenance and support on his or her 18th birthday. Dependent children of firefighters, rescue squad workers, and members of the National Guard are subject to the same terms and conditions as are other dependent children covered by this subdivision. Eligibility of dependent children is subject to the requirements of G.S. 135-45.2(d). The Plan may require documentation from the member confirming a child's eligibility to be covered as the member's dependent."

SECTION 2. This act becomes effective July 1, 2010.

SENATE BILL 1392:
State Health Plan/Court-Ordered Guardianships

2009-2010 General Assembly

Committee:	House Insurance, if favorable, Appropriations	**Date:**	June 28, 2010
Introduced by:	Sen. McKissick	**Prepared by:**	Tim Hovis*
Analysis of:	First Edition		Committee Counsel

SUMMARY: Senate Bill 1392 amends the State Health Plan's definition of "dependent child" so that it includes a child for which an employee is a court-appointed guardian and is legally responsible for the child's maintenance and support.

[As introduced, this bill was identical to H1991, as introduced by Reps. Farmer-Butterfield, Bryant, Goodwin, Hurley, which is currently in House Insurance, if favorable, Appropriations.]

BILL ANALYSIS:

Senate Bill 1392 amends the definition of "dependent child" under the State Health Plan. The amended definition allows coverage of a child whose court-appointed guardian is an employee eligible for coverage, as long as the employee is legally responsible for the child's maintenance and support. This would allow an employee who is a guardian appointed by the court the option of providing insurance coverage under the State Health Plan for the child for whom they are appointed guardian.

Senate Bill 1392 would become effective July 1, 2010.

S1392-SMRG-116(e)(v)

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: Senate Bill 1392 (First Edition)

SHORT TITLE: State Health Plan/Court-Ordered Guardianships.

SPONSOR(S): Senator McKissick

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY: The bill amends the definition of "Dependent child" under G.S. 135-45.1(10) to include a child for which an employee enrolled in the Plan is a court-appointed guardian and who is legally responsible for the child's maintenance and support. The effect of the bill would be to allow a minor child under a court-ordered guardianship to be eligible for health benefit coverage under the Plan.

EFFECTIVE DATE: July 1, 2010

ESTIMATED IMPACT ON STATE:

Aon Consulting, consulting actuary for the State Health Plan estimates the midpoint financial impact to the Plan would be an estimated $18,000 for FY 2010-11. Given there is no readily available experience data to project when a minor child may enter or exit the care of a court-appointed guardian at a particular age, Aon Consulting's financial estimate assumes a uniform distribution of guardianships across all ages up to age 18. The effect of this methodology is to project a cost that assumes the number of years that a minor child remains under guardianship varies from child to child. The effect of the methodology used by Aon Consulting is to project an average annual cost of the bill.

Hartman & Associates, consulting actuary for the General Assembly's Fiscal Research Division, estimates the maximum annual cost to the Plan for FY 2010-11 is $125,000. Given there is no readily available experience data to project when a minor child may enter or exit the care of a court appointed guardian at a particular age, Hartman & Associates' estimate assumes all guardianships have an 18-year duration spanning from birth up through age 17. The effect of the methodology used by Hartman & Associates is to project a maximum annual cost.

The additional cost impact of the requirements of the bill, projected by either consulting actuary, would be expected to impact total claims growth by approximately five one thousandths of one percent (0.005%) for the 2010-2011 fiscal year based on the highest estimate of additional cost (i.e., $125,000).

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note

Each actuary was provided with an estimate of guardianships of minor children appointed per year based on information provided by the Administrative Office of the Courts (AOC). It is estimated that there were 54 guardianships of minor children granted in 2005 and 56 in 2009 based on a count for each those respective years by AOC staff. Given the relatively small variance in the number of guardianship cases for minor children in each of these respective years, the same rate of annual court appointed guardianships was assumed to occur into the future for purposes of estimating financial impact under the bill. There was no readily available experience data reflecting the age at which minor children subject to guardianship entered or exited this status.

Based on the ratio of adult State Health Plan members to the population of the State, the respective consulting actuaries estimated that 7% to 8% of plan members would be projected to be guardians of minor children. This results in an estimated average of 4 additional children annually becoming eligible for coverage under the Plan as a minor child under a guardianship arrangement sanctioned by the courts. On a year-to-year basis, total average membership would be 40 dependent child plan members subject to a guardianship arrangement under the estimation methodology used by Aon Consulting which assumes a uniform distribution by age. Similarly, under the estimation method used by Hartman & Associates, total average membership would be a projected 75 plan members who are minor children under a guardianship arrangement assuming the period of guardianship lasted from birth up through age 17.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2009, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total *revised* requirements for the Plan are estimated to be $2.55 billion for FY 2009-10 and $2.74 billion for FY 2010-11. The Plan's PPO benefit design includes two alternative benefit levels listed below:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums; and

2) The "Standard" 80/20 plan.

The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under both plans is offered on a fully contributory basis.

Financial Condition

Revised Financial Projection 2009-11 Biennium – The following summarizes a revised financial projection by conducted by the Plan's consulting actuary, Aon Consulting, for the 2009-11 biennium. The information is provided by fiscal year based on year-to-date financial experience (through March 2010) and other updated factors.

For the fiscal year beginning July 1, 2009, the Plan began its operations with a beginning cash balance of $189.9 million. Receipts for the year are projected to be $2.41 billion from net premium collections, $74.4 million from Medicare Part D subsidies, and $3.4 million from investment earnings for a total of approximately $2.49 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.39 billion in net claim-payment expenses and $164.1 million in administration and claims-processing expenses for projected total expenses of nearly $2.55 billion for FY 2009-10. The Plan's net operating loss is projected to be approximately $66.3 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan is projected to begin its operations with a beginning cash balance of $123.6 million. Receipts for the year are projected to be $2.68 billion from net premium collections, $56.1 million from Medicare Part D subsidies, and $2.7 million from investment earnings for a total of approximately $2.73 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.55 billion in net claim-payment expenses and $191.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.74 billion for FY 2010-11. The Plan's net operating loss is projected to be approximately $7.1 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Based on the revised financial projection (May 2010), the Plan's estimated ending cash balance on June 30, 2011 is projected to be $116.5 million. This amount is approximately $75.7 million less than the originally projected (April 2009) ending cash balance of $192.2 million.

Original Financial Projection 2009-11 Biennium (April 2009) – Session Law 2009-16 (Senate Bill 287) appropriated funds from various sources, authorized annual premium rate increases, made various benefit and provider related changes to achieve financial savings, and directed other various changes to the Plan. The enacted law also appropriated the sum of $250 million from the Savings Reserve Account ("Rainy Day Fund") of the General Fund for the 2008-09 fiscal year. The following summarizes the original financial projection by fiscal year for the 2009-11 biennium and assumes the changes enacted in Session Law 2009-16 (Senate Bill 287).

For the fiscal year beginning July 1, 2009, the Plan was projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year were projected to be $2.4 billion from net premium collections, $56.3 million from Medicare Part D subsidies, and $8.0 million from investment earnings for a total of approximately $2.5 billion in receipt income for the year. Projected disbursements from the Plan were expected to be $2.3 billion in net claim-payment expenses and $185.6 million in administration and claims-processing expenses for projected total expenses of nearly $2.5 billion for FY 2009-10. The Plan's net operating income was projected to be approximately $14.8 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan was projected to begin its operations with a beginning cash balance of $161.6 million. Receipts for the year were projected to be $2.7 billion from net premium collections, $50.4 million from Medicare Part D subsidies, and $8.8 million from investment earnings for a total of approximately $2.7 billion in receipt income for the year. Projected disbursements from the

Plan were expected to be $2.5 billion in net claim-payment expenses and $191.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.7 billion for FY 2010-11. The Plan's net operating income was projected to be approximately $30.6 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Other Information

Historically, the Plan has applied a premium increase in October of the first fiscal year of a biennium. However, the annual premium increases authorized in Session Law 2009-16 (Senate Bill 287) changes that methodology to an annual increase at the beginning of each fiscal year of the 2009-11 biennium.

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment as of December 31, 2009

I. No. of Participants	Basic	Standard	Total	Percent of Total
Actives				
Employees	13,830	307,541	321,371	48.6%
Dependents	24,593	135,563	160,156	24.2%
Sub-total	38,423	443,104	481,527	72.8%
Retired				
Employees	2,074	151,395	153,469	23.2%
Dependents	1,313	18,075	19,388	2.9%
Sub-total	3,387	169,470	172,857	26.1%
Former Employees with Continuation Coverage				
Employees	121	3,120	3,241	0.5%
Dependents	87	749	836	0.1%
Sub-total	208	3,869	4,077	0.6%
Firefighters, Rescue Squad & National Guard				
Employees	-	5	5	0.0%
Dependents	-	3	3	0.0%
Sub-total	-	8	8	0.0%
Local Governments				
Employees	91	1,829	1,920	0.3%
Dependents	174	777	951	0.1%
Sub-total	265	2,606	2,871	0.4%
Total				
Employees	16,116	463,885	480,001	72.6%
Dependents	26,167	155,164	181,331	27.4%
Grand Total	**42,283**	**619,049**	**661,332**	**100%**
Percent of Total	**6.4%**	**93.6%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Total
Employee Only	3,252	378,539	381,791
Employee Child(ren)	6,026	43,820	49,846
Employee Spouse	2,550	21,785	24,335
Employee Family	4,288	19,741	24,029
Total	**16,116**	**463,885**	**480,001**

Percent Enrollment by Contract	Basic	Standard	Total
Employee Only	20.2%	81.6%	79.5%
Employee Child(ren)	37.4%	9.4%	10.4%
Employee Spouse	15.8%	4.7%	5.1%
Employee Family	26.6%	4.3%	5.0%
Total	**100.0%**	**100.0%**	**100.0%**

III. Enrollment by Sex	Basic	Standard	Total
Female	22,479	390,209	412,688
Male	19,804	228,840	248,644
Total	**42,283**	**619,049**	**661,332**

Percent Enrollment by Sex	Basic	Standard	Total
Female	53.2%	63.0%	62.4%
Male	46.8%	37.0%	37.6%
Total	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Total
19 & Under	17,315	95,431	112,746
20 to 29	3,311	57,142	60,453
30 to 44	9,555	120,292	129,847
45 to 54	6,455	108,447	114,902
55 to 64	4,090	128,933	133,023
65 & Over	1,557	108,804	110,361
Total	**42,283**	**619,049**	**661,332**

Percent Enrollment by Age	Basic	Standard	Total
19 & Under	41.0%	15.4%	17.0%
20 to 29	7.8%	9.2%	9.1%
30 to 44	22.6%	19.4%	19.6%
45 to 54	15.3%	17.5%	17.4%
55 to 64	9.7%	20.8%	20.1%
65 & Over	3.7%	17.6%	16.7%
Total	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	51,747	11,879	63,626
Medicare Eligible	101,722	7,509	109,231
Total	**153,469**	**19,388**	**172,857**

VI. Enrollment By Major Employer Groups	Employees	Dependents	Total
State Agencies	75,367	34,645	110,012
UNC System	50,106	29,726	79,832
Local Public Schools	181,270	88,258	269,528
Local Community Colleges	14,623	7,524	22,147
Other			
Local Goverments	1,920	951	2,871
COBRA	3,241	836	4,077
Nat. Guard, Fire & Rescue	5	3	8
Sub-total	5,166	1,790	6,956
Retirement System	153,469	19,388	172,857
Total	**480,001**	**181,331**	**661,332**

Percent Enrollment by Major Employer Groups	Employees	Dependents	Total
State Agencies	15.7%	19.1%	16.6%
UNC System	10.4%	16.4%	12.1%
Local Public Schools	37.8%	48.7%	40.8%
Local Community Colleges	3.0%	4.1%	3.3%
Other			
Local Goverments	0.4%	0.5%	0.4%
COBRA	0.7%	0.5%	0.6%
Nat. Guard, Fire & Rescue	0.0%	0.0%	0.0%
Sub-total	1.1%	1.0%	1.1%
Retirement System	32.0%	10.7%	26.1%
Total	100.0%	100.0%	100.0%

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, "Senate Bill 1392: An Act to Allow State Employees to Enroll Children For Which They Are Court-Appointed Guardians as Dependents in the State Health Plan for Teachers and State Employees", June 15, 2010, an original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "Senate Bill 1392 State Health Plan/Court-ordered Guardianships", June 18, 2010, an original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Marilyn Chism, Director
Fiscal Research Division

DATE:

Signed Copy Located in the NCGA Principal Clerk's Offices

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☐ Committee Substitute for
SB 1392 A BILL TO BE ENTITLED AN ACT TO ALLOW STATE EMPLOYEES TO ENROLL CHILDREN FOR WHICH THEY ARE COURT-APPOINTED GUARDIANS AS DEPENDENTS IN THE NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES.

☒ With a favorable report and recommendation that the 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 _____.

_____ The bill/resolution is re-referred to the Committee on _____.

PRINTABLE VERSION

<< Previous: S1391 Next: S1393 >>

Senate Bill 1392 / S.L. 2010-120 (= H1991)

2009-2010 Session

State Health Plan/Court-Ordered Guardianships.

View Bill Digest	
Text	**Fiscal Note**
Filed [HTML]	-
Edition 1 [HTML]	SAH1392v1
Ratified [HTML]	-
SL2010-120 [HTML]	-

Status: Ch. SL 2010-120 on 07/20/2010

Sponsors

Primary: Floyd B. McKissick, Jr.;

Co: N/A

Attributes: Public;

Vote History

Date	Subject	RCS #	Aye	No	N/V	Exc. Abs.	Exc. Vote	Total	Result
07/08/2010 11:54AM	Second Reading	[H] - 1731	112	0	2	6	0	112	PASSED
07/08/2010 11:56AM	Third Reading	[H] - 1732	112	0	2	6	0	112	PASSED

Viewing Last 2 Vote(s) *View All Votes*

History RSS

Date	Chamber	Action
05/25/2010	Senate	Filed
05/26/2010	Senate	Ref To Com On Pensions & Retirement & Aging
06/23/2010	Senate	Reptd Fav
/24/2010	Senate	Passed 2nd & 3rd Reading
/24/2010	House	Passed 1st Reading
06/24/2010	House	Ref to the Com on Insurance, if favorable, Appropriations
06/29/2010	House	Reptd Fav
06/29/2010	House	Re-ref Com On Appropriations
07/06/2010	House	Withdrawn From Com
07/06/2010	House	Re-ref Com On Pensions and Retirement
07/07/2010	House	Reptd Fav
07/07/2010	House	Cal Pursuant Rule 36(b)
07/07/2010	House	Placed On Cal For 7/8/2010
07/08/2010	House	Passed 2nd & 3rd Reading
07/08/2010		Ratified
07/08/2010		Pres. To Gov. 7/8/2010
07/20/2010		Signed By Gov. 7/20/2010
07/20/2010		Ch. SL 2010-120

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2009-2010 Session

Bill Number: enter bill # (i.e., S Look-Up

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GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 4

SENATE BILL 354

Appropriations/Base Budget Committee Substitute Adopted 4/23/09
House Committee Substitute Favorable 5/26/09
House Committee Substitute #2 Favorable 6/16/10

Short Title: Continuing Care Retire. Community/Home Care. (Public)

Sponsors:

Referred to:

March 2, 2009

A BILL TO BE ENTITLED

AN ACT TO PERMIT CONTINUING CARE RETIREMENT COMMUNITIES TO PROVIDE OR ARRANGE FOR HOME CARE SERVICES WITHOUT PROVIDING LODGING WHEN THOSE SERVICES ARE PROVIDED ADJUNCT TO A CONTRACT FOR CONTINUING CARE AND TO REQUIRE THE DEPARTMENT OF INSURANCE AND THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES RELATED TO CONTINUING CARE RETIREMENT COMMUNITIES PROVIDING HOME CARE SERVICES WITHOUT PROVIDING LODGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-64-5 reads as rewritten:

"**§ 58-64-5. License.**

(a) No provider shall engage in the business of offering or providing continuing care in this State without a license to do so obtained from the Commissioner as provided in this Article. It is a Class 1 misdemeanor for any person, other than a provider licensed under this Article, to advertise or market to the general public any product similar to continuing care through the use of such terms as "life care", "continuing care", or "guaranteed care for life", or similar terms, words, or phrases. The licensing process may involve a series of steps pursuant to rules adopted by the Commissioner under this Article.

(b) The application for a license shall be filed with the Department by the provider on forms prescribed by the Department and within a period of time prescribed by the Department; and shall include all information required by the Department pursuant to rules adopted by it under this Article including, but not limited to, the disclosure statement meeting the requirements of this Article and other financial and facility development information required by the Department. The application for a license must be accompanied by an application fee of ~~five hundred~~one thousand dollars (~~$500.00~~$1,000).

...."

SECTION 2. G.S. 58-64-1 reads as rewritten:

"**§ 58-64-1. Definitions.**

As used in this Article, unless otherwise specified:

(1) ~~"Continuing care" means the~~Continuing care. – The furnishing to an individual other than an individual related by blood, marriage, or adoption to the person furnishing the care, of lodging together with nursing services, medical services, or other health related services, under ~~an agreement~~a contract approved by the Department in accordance with this Article effective for the life of the individual or for a period longer than one year.

"Continuing care" may also include home care services provided or arranged by a provider of lodging at a facility to an individual who has entered into a continuing care contract with the provider but is not yet receiving lodging.

(2) ~~"Entrance fee" means a~~ Entrance fee. – A payment that assures a resident a place in a facility for a term of years or for life.

(3) ~~"Facility" means the~~Facility. – The retirement community or communities in which a provider undertakes to provide continuing care to an individual.

(4) ~~"Health related services" means, at~~Health-related services. – At a minimum, nursing home admission or assistance in the activities of daily living, exclusive of the provision of meals or cleaning services.

(4a) Home care services. – Defined in G.S. 131E-136.

(5) ~~"Living unit" means a~~Living unit. – A room, apartment, cottage, or other area within a facility set aside for the exclusive use or control of one or more identified residents.

(5a) Lodging. – A living unit as set forth in a contract approved by the Department in accordance with this Article.

(6) ~~"Provider" means the~~Provider. – The promoter, developer, or owner of a facility, whether a natural person, partnership, or other unincorporated association, however organized, trust, or corporation, of an institution, building, residence, or other place, whether operated for profit or not, or any other person, that solicits or undertakes to provide continuing care under a continuing care facility contract, or that represents himself, herself, or itself as providing continuing care or "life care."

(7) ~~"Resident" means a~~Resident. – A purchaser of, a nominee of, or a subscriber to, a continuing care contract.

(8) ~~"Hazardous financial condition" means a~~ Hazardous financial condition. – A provider is insolvent or in eminent danger of becoming insolvent."

SECTION 3. G.S. 58-64-25 reads as rewritten:

"**§ 58-64-25. Contract for continuing care; specifications.**

(a) Each contract for continuing care shall provide that:

...

(b) Each contract shall include provisions that specify the following:

(1) The total consideration to be ~~paid;~~paid.

(2) Services to be ~~provided;~~provided.

(3) The procedures the provider shall follow to change the resident's accommodation if necessary for the protection of the health or safety of the resident or the general and economic welfare of the ~~residents;~~residents.

(4) The policies to be implemented if the resident cannot pay the periodic ~~fees;~~fees.

(5) The terms governing the refund of any portion of the entrance fee in the event of discharge by the provider or cancellation by the ~~resident;~~resident.

(6) The policy regarding increasing the periodic ~~fees;~~fees.

(7) The description of the living ~~quarters;~~quarters.

(8) Any religious or charitable affiliations of the provider and the extent, if any, to which the affiliate organization will be responsible for the financial and contractual obligations of the ~~provider;~~provider.

(9) Any property rights of the ~~resident;~~resident.

(10) The policy, if any, regarding fee adjustments if the resident is voluntarily absent from the ~~facility;~~ facility.

(11) Any requirement, if any, that the resident apply for Medicaid, public assistance, or any public benefit program.

(12) The procedures for determining when the individual will transition to receiving lodging and health-related services in the event that a contract allows for the provision or arrangement of continuing care without lodging."

SECTION 4. Article 64 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-64-7 Continuing care services without lodging.**

(a) A provider of continuing care who has obtained a license pursuant to this Article and desires to provide or arrange for continuing care services, including home care services, to an individual who has entered into a continuing care contract with the provider but is not yet receiving lodging must submit the following to the Commissioner:

(1) An application to offer continuing care services without providing lodging.

(2) An amended Disclosure Statement containing a description of the proposed continuing care services that will be provided without lodging, including the target market, the types of services to be provided, and the fees to be charged.

(3) A copy of the written service agreement which must contain those provisions as prescribed in G.S. 58-64-25(b).

(4) A summary of an actuarial report that presents the impact of providing continuing care services without lodging on the overall operation of the continuing care retirement community.

(5) A financial feasibility study prepared by a certified public accountant that shows the financial impact of providing continuing care services without lodging on the applicant and the continuing care retirement facility or facilities. The financial feasibility study shall include a statement of activities reporting the revenue and expense details for providing continuing care services without lodging, as well as any impact the provision of these services will have on operating reserves.

(6) Evidence of the license required under Part 3 of Article 6 of Chapter 131E of the General Statutes to provide home care services, or a contract with a licensed home care agency for the provision of home care services to the individuals under the continuing care services without lodging program.

(b) A provider issued a start-up certificate for the provision of continuing care services without lodging must enter into binding written service agreements with subscribers to provide continuing care services without lodging.

(c) When providing the financial statements and five-year forecasts required by G.S. 58-64-20, a provider offering continuing care services without lodging must account for the related revenue and expenses generated from the provision of these services separate from the facility's on-site operation."

SECTION 5. The Department of Insurance and the Department of Health and Human Services shall identify any statutory, regulatory, or practical barriers that prevent or discourage individuals that contract with continuing care retirement communities from receiving home care services for as long as they need home care services and are able to be safely cared for in their homes. The Departments shall jointly provide an interim status report on or before November 1, 2010, and a final report on or before September 1, 2011, to the North Carolina Study Commission on Aging and the Joint Legislative Health Care Oversight Committee. Each report shall include findings and recommendations made to date on statutory changes and a timetable for promulgation of rules to eliminate any identified barriers to providing appropriate levels of care.

SECTION 6. Section 1 of this act becomes effective July 1, 2010, and applies to applications filed on or after that date. The remainder of the act is effective when it becomes law, and Sections 2, 3, and 4 expire July 1, 2012. Contracts executed on or after the effective

date of this act that allow for the provision or arrangement of continuing care without lodging remain effective after July 1, 2012, and the continuing care retirement community may provide home care services without lodging under the terms of the contract after July 1, 2012.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 354

Appropriations/Base Budget Committee Substitute Adopted 4/23/09
House Committee Substitute Favorable 5/26/09
House Committee Substitute #2 Favorable 6/16/10
PROPOSED COMMITTEE SUBSTITUTE S354-PCS55635-RCf-76

Short Title:	Continuing Care Retire. Community/Home Care.	(Public)
Sponsors:		
Referred to:		

March 2, 2009

A BILL TO BE ENTITLED

AN ACT TO PERMIT CONTINUING CARE RETIREMENT COMMUNITIES TO PROVIDE OR ARRANGE FOR HOME CARE SERVICES WITHOUT PROVIDING LODGING WHEN THOSE SERVICES ARE PROVIDED ADJUNCT TO A CONTRACT FOR CONTINUING CARE AND TO REQUIRE THE DEPARTMENT OF INSURANCE AND THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES RELATED TO CONTINUING CARE RETIREMENT COMMUNITIES PROVIDING HOME CARE SERVICES WITHOUT PROVIDING LODGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-64-5(b) reads as rewritten:

"(b) The application for a license shall be filed with the Department by the provider on forms prescribed by the Department and within a period of time prescribed by the Department; and shall include all information required by the Department pursuant to rules adopted by it under this Article including, but not limited to, the disclosure statement meeting the requirements of this Article and other financial and facility development information required by the Department. The application for a license must be accompanied by an application fee of ~~five hundred~~one thousand dollars (~~$500.00~~$1,000)."

SECTION 2. G.S. 58-64-1 reads as rewritten:

"**§ 58-64-1. Definitions.**

As used in this Article, unless otherwise specified:

(1) ~~"Continuing care" means the~~Continuing care. – The furnishing to an individual other than an individual related by blood, marriage, or adoption to the person furnishing the care, of lodging together with nursing services, medical services, or other health related services, under ~~an agreement~~a contract approved by the Department in accordance with this Article effective for the life of the individual or for a period longer than one year. "Continuing care" may also include home care services provided or arranged by a provider of lodging at a facility to an individual who has entered into a continuing care contract with the provider but is not yet receiving lodging.

(2) ~~"Entrance fee" means a~~ Entrance fee. – A payment that assures a resident a place in a facility for a term of years or for life.

(3) ~~"Facility" means the~~Facility. – The retirement community or communities in which a provider undertakes to provide continuing care to an individual.

(4) ~~"Health related services" means, at~~Health-related services. – At a minimum, nursing home admission or assistance in the activities of daily living, exclusive of the provision of meals or cleaning services.

(4a) Home care services. – Defined in G.S. 131E-136.

(5) ~~"Living unit" means a~~Living unit. – A room, apartment, cottage, or other area within a facility set aside for the exclusive use or control of one or more identified residents.

(5a) Lodging. – A living unit as set forth in a contract approved by the Department in accordance with this Article.

(6) ~~"Provider" means the~~Provider. – The promoter, developer, or owner of a facility, whether a natural person, partnership, or other unincorporated association, however organized, trust, or corporation, of an institution, building, residence, or other place, whether operated for profit or not, or any other person, that solicits or undertakes to provide continuing care under a continuing care facility contract, or that represents himself, herself, or itself as providing continuing care or "life care."

(7) ~~"Resident" means a~~Resident. – A purchaser of, a nominee of, or a subscriber to, a continuing care contract.

(8) ~~"Hazardous financial condition" means a~~ Hazardous financial condition. – A provider is insolvent or in eminent danger of becoming insolvent."

SECTION 3. G.S. 58-64-25(b)reads as rewritten:

"(b) Each contract shall include provisions that specify the following:

(1) The total consideration to be ~~paid;~~paid.

(2) Services to be ~~provided;~~provided.

(3) The procedures the provider shall follow to change the resident's accommodation if necessary for the protection of the health or safety of the resident or the general and economic welfare of the ~~residents;~~residents.

(4) The policies to be implemented if the resident cannot pay the periodic ~~fees;~~fees.

(5) The terms governing the refund of any portion of the entrance fee in the event of discharge by the provider or cancellation by the ~~resident;~~resident.

(6) The policy regarding increasing the periodic ~~fees;~~fees.

(7) The description of the living ~~quarters;~~quarters.

(8) Any religious or charitable affiliations of the provider and the extent, if any, to which the affiliate organization will be responsible for the financial and contractual obligations of the ~~provider;~~provider.

(9) Any property rights of the ~~resident;~~resident.

(10) The policy, if any, regarding fee adjustments if the resident is voluntarily absent from the ~~facility;~~ facility.

(11) Any requirement, if any, that the resident apply for Medicaid, public assistance, or any public benefit program.

(12) The procedures for determining when the individual will transition to receiving lodging and health-related services in the event that a contract allows for the provision or arrangement of continuing care without lodging."

SECTION 4. Article 64 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-64-7 Continuing care services without lodging.**

(a) A provider of continuing care who has obtained a license pursuant to this Article and desires to provide or arrange for continuing care services, including home care services, to

an individual who has entered into a continuing care contract with the provider but is not yet receiving lodging must submit the following to the Commissioner:

(1) An application to offer continuing care services without providing lodging.

(2) An amended disclosure statement containing a description of the proposed continuing care services that will be provided without lodging, including the target market, the types of services to be provided, and the fees to be charged.

(3) A copy of the written service agreement, which must contain those provisions as prescribed in G.S. 58-64-25(b).

(4) A summary of an actuarial report that presents the impact of providing continuing care services without lodging on the overall operation of the continuing care retirement community.

(5) A financial feasibility study prepared by a certified public accountant that shows the financial impact of providing continuing care services without lodging on the applicant and the continuing care retirement facility or facilities. The financial feasibility study shall include a statement of activities reporting the revenue and expense details for providing continuing care services without lodging, as well as any impact the provision of these services will have on operating reserves.

(6) Evidence of the license required under Part 3 of Article 6 of Chapter 131E of the General Statutes to provide home care services, or a contract with a licensed home care agency for the provision of home care services to the individuals under the continuing care services without lodging program.

(b) A provider issued a start-up certificate for the provision of continuing care services without lodging must enter into binding written service agreements with subscribers to provide continuing care services without lodging.

(c) When providing the financial statements and five-year forecasts required by G.S. 58-64-20, a provider offering continuing care services without lodging must account for the related revenue and expenses generated from the provision of these services separate from the facility's on-site operation."

SECTION 5. The Department of Insurance and the Department of Health and Human Services shall identify any statutory, regulatory, or practical barriers that prevent or discourage individuals that contract with continuing care retirement communities from receiving home care services for as long as they need home care services and are able to be safely cared for in their homes. The Departments shall jointly provide an interim status report on or before November 1, 2010, and a final report on or before September 1, 2011, to the North Carolina Study Commission on Aging and the Joint Legislative Health Care Oversight Committee. Each report shall include findings and recommendations made to date on statutory changes and a timetable for adopting rules to eliminate any identified barriers to providing appropriate levels of care.

SECTION 6. If the Joint Conference Committee Report on the Continuation, Expansion and Capital Budgets for Senate Bill 897, 2009 Regular Session is not enacted or is enacted but does not contain a provision transferring Position #60013545 within the Office of the State Fire Marshal Division to the Financial Evaluation Division as an Insurance Company Manager Position at the recurring budgeted amount of $111,623, then Section 1 of this act becomes effective July 1, 2010, and applies to applications filed on or after that date, Section 7 is repealed, the remainder of the act is effective when it becomes law, and Sections 2, 3, and 4 expire July 1, 2012. Contracts executed on or after the effective date of Sections 2, 3, and 4 that allow for the provision or arrangement of continuing care without lodging remain effective after July 1, 2012, and the continuing care retirement community may provide home care services without lodging under the terms of the contract after July 1, 2012.

SECTION 7. If the Joint Conference Committee Report on the Continuation, Expansion and Capital Budgets for Senate Bill 897, 2009 Regular Session is enacted and contains a provision transferring Position #60013545 within the Office of the State Fire Marshal Division to the Financial Evaluation Division as an Insurance Company Manager Position at the recurring budgeted amount of $111,623, then Section 1 of this act becomes effective July 1, 2010, and applies to applications filed on or after that date, Section 6 is repealed, and the remainder of the act is effective when it becomes law.

SENATE BILL 354:
Continuing Care Retire. Community/Home Care

2009-2010 General Assembly

Committee:	House Insurance	**Date:**	June 28, 2010
Introduced by:	Sen. Kinnaird	**Prepared by:**	Kory Goldsmith Committee Counsel
Analysis of:	PCS to Fourth Edition S354-CSRCf-76		

SUMMARY: ***The Proposed Committee Substitute for SB 354 increases the application fee for a continuing care license. It would also allow continuing care retirement communities (CCRCs) to provide or arrange for home care services for an individual who has entered into a continuing care contract, but who is not receiving lodging. The fee provision would become effective July 1, 2010. The other provisions would be effective when the bill becomes law, but would sunset on July 1, 2012, unless the Continuation Budget transfers a position within the Department of Insurance (DOI) to provide oversight of the new home care services to be provided by CCRCs.***

CURRENT LAW:

G.S. 58-64-1 (1) defines "continuing care" as the "furnishing to an individual other than an individual related by blood, marriage, or adoption to the person furnishing the care, of lodging together with nursing services, medical services, or other health related services, under an agreement effective for the life of the individual or for a period longer than one year." G.S. 58-64-5 requires a provider offering or providing continuing care to obtain a license from the Commissioner of Insurance. G.S. 58-64-25 specifies the continuing care contract requirements.

G.S. 131E-136 (3) defines "Home care services" as any of the following services and directly related medical supplies and appliances, which are provided to an individual in a place of temporary or permanent residence used as an individual's home:

a. Nursing care provided by or under the supervision of a registered nurse.
b. Physical, occupational, or speech therapy, when provided to an individual who also is receiving nursing services, or any other of these therapy services, in a place of temporary or permanent residence used as the individual's home.
c. Medical social services.
d. In-home aide services that involve hands-on care to an individual.
e. Infusion nursing services.
f. Assistance with pulmonary care, pulmonary rehabilitation or ventilation.
g. In-home companion, sitter, and respite care services provided to an individual.
h. Homemaker services provided in combination with in-home companion, sitter, respite, or other home care services.

BILL ANALYSIS:

Section 1 of the bill amends G.S. 58-64-5(b) to increase the application fee for a continuing care license from $500 to $1000.

Section 2 amends the definitions contained in G.S. 58-64-1 as follows:

- "*Continuing care*" is amended to include the provision or arrangement of home care services by a provider of lodging at a facility to an individual who has entered into a continuing care contract with the provider, but is not yet receiving lodging.

- "*Home care services*" -- as defined in G.S. 131E-136 (see above).
- "*Lodging*" -- a living unit and meals as set forth in a contract approved by DOI.

Section 3 amends G.S. 58-64-25(b) regarding the provisions that must be contained in a continuing care contract to require that when a contract provides for the provision or arrangement of continuing care without lodging, the contract must specify the procedures for determining when the individual will transition to receiving both lodging and health related services.

Section 4 amends Article 64 of Chapter 58 by adding a new section to specify the information a continuing care retirement community (CCRC) that wishes to provide continuing care services without lodging must submit to the Department of Insurance:

- An application to offer continuing care services without lodging
- An amended disclosure statement (currently required for regular CCRC operation under G.S. 58-64-20 and G.S. 58-64-30) with a description of the proposed continuing care services that will be provided without lodging, including the target market, the types of services to be provided, and the fees to be charged.
- A copy of the written service agreement which must contain those provisions as prescribed in current law.
- A summary of an actuarial report that presents the impact of providing continuing care services without lodging on the overall operation of the continuing care retirement community.
- A financial feasibility study prepared by a certified public accountant showing the financial impact of providing continuing care services without lodging on the applicant and the continuing care retirement facility or facilities. The study must include a statement of activities reporting the revenue and expense details for providing continuing care services without lodging, as well as, any impact the provision of these services will have on operating reserves.
- Evidence of the license required under Part 3, Article 6, of Chapter 131E (Home Care Agency Licensure Act) to provide home care services, or a contract with a licensed home care agency for the provision of home care services to the individuals under the continuing care services without lodging program.

Section 5 requires DOI and the Department of Health and Human Services to identify any statutory, regulatory, or practical barriers that prevent or discourage individuals that contract with continuing care retirement communities from receiving home care services for as long they need home care services and are able to be safely cared for in their homes. The Departments are required to provide an interim status report on or before November 1, 2010, and a final report on or before September 1, 2011, to the NC Study Commission on Aging and the Joint Legislative Health Care Oversight Committee.

EFFECTIVE DATE:

The fee increase would become effective July 1, 2010, and apply to applications filed on or after that date. Sections 2, 3, 4, and 5 would become effective when the act becomes law. If funding is not provided in the 2010 budget for a specified position within DOI to oversee the new services, Sections 2, 3, and 4 would expire July 1, 2012. In that event, CCRCs would not be permitted to continue to enter into contracts for the provision or arrangement of continuing care without lodging, but existing contracts executed prior to the sunset date would remain in effect, and CCRCs would be permitted to provide home care service without lodging after July 1, 2012, pursuant to the terms of such contracts.

Theresa Matula, Staff to House Aging, substantially contributed to this summary.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 354

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

S354-ARC-50 [v.1]

Comm. Sub. [YES]
Amends Title [NO]
S354-PCS55635-RCf-76

Date 6/29 ,2010

Represenative Faison

moves to amend the bill on page 3, line 42, by inserting the phrase "dated June 28, 2010" after the word "Budgets";

and on page 3, line 43, by deleting the phrase "a provision" and substituting "Item 73, Page J-25";

and on page 4, line 2, by inserting the phrase "dated June 28, 2010" after the word "Budgets";

and on page 4, line 3, by deleting the phrase "a provision" and substituting "Item 73, Page J-25";

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED X FAILED _____ TABLED _____

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☒ House Committee Substitute # 2 for

SB 354 A BILL TO BE ENTITLED AN ACT TO PERMIT CONTINUING CARE RETIREMENT COMMUNITIES TO PROVIDE OR ARRANGE FOR HOME CARE SERVICES WITHOUT PROVIDING LODGING WHEN THOSE SERVICES ARE PROVIDED ADJUNCT TO A CONTRACT FOR CONTINUING CARE AND TO REQUIRE THE DEPARTMENT OF INSURANCE AND THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES RELATED TO CONTINUING CARE RETIREMENT COMMUNITIES PROVIDING HOME CARE SERVICES WITHOUT PROVIDING LODGING.

☒ With a favorable report as to House Committee Substitute Bill 3, unfavorable as to House Committee Substitute Bill 2, and recommendation that House Committee Substitute Bill 3 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.

Senate Bill 354 / S.L. 2010-128

2009-2010 Session

Continuing Care Retire. Community/Home Care.

View Bill Digest	
Text	**Fiscal Note**
Filed [HTML]	-
Edition 1 [HTML]	-
Edition 2 [HTML]	-
Edition 3 [HTML]	-
Edition 4 [HTML]	-
Edition 5 [HTML]	SFN0354v5r1
Edition 6 [HTML]	-
Ratified [HTML]	-
SL2010-128 [HTML]	-

Status: Ch. SL 2010-128 on 07/21/2010

Sponsors

Primary: Eleanor Kinnaird;

Co: Bob Atwater; Doug Berger; Tony Foriest; Floyd B. McKissick, Jr.; Martin L. Nesbitt, Jr.; Richard Stevens;

Attributes: Public; Text has changed;

Vote History

Date	Subject	RCS #	Aye	No	N/V	Exc. Abs.	Exc. Vote	Total	Result
07/06/2010 3:08PM	Third Reading	[H] - 1656	112	1	3	4	0	113	PASSED
07/07/2010 6:09PM	Motion 8\To Concur	[S] - 1529	48	0	0	2	0	48	PASSED

Viewing Last 2 Vote(s) *View All Votes*

History RSS

te	Chamber	Action
02/26/2009	Senate	Filed
03/02/2009	Senate	Ref to Health Care. If fav, re-ref to Appropriations/Base Budget
03/18/2009	Senate	Reptd Fav
03/18/2009	Senate	Re-ref Com On Appropriations/Base Budget
04/23/2009	Senate	Reptd Fav Com Substitute
04/23/2009	Senate	Com Substitute Adopted
04/23/2009	Senate	Placed On Cal For 4/28/2009
04/28/2009	Senate	Passed 2nd & 3rd Reading
04/30/2009	House	Passed 1st Reading
04/30/2009	House	Ref to the Com on Health, if favorable, Appropriations
05/26/2009	House	Reptd Fav Com Substitute
05/26/2009	House	Re-ref Com On Appropriations
06/02/2010	House	Withdrawn From Com
06/02/2010	House	Re-ref to the Com on Aging, if favorable, Insurance, if favorable, Finance
06/16/2010	House	Reptd Fav Com Sub 2
06/16/2010	House	Re-ref Com On Insurance
06/29/2010	House	Reptd Fav Com Sub 3
06/29/2010	House	Re-ref Com On Finance
06/30/2010	House	Reptd Fav
06/30/2010	House	Cal Pursuant Rule 36(b)
06/30/2010	House	Placed On Cal For 7/1/2010
07/01/2010	House	Amend Adopted 1
07/01/2010	House	Passed 2nd Reading
07/06/2010	House	Withdrawn From Cal
07/06/2010	House	Re-ref Com On Appropriations
07/06/2010	House	Withdrawn From Com
07/06/2010	House	Cal For Immediate Consid
)6/2010	House	Passed 3rd Reading
)6/2010	Senate	Rec From House
07/06/2010	Senate	Rec To Concur H Com Sub
07/06/2010	Senate	Placed On Cal For 7/7/2010
07/07/2010	Senate	Withdrawn From Cal
07/07/2010	Senate	Re-ref Com On Finance

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07/07/2010	Senate	Reptd Fav To Concur
07/07/2010	Senate	Placed On Cal For 7/7/2010
07/07/2010	Senate	Concurred In H/com Sub
07/08/2010		Ratified
'08/2010		Pres. To Gov. 7/8/2010
'21/2010		Signed By Gov. 7/21/2010
07/21/2010		Ch. SL 2010-128

Note: a bill listed on this website is not law until passed by the House and the Senate, ratified, and, if required, signed by the Governor.

2009-2010 Session

Bill Number: enter bill # (i.e., S Look-Up

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 2

SENATE BILL 1251*
Pensions & Retirement & Aging Committee Substitute Adopted 6/16/10

Short Title: State Health Plan/Treat Teachers Equitably. (Public)

Sponsors:

Referred to:

May 20, 2010

A BILL TO BE ENTITLED

AN ACT TO GRANT THE SAME HEALTH BENEFIT COVERAGE CURRENTLY PROVIDED TO OTHER STATE EMPLOYEES TO TEACHERS WHO HAVE WORKED A FULL SCHOOL YEAR.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-45.2(a)(8) reads as rewritten:

"**§ 135-45.2. Eligibility.**

(a) Noncontributory Coverage. – The following persons are eligible for coverage under the Plan, on a noncontributory basis, subject to the provisions of G.S. 135-45.4:

...

(8) Notwithstanding the provisions of ~~G.S.~~ G.S. 135-45.12 employees formerly covered by the provisions of this section, other than retired employees, who have been employed for 12 or more months by an employing ~~unit~~ unit, or who have completed a contract term of employment of 10 or 11 months and whose employing unit is a local school administrative unit, and whose jobs are eliminated because of a reduction, in total or in part, in the funds used to support the job or its responsibilities, provided the employees were covered by the Plan at the time of separation from service resulting from a job elimination. Employees covered by this subsection shall be covered for a period of up to 12 months following a separation from service because of a job elimination."

SECTION 2. This act becomes effective July 1, 2010.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

REVISED

BILL NUMBER: Senate Bill 1251 (First Edition)

SHORT TITLE: State Health Plan/Treat Teachers Equitably.

SPONSOR(S): Senator Blue

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY: Amends a section of the Plan's governing statute under G.S. 135-45.2, entitled "Eligibility", to allow a local school administrative unit employee enrolled in the Plan, who has been employed a minimum period of 10 or 11 months, to be eligible for one-year of non contributory coverage under the Plan if the employee subsequently has their job eliminated because of a reduction, in total or part, in the funds to support the job.

EFFECTIVE DATE: July 1, 2010

ESTIMATED IMPACT ON STATE:

Aon Consulting, the consulting actuary for the State Health Plan for Teachers and State Employees, estimates that the bill's requirements will not have a fiscal impact on the Plan.

Hartman & Associates, the consulting actuary for the General Assembly's Fiscal Research Division, estimates that the bill will not have a material impact on the Plan.

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Additional Information Provided to Each Consulting Actuary

According to the Department of Public Instruction, there were 4,283 employees of local public schools subject to reduction-in-force for the current FY 2009-2010 school year. Of this total, the Department estimates that 3,726 employees were 10-month employees.

Of the 3,726 10-month employees subject to RIF, 2,271 were teachers and instructional support with the balance being teacher assistants. Of the 2,271 teachers/instructional support, the Department estimates that 10% of the RIF'd employees were first year 10-month teachers/instructional support employees.

As a basis for estimating the future affected population for any potential reductions-in-force effective for the FY 2010-2011, data from the Retirement Systems' Division of the Department of State Treasurer indicates that, there were 4,525 first year 10-month local public school employees hired in the months of August 2009 and September 2009 who became contributing members of the retirement system. The months of August 2009 and September 2009 were selected to reflect the possible population of first year 10-month employees assuming the school year ends in late May 2010 and early June 2010. The data count reflects the enrollees under Job Classification code "100" which includes "Teachers, Teacher Aides, Coaches, Guidance Counselors, and Librarians", and were assumed to be 10-month employees.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2009, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total *revised* requirements for the Plan are estimated to be $2.55 billion for FY 2009-10 and $2.74 billion for FY 2010-11. The Plan's PPO benefit design includes two alternative benefit levels listed below:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums; and

2) The "Standard" 80/20 plan.

The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under both plans is offered on a fully contributory basis.

Financial Condition

Revised Financial Projection 2009-11 Biennium – The following summarizes a revised financial projection by conducted by the Plan's consulting actuary, Aon Consulting, for the 2009-11 biennium. The information is provided by fiscal year based on year-to-date financial experience (through March 2010) and other updated factors.

For the fiscal year beginning July 1, 2009, the Plan began its operations with a beginning cash balance of $189.9 million. Receipts for the year are projected to be $2.41 billion from net premium collections, $74.4 million from Medicare Part D subsidies, and $3.4 million from investment earnings for a total of

approximately $2.49 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.39 billion in net claim-payment expenses and $164.1 million in administration and claims-processing expenses for projected total expenses of nearly $2.55 billion for FY 2009-10. The Plan's net operating loss is projected to be approximately $66.3 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan is projected to begin its operations with a beginning cash balance of $123.6 million. Receipts for the year are projected to be $2.68 billion from net premium collections, $56.1 million from Medicare Part D subsidies, and $2.7 million from investment earnings for a total of approximately $2.73 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.55 billion in net claim-payment expenses and $191.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.74 billion for FY 2010-11. The Plan's net operating loss is projected to be approximately $7.1 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Based on the revised financial projection (May 2010), the Plan's estimated ending cash balance on June 30, 2011 is projected to be $116.5 million. This amount is approximately $75.7 million less than the originally projected (April 2009) ending cash balance of $192.2 million.

Original Financial Projection 2009-11 Biennium (April 2009) – Session Law 2009-16 (Senate Bill 287) appropriated funds from various sources, authorized annual premium rate increases, made various benefit and provider related changes to achieve financial savings, and directed other various changes to the Plan. The enacted law also appropriated the sum of $250 million from the Savings Reserve Account ("Rainy Day Fund") of the General Fund for the 2008-09 fiscal year. The following summarizes the original financial projection by fiscal year for the 2009-11 biennium and assumes the changes enacted in Session Law 2009-16 (Senate Bill 287).

For the fiscal year beginning July 1, 2009, the Plan was projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year were projected to be $2.4 billion from net premium collections, $56.3 million from Medicare Part D subsidies, and $8.0 million from investment earnings for a total of approximately $2.5 billion in receipt income for the year. Projected disbursements from the Plan were expected to be $2.3 billion in net claim-payment expenses and $185.6 million in administration and claims-processing expenses for projected total expenses of nearly $2.5 billion for FY 2009-10. The Plan's net operating income was projected to be approximately $14.8 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan was projected to begin its operations with a beginning cash balance of $161.6 million. Receipts for the year were projected to be $2.7 billion from net premium collections, $50.4 million from Medicare Part D subsidies, and $8.8 million from investment earnings for a total of approximately $2.7 billion in receipt income for the year. Projected disbursements from the Plan were expected to be $2.5 billion in net claim-payment expenses and $191.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.7 billion for FY 2010-11. The Plan's net operating income was projected to be approximately $30.6 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Other Information

Historically, the Plan has applied a premium increase in October of the first fiscal year of a biennium. However, the annual premium increases authorized in Session Law 2009-16 (Senate Bill 287) changes that methodology to an annual increase at the beginning of each fiscal year of the 2009-11 biennium.

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment as of December 31, 2009

I. No. of Participants	Basic	Standard	Total	Percent of Total
Actives				
Employees	13,830	307,541	321,371	48.6%
Dependents	24,593	135,563	160,156	24.2%
Sub-total	38,423	443,104	481,527	72.8%
Retired				
Employees	2,074	151,395	153,469	23.2%
Dependents	1,313	18,075	19,388	2.9%
Sub-total	3,387	169,470	172,857	26.1%
Former Employees with Continuation Coverage				
Employees	121	3,120	3,241	0.5%
Dependents	87	749	836	0.1%
Sub-total	208	3,869	4,077	0.6%
Firefighters, Rescue Squad & National Guard				
Employees	-	5	5	0.0%
Dependents	-	3	3	0.0%
Sub-total	-	8	8	0.0%
Local Governments				
Employees	91	1,829	1,920	0.3%
Dependents	174	777	951	0.1%
Sub-total	265	2,606	2,871	0.4%
Total				
Employees	16,116	463,885	480,001	72.6%
Dependents	26,167	155,164	181,331	27.4%
Grand Total	**42,283**	**619,049**	**661,332**	**100%**
Percent of Total	**6.4%**	**93.6%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Total
Employee Only	3,252	378,539	381,791
Employee Child(ren)	6,026	43,820	49,846
Employee Spouse	2,550	21,785	24,335
Employee Family	4,288	19,741	24,029
Total	**16,116**	**463,885**	**480,001**

Percent Enrollment by Contract	Basic	Standard	Total
Employee Only	20.2%	81.6%	79.5%
Employee Child(ren)	37.4%	9.4%	10.4%
Employee Spouse	15.8%	4.7%	5.1%
Employee Family	26.6%	4.3%	5.0%
Total	**100.0%**	**100.0%**	**100.0%**

III. Enrollment by Sex	Basic	Standard	Total
Female	22,479	390,209	412,688
Male	19,804	228,840	248,644
Total	**42,283**	**619,049**	**661,332**

Percent Enrollment by Sex	Basic	Standard	Total
Female	53.2%	63.0%	62.4%
Male	46.8%	37.0%	37.6%
Total	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Total
19 & Under	17,315	95,431	112,746
20 to 29	3,311	57,142	60,453
30 to 44	9,555	120,292	129,847
45 to 54	6,455	108,447	114,902
55 to 64	4,090	128,933	133,023
65 & Over	1,557	108,804	110,361
Total	**42,283**	**619,049**	**661,332**

Percent Enrollment by Age	Basic	Standard	Total
19 & Under	41.0%	15.4%	17.0%
20 to 29	7.8%	9.2%	9.1%
30 to 44	22.6%	19.4%	19.6%
45 to 54	15.3%	17.5%	17.4%
55 to 64	9.7%	20.8%	20.1%
65 & Over	3.7%	17.6%	16.7%
Total	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	51,747	11,879	63,626
Medicare Eligible	101,722	7,509	109,231
Total	**153,469**	**19,388**	**172,857**

VI. Enrollment By Major Employer Groups	Employees	Dependents	Total
State Agencies	75,367	34,645	110,012
UNC System	50,106	29,726	79,832
Local Public Schools	181,270	88,258	269,528
Local Community Colleges	14,623	7,524	22,147
Other			
Local Governments	1,920	951	2,871
COBRA	3,241	836	4,077
Nat. Guard, Fire & Rescue	5	3	8
Sub-total	5,166	1,790	6,956
Retirement System	153,469	19,388	172,857
Total	**480,001**	**181,331**	**661,332**

Percent Enrollment by Major Employer Groups	Employees	Dependents	Total
State Agencies	15.7%	19.1%	16.6%
UNC System	10.4%	16.4%	12.1%
Local Public Schools	37.8%	48.7%	40.8%
Local Community Colleges	3.0%	4.1%	3.3%
Other			
Local Governments	0.4%	0.5%	0.4%
COBRA	0.7%	0.5%	0.6%
Nat. Guard, Fire & Rescue	0.0%	0.0%	0.0%
Sub-total	1.1%	1.0%	1.1%
Retirement System	32.0%	10.7%	26.1%
Total	100.0%	100.0%	100.0%

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, "Senate Bill 1251: An Act to Grant the Same Health Benefit Coverage Currently Available to Other State Employees to Teachers Who Have Worked a Full School Year", June 4, 2010, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "Senate Bill 1251 State Health Plan/Treat Teachers Equitably", June 4, 2010, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Marilyn Chism, Director
Fiscal Research Division

DATE: June 15, 2010

Signed Copy Located in the NCGA Principal Clerk's Offices

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☒Committee Substitute for

SB 1251 A BILL TO BE ENTITLED AN ACT TO GRANT THE SAME HEALTH BENEFIT COVERAGE CURRENTLY PROVIDED TO OTHER STATE EMPLOYEES TO TEACHERS WHO HAVE WORKED A FULL SCHOOL YEAR.

☒ With a favorable report and recommendation that the 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 _____.

_____ The bill/resolution is re-referred to the Committee on _____.

PRINTABLE VERSION

<< Previous: S1250 Next: S1252 >>

Senate Bill 1251 / S.L. 2010-136 (= H1853)

2009-2010 Session

State Health Plan/Treat Teachers Equitably.

View Bill Digest	
Text	**Fiscal Note**
Filed [HTML]	-
Edition 1 [HTML]	SAH1251v1r1
Edition 2 [HTML]	-
Ratified [HTML]	-
SL2010-136 [HTML]	-

Status: Ch. SL 2010-136 on 07/21/2010

Sponsors

Primary: Dan Blue;

Co: Bob Atwater;

Attributes: Public; Text has changed;

Vote History

Date	Subject	RCS #	Aye	No	N/V	Exc. Abs.	Exc. Vote	Total	Result
07/09/2010 10:39AM	Conference Rpt\Motion 7\To Adopt	[S] - 1578	49	0	1	0	0	49	PASSED
07/09/2010 11:01AM	C Rpt Adopt	[H] - 1770	107	2	3	8	0	109	PASSED

Viewing Last 2 Vote(s) *View All Votes*

History RSS

Date	Chamber	Action
05/19/2010	Senate	Filed
05/20/2010	Senate	Ref To Com On Pensions & Retirement & Aging
16/2010	Senate	Reptd Fav Com Substitute
16/2010	Senate	Com Substitute Adopted
06/17/2010	Senate	Passed 2nd & 3rd Reading
06/22/2010	House	Passed 1st Reading
06/22/2010	House	Ref to the Com on Insurance, if favorable, Appropriations
06/29/2010	House	Reptd Fav
06/29/2010	House	Re-ref Com On Appropriations
06/30/2010	House	Withdrawn From Com
06/30/2010	House	Cal Pursuant Rule 36(b)
06/30/2010	House	Placed On Cal For 7/1/2010
07/01/2010	House	Passed 2nd Reading
07/06/2010	House	Amend Adopted 1
07/06/2010	House	Passed 3rd Reading
07/06/2010	Senate	Rec From House
07/06/2010	Senate	Rec To Concur In H Amend
07/06/2010	Senate	Placed On Cal For 7/7/2010
07/07/2010	Senate	Withdrawn From Cal
07/07/2010	Senate	Placed On Cal For 7/8/2010
07/08/2010	Senate	Fail Concur In H Amend # 1
07/08/2010	Senate	**Conf Com Appointed**
07/08/2010	House	**Conf Com Appointed**
07/08/2010	House	Conf Com Reported
07/08/2010	House	Placed On Cal For 7/9/2010
07/08/2010	Senate	Conf Com Reported
07/08/2010	Senate	Placed On Cal For 7/9/2010
07/09/2010	Senate	Conf Report Adopted
07/09/2010	House	Conf Report Adopted
07/09/2010		Ratified
07/09/2010		Pres. To Gov. 7/9/2010
21/2010		Signed By Gov. 7/21/2010
21/2010		Ch. SL 2010-136

Note: a bill listed on this website is not law until passed by the House and the Senate, ratified, and, if required, signed by the Governor.

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2009-2010 Session

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Attachment 1

VISITOR REGISTRATION SHEET

House Committee on Insurance — June 29, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Carsley	BSCBC
Cam Grey	BP MRL
Mitney Campbell	Jordan Price
Annalise Dolph	DRNC
Doug Parks	City of Salisbury
Erin Robinson	MCPHA

VISITOR REGISTRATION SHEET

House Committee on Insurance — 6-29-2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Suzanne Beasley	SEANC
Chuck Stone	SEANC
Allison Calder	Paulatic
Andrew Cagle	DLC + Assoc.
Rose Willis	NCDOT

HOUSE INSURANCE COMMITTEE

June 29, 2010
11:00 AM
Room 1228 – LB

Rep. Michael H. Wray, Chairman
Rep. Bruce Goforth, Chairman

Vice-Chairs
Rep. Van Braxton
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

SB 354 – Continuing Care Retire. Community/Home Care
Sen. Kinnaird

SB 1251 – State Health Plan/Treat Teachers Equitably
Sen. Blue

SB 1392 – State Health Plan/Court-Ordered Guardianships
Sen. McKissick

Adjourn

Mary Capps (Rep. Wray)

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m: Mary Capps (Rep. Wray)

t: Thursday, June 24, 2010 5:22 PM

o: Sen. Ellie Kinnaird; Sen. Dan Blue; Sen. Floyd McKissick; Rep. Rick Glazier; Rep. Tricia Cotham; Rep. Earline W. Parmon; Rep. Jane Whilden; Rep. Jean Farmer-Butterfield; Rep. Angela Bryant; Rep. Melanie Goodwin; Rep. Pat Hurley

Cc: Maria Kinnaird (Sen. Kinnaird); Barbara McMillan (Sen. Blue); Rosita Littlejohn (Sen. McKissick); Carin Savel (Rep. Glazier); Rosa Kelley (Rep. Cotham); Pat Christmas (Rep. Parmon); Beth LeGrande (Rep. Whilden); Wanda Kay (Rep. Farmer-Butterfield); Karon Hardy (Rep. Bryant); Jane McMillan (Rep. Goodwin); Nicole McGuinness (Rep. Hurley)

Subject: <NCGA> House Insurance Committee Meeting Notice for Tuesday, June 29, 2010

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2009-2010 SESSION

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

& DATE: Tuesday, June 29, 2010
: 11:00 am
ATION: 1228 LB
COMMENTS:

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 354	Continuing Care Retire. Community/Home Care.	Senator Kinnaird
SB 1251	State Health Plan/Treat Teachers Equitably.	Senator Blue
SB 1392	State Health Plan/Court-Ordered Guardianships.	Senator McKissick

Respectfully,
Representative Goforth, Chair
Representative Wray, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **5:30** o'clock on **June 24, 2010**.

ipal Clerk
ing Clerk – House Chamber

Mary Capps (Committee Assistant)

06/24/2010

MINUTES

HOUSE COMMITTEE ON INSURANCE

July 7, 2010

The House Committee on Insurance met at 1:30 PM on Wednesday, July 7, 2010 in Room 1228. The following Representatives attended, Chairmen Bruce Goforth and Michael Wray; Vice Chairs: M. Dickson, J. Dockham and M. Setzer. Members attending were Reps. Barnhart, Blust, Braxton, Brubaker, Cole, Current, Faison, Gibson, Howard, Spaulding Hughes, Lewis Pierce, and Wainwright.

Chairman Goforth called the meeting to order and welcomed visitors. He recognized Sgt-At Arms and Pages. Visitor Registration Sheets are attached and made part of the record. (Attachments).

Chairman Goforth called on Senator Doug Berger to explained House Bill 144: Special Care Dentistry Collaboration. The bill would prohibit agreements between a dentist ran insurer or an entity that writes stand alone dental insurance that limit fees for dental services unless the services are reimbursed as covered services under the contract. The Proposed Committee Substitute adds a definition of 'covered services'. The act is effective when it becomes law and applies to contracts between dentists and plans delivered; amended or renewed on or after the date.

After Senator Berger explained the bill, general discussion ensued. Questions were raised by Representatives Dockham and Brubaker. Once there was no more general discussion Representative Braxton moved to concur with the bill and it was moved to the House floor.

Chairman Goforth adjourned the meeting at 1:35.

Representative Bruce Goforth, Chairman

Meredith Matney – Committee Assistant

HOUSE BILL 144:
No Set Fee/Noncovered Dental Srvcs

2009-2010 General Assembly

Committee:	House Insurance	**Date:**	July 7, 2010
Introduced by:	Reps. Farmer-Butterfield, Pierce, Bordsen, Mobley	**Prepared by:**	Kory Goldsmith Committee Counsel
Analysis of:	Fourth Edition		

SUMMARY: House Bill 144 would prohibit agreements between a dentist and an insurer or an entity that writes stand alone dental insurance that limit fees for dental services unless the services are reimbursed as covered services under the contract. The Proposed Committee Substitute adds a definition of 'covered services'.

The act is effective when it becomes law and applies to contracts between dentists and plans delivered, amended or renewed on or after that date.

BILL ANALYSIS:

Section 1 would enact G.S. 58-50-290 to prohibit fee limitations in agreements between a dentist and an insurer or between a dentist and an entity that writes stand alone dental insurance for the provision of dental services on a preferred or in-network basis unless the service in question is covered service under the contract.

A "covered service" is defined as services for which reimbursement is available under an insurer's policy, without regard to contractual limitations by a deductible, co-payment or other limitation.

Section 2 provides that the prohibition contained in new G.S. 58-50-290 applies to dental service corporations.

EFFECTIVE DATE: This act is effective when it becomes law and applies to contracts between dentists and health benefit plans or insurers delivered, amended, or renewed on or after that date.

Ben Popkin, counsel to Senate Health Care Committee, substantially contributed to this summary.

H144-SMRC-91(e4) v1

HOUSE BILL 144*

Committee Substitute Favorable 3/19/09
Senate Health Care Committee Substitute Adopted 6/3/10
Senate Judiciary II Committee Substitute Adopted 7/1/10

Short Title: No Set Fee/Noncovered Dental Srvcs. (Public)

Sponsors:

Referred to:

February 12, 2009

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT HEALTH BENEFIT PLANS AND INSURERS FROM LIMITING OR FIXING THE FEE A DENTIST MAY CHARGE PATIENTS FOR SERVICES UNLESS THE SERVICES ARE COVERED FOR REIMBURSEMENT UNDER THE PLAN OR INSURER CONTRACT WITH THE DENTIST.

The General Assembly of North Carolina enacts:

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

"**§ 58-50-290. Health benefit plans or insurers contracting for provision of dental services; no limitation on fees for noncovered services.**

(a) No agreement between an insurer or an entity that writes stand-alone dental insurance and a dentist for the provision of dental services on a preferred or in-network basis to plan members or insurance subscribers in connection with coverage under a stand-alone dental plan, but not in connection with or incidental to coverage under a medical plan or health insurance policy, may require that a dentist provide services at a fee limited or set by the plan or insurer, unless the services are reimbursed as covered services under the contract.

(b) For purposes of this section, "covered services" means a service for which reimbursement is available under an insurer's policy, without regard to contractual limitations by a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, or other limitation."

SECTION 2. 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.
Part 7 of Article 10.	Annual Financial Reporting.
G.S. 58-50-35.	Notice of nonpayment of premium required before forfeiture.
G.S. 58-50-290.	Health benefit plans or insurers contracting for the provision of dental services; no limitation on fees for noncovered services.
G.S. 58-51-15(a)(2)b.	Accident and health policy provisions.
G.S. 58-51-17	Portability for accident and health insurance.
G.S. 58-51-25.	Policy coverage to continue as to mentally retarded or physically handicapped children.
G.S. 58-51-95(h),(i),(j).	Approval by Commissioner of forms, classification and rates; hearings; exceptions."

SECTION 3. This act is effective when it becomes law and applies to contracts between dentists and heath benefit plans or insurers delivered, amended, or renewed on or after that date.

VISITOR REGISTRATION SHEET

Insurance | [redacted] | 7-7-2010

Name of Committee | **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	NW
[signature]	NCREEA
DANIEL BAUM	TROUTMAN SANDERS
M. Alec Pridgen	NC Dental Society
[signature]	SEANC

VISITOR REGISTRATION SHEET

Insurance — 7-7-2010

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Shannon McCoy	Nationwide
[signature]	JD, AL, PA
Mark Fleming	BCBSNC
Bill Scoggin	TSS
[signature]	NMRS
Piggie Patton	NCDS
Lisa Piercy	Ragsdale Liggett

HOUSE PAGES

NAME OF COMMITTEE Insurance DATE 7-7-10

1. Name: Kristen Johnson
   County: Wake
   Sponsor: Gill
2. Name: Gabby Burnett
   County: Durham
   Sponsor: Lubke
3. Name: Elizabeth Brewer
   County: Watauga
   Sponsor: Tarleton
4. Name: Louisa Clark
   County: Pitt
   Sponsor: McLawhorn
5. Name:
   County:
   Sponsor:

SGT-AT-ARM

1. Name: Judy Turner
2. Name: Bill Bass
3. Name: Martha Gadison
4. Name:

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

Senate ☒ Committee Substitute for

HB 144 A BILL TO BE ENTITLED AN ACT TO PROHIBIT HEALTH BENEFIT PLANS AND INSURERS FROM LIMITING OR FIXING THE FEE A DENTIST MAY CHARGE PATIENTS FOR SERVICES UNLESS THE SERVICES ARE COVERED FOR REIMBURSEMENT UNDER THE PLAN OR INSURER CONTRACT WITH THE DENTIST.

☒ 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 _____.

HOUSE INSURANCE COMMITTEE

July 7, 2010
1:30 p.m.
Room 1228 LB

Rep. Bruce Goforth, Chairman
Rep. Michael Wray, Chairman

Vice-Chairs:
Rep. Van Braxton
Rep. Jerry Dockham
Rep. Mitchell Setzer

Agenda

HB 144- Special Care Dentistry Collaboration – Reps. Farmer-Butterfield, Pierce, Bordsen, Mobley

Adjourn

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2009-2010 SESSION

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

DAY & DATE: Wednesday, July 7, 2010
TIME: 1:30 pm
LOCATION: 1228 LB
COMMENTS:

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 144	Special Care Dentistry Collaboration.	Representative Farmer-Butterfield Representative Pierce Representative Bordsen Representative Mobley

Respectfully,
Representative Goforth, Chair
Representative Wray, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **5:55** o'clock on **July 6, 2010.**

☐ Principal Clerk
☐ Reading Clerk – House Chamber

Meredith Matney (Committee Assistant)

MINUTES

HOUSE COMMITTEE ON INSURANCE
July 8, 2010

The House Committee on Insurance met at 4:45 PM on Thursday, July 8, 2010 at Representative Michael H. Wray's Chamber Seat. The following Representatives attended, Chairmen Bruce Goforth and Michael H. Wray; Vice Chairs: V. Braxton, J. Dockham and M. Setzer. Members attending were Reps. Brubaker, Cole, Holliman, and Wainwright.

Chairman Wray called the meeting to order. He called upon Rep. Glazier to discuss a Senate Committee Substitute for HB 1035-Performance & Payment Bond Modification. Rep. Glazier shared HB 1035 Informal Bonding Requirements information with the committee and asked for the committee's support.

Chairman Wray recognized Rep. Wainwright who recommended that the House concur with the Senate Committee Substitute for HB 1035 and the motion carried.

Chairman Wray adjourned the meeting at 4:50 PM.

Representative Michael H. Wray, Chairman

Mary Capps, Committee Assistant

Diane Russell, Legislative Assistants Director, covered the meeting.

HOUSE BILL 1035
Senate Commerce Committee Substitute Adopted 7/7/10
Third Edition Engrossed 7/8/10

Short Title: Performance & Payment Bond Modification. (Public)

Sponsors:

Referred to:

April 6, 2009

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE PERFORMANCE AND PAYMENT BONDING REQUIREMENT FOR CONSTRUCTION PROJECT CONTRACTS AWARDED BY STATE DEPARTMENTS, STATE AGENCIES, AND THE UNIVERSITY OF NORTH CAROLINA THAT EXCEED FIVE HUNDRED THOUSAND DOLLARS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 44A-26 reads as rewritten:

"**§ 44A-26. Bonds required.**

(a) When the total amount of construction contracts awarded for any one project exceeds three hundred thousand dollars ($300,000), a performance and payment bond as set forth in (1) and (2) is required by the contracting body from any contractor or construction manager at risk with a contract more than fifty thousand dollars ~~($50,000).~~($50,000); provided that, for State departments, State agencies, and The University of North Carolina and its constituent institutions, a performance and payment bond is required in accordance with this subsection if the total amount of construction contracts awarded for any one project exceeds five hundred thousand dollars ($500,000). In the discretion of the contracting body, a performance and payment bond may be required on any construction contract as follows:

(1) A performance bond in the amount of one hundred percent (100%) of the construction contract amount, conditioned upon the faithful performance of the contract in accordance with the plans, specifications and conditions of the contract. Such bond shall be solely for the protection of the contracting body that is constructing the project.

(2) A payment bond in the amount of one hundred percent (100%) of the construction contract amount, conditioned upon the prompt payment for all labor or materials for which a contractor or subcontractor is liable. The payment bond shall be solely for the protection of the persons furnishing materials or performing labor for which a contractor, subcontractor, or construction manager at risk is liable.

(b) The performance bond and the payment bond shall be executed by one or more surety companies legally authorized to do business in the State of North Carolina and shall become effective upon the awarding of the construction contract."

SECTION 1.1. The Department of Administration, State Building Commission, is directed to simplify the process of prequalification for publicly funded construction projects and to report to the Joint Legislative Commission on Governmental Operations on the steps it is taking to implement this objective by December 31, 2010.

SECTION 1.2. The Department of Transportation ("DOT"), The University of North Carolina and its constituent institutions ("UNC"), and the Department of Administration ("DOA") shall monitor all projects in those agencies and institutions that are let without a performance or payment bond to determine the number of defaults on those projects, the cost to complete each defaulted project, and each project's contract price. Beginning March 1, 2011, and annually thereafter, DOT, UNC, and DOA shall report this information to the Joint Legislative Committee on Governmental Operations.

SECTION 2. This act becomes effective October 1, 2010, and applies to construction contracts awarded on or after that date.

2009 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:

By Representative Goforth, Wray (Chairs) for the Committee on INSURANCE.

☒ Senate Committee Substitute for

HB 1035 A BILL TO BE ENTITLED AN ACT TO INCREASE THE PERFORMANCE AND PAYMENT BONDING REQUIREMENT FOR CONSTRUCTION PROJECT CONTRACTS AWARDED BY STATE DEPARTMENTS, STATE AGENCIES, AND THE UNIVERSITY OF NORTH CAROLINA THAT EXCEED FIVE HUNDRED THOUSAND DOLLARS.

☒ 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 _____.

HB 1035 Informal Bonding Requirements

- Provides consistency and eliminates confusion in bid procedures throughout State agencies
- Once again, North Carolina takes a leadership role in creating and enhancing opportunities for local and small business
- *GS 143-135.8 Bidders may be prequalified for any public construction project (1995;c. 367, s. 8)*
  - The NC State Building Commission working with Universities, State Agencies, State Construction Office, Attorney General's Office , Office of Historically Underutilized Businesses and both General and Subcontractor representatives developed guidelines for a uniform prequalification for single-prime contractors
  - The uniform prequalification process tool aids in the selection of quality firms for public construction projects in the prequalification process, contractors must be reviewed upon thorough criteria
- Flexibility in bonding requirements below $500,000 would allow the institutions to work closely with small and minority firms
-

Construction Contract Amounts based on package award date

January 1 2009 thru June 30, 2010 *(does not include University projects)*

Project Size	Total Value	Project Count	% of Total	% of Cost
$100-$300k	$14,592,512.45	70	32%	3%
$300-$500k	$14,737,820.62	38	17%	3%
$500k or greater	$510,625,676.54	110	50%	95%

- Between January 1 2009 and June 31 2010, there were 38 projects (of 218 total projects) that fell within the $300-$500k range. Those projects represented $14,737 million, which was 3% of the total cost of all construction projects (Total cost was $539,956 million.)

- Based on the fiscal projections, the State could expect to save between $236 k and $354k. Over five years that amount could be $1,184 million to $1.774 million.

House Bill 1035

2009-2010 Session

Performance & Payment Bond Modification.

View Bill Digest	
Text	**Fiscal Note**
Filed [HTML]	-
Edition 1 [HTML]	HFN1035v1
Edition 2 [HTML]	-
Edition 3 [HTML]	-

Status: Ref To Com On Insurance on 07/08/2010

Sponsors

Primary: Glazier; Goforth; McLawhorn; Yongue;

Co: Harrison; Insko; Lucas; Parmon;

Attributes: Public; Text has changed;

Vote History

Date	Subject	RCS #	Aye	No	N/V	Exc. Abs.	Exc. Vote	Total	Result
07/07/2010 5:50PM	Amendment 1	[S] - 1524	48	0	0	2	0	48	PASSED
07/07/2010 5:52PM	Second Reading	[S] - 1525	30	18	0	2	0	48	PASSED

Viewing Last 2 Vote(s) *View All Votes*

History RSS

Date	Chamber	Action
04/02/2009	House	Filed
04/06/2009	House	Passed 1st Reading
04/06/2009	House	Ref to the Com on State Government/State Personnel, if favorable, Appropriations
/13/2009	House	Reptd Fav
/13/2009	House	Re-ref Com On Appropriations
05/14/2009	House	Withdrawn From Com
05/14/2009	House	Cal Pursuant Rule 36(b)
05/14/2009	House	Placed On Cal For 5/14/2009
05/14/2009	House	Passed 2nd & 3rd Reading
05/14/2009	Senate	Rec From House
05/19/2009	Senate	Ref To Com On Commerce
07/07/2010	Senate	Reptd Fav Com Substitute
07/07/2010	Senate	Com Substitute Adopted
07/07/2010	Senate	Placed On Cal For 7/7/2010
07/07/2010	Senate	Amend Adopted # 1
07/07/2010	Senate	Passed 2nd Reading
07/08/2010	Senate	Passed 3rd Reading
07/08/2010	Senate	Engrossed
07/08/2010	House	Rec To Concur S Com Sub
07/08/2010	House	Ref To Com On Insurance

Note: a bill listed on this website is not law until passed by the House and the Senate, ratified, and, if required, signed by the Governor.

2009-2010 Session

Bill Number: enter bill # (i.e., S Look-Up

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2009-2010 nium

Bill	Introducer	Short Title		Date	Latest Action
H 26	Spear	STAY BEACH PLAN RATES, DEDUCTIBLE, SURCHARGES.	H	02-12-2009	Ref to the Com on Insurance, if favorable, Judiciary II
H 29	Faison	ALLOW UM/UIM STACKING.	H	02-12-2009	Ref to the Com on Insurance, if favorable, Judiciary III
H 82	Faison	INCREASE AUTO INSURANCE LIABILITY LIMITS.	H	02-12-2009	Ref to the Com on Insurance, if favorable, Ways & Means / Broadband Connectivity
H 332=	England, M.D.	MEDICAL MALPRACTICE SETTLEMENT REPORTS.	*H	03-02-2009	Ref to the Com on Insurance, if favorable, Judiciary I
H 426=	Spear	STAY ON HOMEOWNERS INSURANCE ACTIONS.	H	03-05-2009	Ref to the Com on Insurance, if favorable, Commerce, Small Business, and Entrepreneurship
H 678	Allen	MAKE UM/UIM INSURANCE OPTIONAL AGAIN.	H	03-19-2009	Ref to the Com on Insurance, if favorable, Ways and Means/ Broadband Connectivity
H 919	Martin	CASA ESPERANZA MONTESSORI/STATE HEALTH PLAN.	H	05-07-2009	Re-ref to the Com on Insurance, if favorable, Pensions and Retirement, if favorable, Appropriations
H1023	Goforth	PEO AMENDMENTS.	H	04-02-2009	Ref to the Com on Insurance, if favorable, Finance
H1040	Dockham	AMEND VIATICAL SETTLEMENT CONTRACT DEFINITION.	H	04-06-2009	Ref to the Com on Insurance, if favorable, Judiciary I
H1061	Allen	REVISE UM/UIM LIABILITY COVERAGE REQUIREMENTS.	H	04-06-2009	Ref to the Com on Insurance, if favorable, Ways and Means/ Broadband Connectivity
H1247	Haire	STATE HEALTH PLAN/EMPLOYEE-ONLY PREMIUM.	H	04-09-2009	Ref to the Com on Insurance, if favorable, Appropriations
H1293	Dockham	NC RISK POOL CHANGES/OUT-OF-STATE SERVICES.	H	04-09-2009	Ref to the Com on Insurance, if favorable, Judiciary II
H1302	Blust	STATE HEALTH PLAN/TRANSFER TO OSBM.	H	04-09-2009	Ref to the Com on Insurance, if favorable, Appropriations
H1321	Starnes	ALLOW UM/UIM COVERAGE CHOICE.	H	04-09-2009	Ref to the Com on Insurance, if favorable, Ways and Means/ Broadband Connectivity
H1391	Insko	NC RISK POOL CLARIFICATIONS.	*H	05-06-2009	Re-ref Com On Insurance
H1439	Spear	REFORM INSURANCE RATE FILING PROCESS.	H	04-13-2009	Ref to the Com on Insurance, if favorable, Judiciary II
H1458	Stewart	REVISE INSURANCE GUARANTY ASSOCIATION LIMITS.	H	04-13-2009	Ref to the Com on Insurance, if favorable, Judiciary II
H1483	Folwell	UNC INFIRMARIES/STATE HEALTH PLAN NETWORK.	H	04-13-2009	Ref to the Com on Insurance, if favorable, Appropriations

'$' indicates the bill is an appropriations bill.
A bold line indicates the bill is an appropriations 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		Date	Latest Action
H1494=	Goforth	REVISE UM/UIM COVERAGE REQUIREMENTS.	H	04-13-2009	Ref to the Com on Insurance, if favorable, Ways and Means/ Broadband Connectivity
H1647	Bryant	INSURANCE BURIAL BENEFITS NOTIFICATION.	H	05-07-2009	Ref to the Com on Insurance, if favorable, Finance
H1730	Insko	AUTH. STATE RISK POOL TO ADMIN. FED RISK POOL.	*H	05-24-2010	Re-ref Com On Insurance
H1853=	Glazier	STATE HEALTH PLAN/TREAT TEACHERS EQUITABLY.	H	05-20-2010	Ref to the Com on Insurance, if favorable, Appropriations
H1931=	Rapp	STATE HEALTH PLAN/ADD LOCAL GOVERNMENT.	H	05-24-2010	Ref to the Com on Insurance, if favorable, Appropriations
H1991=	Farmer-Butterfield	STATE HEALTH PLAN/COURT-ORDERED GUARDIANSHIPS.	H	05-26-2010	Ref to the Com on Insurance, if favorable, Appropriations
H2037	Dollar	STATE HEALTH PLAN/TRANSFER TO DEPT INSURANCE.	H	05-26-2010	Ref to the Com on Insurance, if favorable, Appropriations

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Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H0014	Tarleton	CHIROPRACTIC SERVICES/ INSURANCE.	*H	Re-ref Com On Health	02-12-09	05-07-09
26	Spear	STAY BEACH PLAN RATES, DEDUCTIBLE, SURCHARGES.	H	Ref to the Com on Insurance, if favorable, Judiciary II	02-12-09	
H0029	Faison	ALLOW UM/UIM STACKING.	H	Ref to the Com on Insurance, if favorable, Judiciary III	02-12-09	
H0082	Faison	INCREASE AUTO INSURANCE LIABILITY LIMITS.	H	Ref to the Com on Insurance, if favorable, Ways & Means / Broadband Connectivity	02-12-09	
H0144=	Farmer-Butterfie	NO SET FEE/NONCOVERED DENTAL SERVICES.	*HR	Ch. SL 2010-138	07-06-10	07-07-10
H0212	Goforth	HEALTH INSURANCE POOL PILOT PROGRAM.	*HR	Ch. SL 2009-568	02-18-09	03-16-09
H0332=	England	MEDICAL MALPRACTICE SETTLEMENT REPORTS.	*H	Ref to the Com on Insurance, if favorable, Judiciary I	03-02-09	
H0426=	Spear	STAY ON HOMEOWNERS INSURANCE ACTIONS.	H	Ref to the Com on Insurance, if favorable, Commerce, Small Business, and Entrepreneurship	03-05-09	
H0438	Folwell	STATE HEALTH PLAN/ CALENDAR YEAR.	H	Assigned To Appropriations Subcommittee on Health and Human Services	03-09-09	05-07-09
H0439	Folwell	STATE HEALTH PLAN/ TAXPAYER RECOVERY ACT.	HR	Ch. SL 2009-83	03-09-09	04-28-09
H0535	Cotham	HEALTH INSURANCE COVERAGE/LYMPHEDEMA.	*HR	Ch. SL 2009-313	05-05-09	05-13-09
H0589=	England	INS. & ST. HLTH PLAN COVER/HEARING AIDS/ AUTISM.	*HR	Ch. SL 2010-2	05-26-09	06-03-09
H0678	Allen	MAKE UM/UIM INSURANCE OPTIONAL AGAIN.	H	Ref to the Com on Insurance, if favorable, Ways and Means/ Broadband Connectivity	03-19-09	
H0742	Spear	PROHIBIT BEACH PLAN SURPLUS DISTRIBUTION.	H	Re-ref Com On Judiciary II	03-24-09	04-28-09
H0766=	Womble	ANNUITY INSOLVENCY COVERAGE/INS. GUAR. ASSN.	*HR	Ch. SL 2010-11	06-07-10	06-10-10
H0889=	Haire	CHANGE PENALTY FOR MISD. DEATH BY VEHICLE.	*HR	Ch. SL 2009-528	03-31-09	04-13-09
H0896	Harrell	CANCER DRUG COVERAGE	HR	Ch. SL 2009-170	04-16-09	04-28-09

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Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		CHANGES.				
119	Martin	CASA ESPERANZA MONTESSORI/STATE HEALTH PLAN.	H	Re-ref to the Com on Insurance, if favorable, Pensions and Retirement, if favorable, Appropriations	05-07-09	
H0964	Dockham	INSURANCE GUARANTY ASSOCIATION AMENDMENTS.	*HR	Ch. SL 2009-130	04-02-09	04-28-09
H0989	Bordsen	DOC LIABILITY INSURANCE.	*H	Re-ref Com On Appropriations	04-02-09	04-13-09
H1022=	Goforth	WORKERS' COMP./ DURATION OF TOTAL DISABILITY.	*H	Re-ref Com On Judiciary II	04-02-09	05-11-09
H1023	Goforth	PEO AMENDMENTS.	H	Ref to the Com on Insurance, if favorable, Finance	04-02-09	
H1035	Glazier	PERFORMANCE & PAYMENT BOND MODIFICATION.	*HR	Ch. SL 2010-148	07-08-10	07-08-10
H1040	Dockham	AMEND VIATICAL SETTLEMENT CONTRACT DEFINITION.	H	Ref to the Com on Insurance, if favorable, Judiciary I	04-06-09	
H1061	Allen	REVISE UM/UIM LIABILITY COVERAGE REQUIREMENTS.	H	Ref to the Com on Insurance, if favorable, Ways and Means/ Broadband Connectivity	04-06-09	
184	Hill	REVISE LPG DEALER REQUIREMENTS.	*HR	Ch. SL 2009-386	04-07-09	05-05-09
H1090	Wainwright	UI/SEVERANCE MODIFICATIONS.	*HR	Ch. SL 2009-366	04-07-09	05-05-09
H1159	Wray	INSURANCE LICENSING CHANGES.-AB	*HR	Ch. SL 2009-383	04-08-09	04-20-09
H1160	Wray	FIRE AND RESCUE PENSION FUND ADDITIONS.	*HR	Ch. SL 2009-567	04-08-09	05-07-09
H1161	Wray	REVISE INSURANCE FINANCIAL CONDITIONS.-AB	*HR	Ch. SL 2009-172	04-08-09	04-20-09
H1162	Wray	DOI DISASTER POWERS APPLY TO SHP-AB.	*H	Re-ref Com On Appropriations	04-08-09	05-05-09
H1164	Goforth	MODERNIZE HMO OVERSIGHT REQUIREMENTS.	HR	Ch. SL 2009-173	04-16-09	04-22-09
H1165	Goforth	UPDATE STANDARD FIRE INSURANCE POLICY.-AB	*HR	Ch. SL 2009-171	04-08-09	05-04-09
H1166	Goforth	INSURANCE LAW CHANGES.-AB	*HR	Ch. SL 2009-566	04-08-09	06-01-09
H1183	Goforth	HEALTH AND OTHER INSURANCE LAW CHANGES.-AB	*HR	Ch. SL 2009-382	04-16-09	04-22-09
H1183	Goforth	HEALTH AND OTHER	*HR	Ch. SL 2009-382	06-22-09	07-16-09

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Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		INSURANCE LAW CHANGES.-AB				
:47	Haire	STATE HEALTH PLAN/ EMPLOYEE-ONLY PREMIUM.	H	Ref to the Com on Insurance, if favorable, Appropriations	04-09-09	
H1293	Dockham	NC RISK POOL CHANGES/ OUT-OF-STATE SERVICES.	H	Ref to the Com on Insurance, if favorable, Judiciary II	04-09-09	
H1294	Dockham	NC RISK POOL PREMIUMS/ NOTICE REQUIREMENTS.	*HR	Ch. SL 2009-286	04-09-09	05-05-09
H1294	Dockham	NC RISK POOL PREMIUMS/ NOTICE REQUIREMENTS.	*HR	Ch. SL 2009-286	06-08-09	06-25-09
H1297	Stewart	PROVIDER CREDENTIALS/ INSURER/PROVIDER CONTRAC.	*HR	Ch. SL 2009-487	05-11-09	05-12-09
H1302	Blust	STATE HEALTH PLAN/ TRANSFER TO OSBM.	H	Ref to the Com on Insurance, if favorable, Appropriations	04-09-09	
H1305	Holliman	BEACH PLAN CHANGES.	*HR	Ch. SL 2009-472	04-09-09	07-01-09
H1313	Goforth	REGULATE PUBLIC ADJUSTERS.-AB	*HR	Ch. SL 2009-565	04-09-09	05-04-09
H1314	Goforth	ANNUAL FINANCIAL REPORTING.-AB	*HR	Ch. SL 2009-384	04-09-09	04-20-09
H1314	Goforth	ANNUAL FINANCIAL REPORTING.-AB	*HR	Ch. SL 2009-384	06-22-09	07-16-09
H1321	Starnes	ALLOW UM/UIM COVERAGE CHOICE.	H	Ref to the Com on Insurance, if favorable, Ways and Means/ Broadband Connectivity	04-09-09	
H1391	Insko	NC RISK POOL CLARIFICATIONS.	*H	Re-ref Com On Insurance	05-06-09	
H1392	Insko	NC RISK POOL CHANGES/ OUT-OF-STATE SERVICES.	*H	Ref To Com On Commerce	04-21-09	05-05-09
H1439	Spear	REFORM INSURANCE RATE FILING PROCESS.	H	Ref to the Com on Insurance, if favorable, Judiciary II	04-13-09	
H1458	Stewart	REVISE INSURANCE GUARANTY ASSOCIATION LIMITS.	H	Ref to the Com on Insurance, if favorable, Judiciary II	04-13-09	
H1483	Folwell	UNC INFIRMARIES/STATE HEALTH PLAN NETWORK.	H	Ref to the Com on Insurance, if favorable, Appropriations	04-13-09	
H1485	Steen	INSURANCE/HEALTH CARE PROVIDER RELATIONSHIP.	*H	Ref To Com On Commerce	04-13-09	05-11-09
H1494=	Goforth	REVISE UM/UIM COVERAGE REQUIREMENTS.	H	Ref to the Com on Insurance, if favorable, Ways and Means/	04-13-09	

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Bill	Introducer	Short Title		Latest Action	In Date	Out Date
				Broadband Connectivity		
47	Bryant	INSURANCE BURIAL BENEFITS NOTIFICATION.	H	Ref to the Com on Insurance, if favorable, Finance	05-07-09	
H1707	Holliman	SHP/ AGE-OUT DEPENDENTS; TOBACCO USE TESTING.	HR	Ch. SL 2010-3	05-17-10	05-20-10
H1730	Insko	AUTH. STATE RISK POOL TO ADMIN. FED RISK POOL.	*H	Re-ref Com On Insurance	05-24-10	
H1853=	Glazier	STATE HEALTH PLAN/ TREAT TEACHERS EQUITABLY.	H	Ref to the Com on Insurance, if favorable, Appropriations	05-20-10	
H1905=	Insko	FIRE SAFE CIGARETTES.	HR	Ch. SL 2010-101	05-20-10	06-10-10
H1931=	Rapp	STATE HEALTH PLAN/ADD LOCAL GOVERNMENT.	H	Ref to the Com on Insurance, if favorable, Appropriations	05-24-10	
H1991=	Farmer-Butterfie	STATE HEALTH PLAN/ COURT-ORDERED GUARDIANSHIPS.	H	Ref to the Com on Insurance, if favorable, Appropriations	05-26-10	
H2037	Dollar	STATE HEALTH PLAN/ TRANSFER TO DEPT INSURANCE.	H	Ref to the Com on Insurance, if favorable, Appropriations	05-26-10	
H2055=	England	STATE HEALTH PLAN/ LOCAL GOVT RETIREE CONTRIB.	*H	Ref To Com On Pensions & Retirement & Aging	05-27-10	06-21-10
87	**Tony Rand**	**STATE HLTH PLAN $/ GOOD HEALTH INITIATIVES.**	***HR**	**Ch. SL 2009-16**	**03-25-09**	**04-06-09**
S0354	Eleanor Kinnaird	CONTINUING CARE RETIRE. COMMUNITY/ HOME CARE.	*HR	Ch. SL 2010-128	06-16-10	06-29-10
S0468	Floyd B. McKissi	AUTHORIZE INSURANCE FOR FORMER EMPLOYEES.	*HR	Ch. SL 2009-564	06-03-09	06-18-09
S0563=	Don Davis	PYROTECHNICS SAFETY PERMITTING ACT.	*HR	Ch. SL 2009-507	07-28-09	08-04-09
S0660=	Bob Rucho	AUTO INSURANCE/ DIMINUTION IN VALUE.	*HR	Ch. SL 2009-440	06-29-09	07-14-09
S0749	Daniel G. Clodfe	REVISE UM/UIM LIABILITY COVERAGE REQUIREMENTS.	*HR	Ch. SL 2009-561	05-14-09	07-06-09
S0780=	Doug Berger	STRUC. SETTLEMENT ANNUITIES/INS. GUAR. ASSN.	*HR	Ch. SL 2009-448	05-04-09	06-03-09
S0877	Daniel G. Clodfe	HEALTH PLAN PROVIDER CONTRACTS/ TRANSPARENCY .	*HR	Ch. SL 2009-352	06-17-09	07-09-09
S0893	Fletcher L. Hart	WORKERS' COMP SELF-INSURANCE SECURITY ASS'N.	*HR	Ch. SL 2009-242	05-18-09	06-03-09
S0957	Martin L. Nesbit	SPECIAL ENROLLMENT	HR	Ch. SL 2009-62	05-26-09	05-28-09

'$' 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
		PERIOD/GROUP HEALTH INS.				
181=	Clark Jenkins	MORTGAGE GUARANTY INSURANCE REVISIONS.	*HR	Ch. SL 2009-254	06-17-09	06-23-09
S1029	Stan Bingham	PEO AMENDMENTS.	*HR	Ch. SL 2009-552	06-10-09	07-07-09
S1193=	A. B Swindell	IMPLEMENT LTC PARTNERSHIP PROGRAM.	*HR	Ch. SL 2010-68	06-16-10	06-21-10
S1251=	Dan Blue	STATE HEALTH PLAN/ TREAT TEACHERS EQUITABLY.	*HR	Ch. SL 2010-136	06-22-10	06-29-10
S1392=	Floyd B. McKissi	STATE HEALTH PLAN/ COURT-ORDERED GUARDIANSHIPS.	HR	Ch. SL 2010-120	06-24-10	06-29-10

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