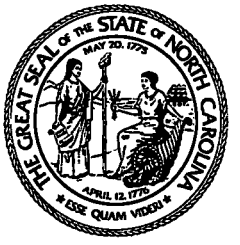
2011-2012

HOUSE INSURANCE

MINUTES



NORTH CAROLINA HOUSE OF REPRESENTATIVES

2011 -2012 SESSION

HOUSE STANDING COMMITTEE ON INSURANCE

REPRESENTATIVE JERRY C. DOCKHAM
CHAIRMAN

REGINA IRWIN, COMMITTEE CLERK

HOUSE COMMITTEE ON INSURANCE
2011 – 2012 SESSION

MEMBER		ASSISTANT	PHONE	OFFICE	SEAT
DOCKHAM, Jerry	Chairman	Regina Irwin Committee Assistant	715-2526	2204	3
COLLINS, Jeff *	Vice-Chair	Marissa Farrell	733-5802	1006	65
MCELRAFT, Pat	Vice-Chair	Nancy Fox	733-6275	637	38
SETZER, Mitchell	Vice-Chair	Margaret Herring	733-4948	1206	13
BLUST, John		Betty Childress	733-5781	1229	25
BROWN, Larry		Zane Stilwell	733-5607	303	26
BRUBAKER, Harold "Bru"		Cindy Coley	715-4946	302	1
BRYANT, Angela		Karon Hardy	733-5878	542	102
BURR, Justin		Dina Long	733-5908	538	40
CRAWFORD, Jim		Linda Winstead	733-5824	1321	24
CURRENT, William		Wendy Miller	733-5809	418B	41
FAISON, Bill		Lavada Vitalis	715-3019	405	84
FLOYD, Elmer		Latasha McPhaul	733-5959	1311	114
FOLWELL, Dale		Paige Fitzgerald	733-5787	301F	99
GLAZIER, Rick		Carin Savel	733-5601	1021	92
GRAHAM, Charles *		Linda Laton	715-0875	1315	115
HAMILTON, Susi *		Ruth Merkle	733-5754	1319	117
HOWARD, Julia		Ernie Parker	733-5904	1106	2
HURLEY, Pat		Susan Whitehead	733-5865	532	44
INSKO, Verla		Gina Insko	733-7208	603	70
JACKSON, Darren		Angela McMillian	733-5974	1019	106
MCGUIRT, Frank *		Susanna Davis	715-3007	1015	101

JOHNSON, Linda	Diane Wraight	733-5861	301D	15
MILLS, Grey	Wanda Benson	733-5741	2221	50
MURRY, Tom *	Linda Sebastian	733-5602	2121	86
PIERCE, Garland	Mildred Alston	733-5803	1204	46
SHEPARD, Phillip *	Pamela Pate	715-9644	301N	98
STEEN, Fred	Chris Floyd	733-5881	305	27
STEVENS, Sarah	Julie Garrison	715-1883	416A	56
WAINWRIGHT, William	Blinda Edwards	733-5995	613	12
WARREN, Harry *	Shara Graham	733-5784	533	74
WILKINS, W. A. "Winkie"	Nancy Brantley	715-0850	1301	47
WRAY, Michael	Lisa Brown	733-5662	502	60

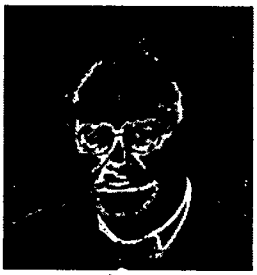
New Members *

Tim Hovis
Bill Patterson
Kory Goldsmith
Committee Counsel
LOB – Room 545
Tel: 733-2578

NORTH CAROLINA GENERAL ASSEMBLY

INSURANCE

2011-2012 SESSION



REP. DOCKHAM
CHAIRMAN



REP. COLLINS *
VICE - CHAIR



REP. MCELRAFT
VICE - CHAIR



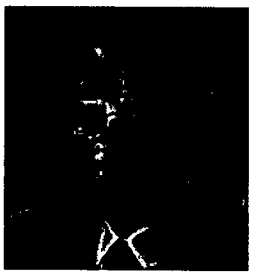
REP. SETZER
VICE - CHAIR



REP. BLUST



REP. BROWN



REP. BRUBAKER



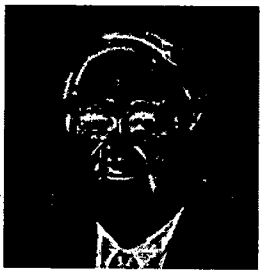
REP. BRYANT



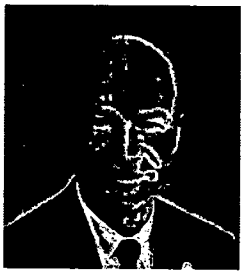
REP. BURR



REP. CRAWFORD



REP. CURRENT



REP. FAISON



REP. FLOYD



REP. FOLWELL



REP. GLAZIER



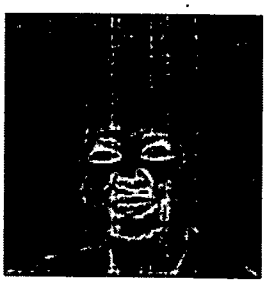
REP. GRAHAM *



REP. HAMILTON *



REP. HOWARD



REP. HURLEY

NORTH CAROLINA GENERAL ASSEMBLY

INSURANCE

2011-2012 SESSION



REP. INSKO



REP. JACKSON



REP. JOHNSON



REP. MILLS



REP. MURRY *



REP. PIERCE



REP. SHEPARD *



REP. STEEN



REP. STEVENS



REP. WAINWRIGHT



REP. WARREN *



REP. WILKINS



REP. WRAY

New Members *

ATTENDANCE

HOUSE COMMITTEE ON INSURANCE

2011 - 2012

DATES	02-15-2011	02-22-2011	03-01-2011	03-29-2011	04-05-2011	04-12-2011	04-19-2011	04-26-2011	05-10-2011	05-17-2011	05-24-2011	05-31-2011	06-07-2011	06-14-2011	
DOCKHAM, Jerry **Chair**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
BLUST, John	X	X	X	X	X	X	X	X		X	X	X			
BROWN, Larry		X		X	X	X	X	X	X	X	X	X			
BRUBAKER, Harold			X	X				X	X		X	X	X		
BRYANT, Angela	X	X	X	X	X	X	X	X	X			X			
BURR, Justin	X		X	X	X		X		X	X			X		
COLLINS, Jeff **Vice-Chair**		X	X	X	X	X	X	X	X	X	X	X	X		
CRAWFORD, Jim	X	X	X	X	X	X		X	X	X	X	X	X		
CURRENT, William	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	
FLOYD, Elmer	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
FOLWELL, Dale	X	X	X	X	X	X	X	X	X			X		X	
GLAZIER, Rick		X	X	X	X	X	X		X	X	X			X	
GRAHAM, Charles			X	X		X	X	X				X		X	
HAMILTON, Susi	X	X	X	X	X	X	X	X	X			X		X	
HOWARD, Julia	X		X	X	X	X	X	X	X	X	X	X			
HURLEY, Pat	X	X	X	X	X	X	X	X	X		X	X	X	X	
INSKO, Verla	X	X	X	X		X	X	X	X	X	X	X	X	X	
JACKSON, Darren		X		X	X		X	X		X			X		
JOHNSON, Linda	X	X	X	X	X		X	X	X	X	X	X			
MCELRAFT, Pat **Vice-Chair**			X	X	X	X	X	X	X		X				
MCGUIRT, Frank				X	X	X	X	X		X	X	X	X	X	
MILLS, Grey	X	X	X	X	X	X	X	X	X	X			X		
MURRY, Tom	X	X	X	X	X	X	X	X	X	X	X			X	
PIERCE, Garland	X	X	X	X	X	X	X	X			X	X	X	X	
SETZER, Mitchell **Vice-Chair**						X	X		X	X				X	

SHEPARD, Phillip	X	X	X	X	X	X	X	X	X	X	X	X		X	
STEEN, Fred	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
STEVENS, Sarah	X	X	X	X	X	X	X	X	X	X	X			X	
WAINWRIGHT, William				X	X				X						
WARREN, Harry	X	X	X	X	X	X	X	X	X	X	X	X		X	
WILKINS, W. A. "Winkie"	X	X	X	X	X	X	X	X	X	X	X			X	
WRAY, Michael		X	X	X		X	X	X	X			X		X	

2011-2012 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H0115	Dockham	NORTH CAROLINA HEALTH BENEFIT EXCHANGE.	*H	Ref To Com On Rules and Operations of the Senate	03-30-11	05-10-11
H0138	Dockham	AMEND HEALTH INSURANCE RISK POOL STATUTES.	*HR	Ch. SL 2011-58	02-21-11	03-02-11
H0155	Faison	MEDICAL MALPRACTICE INSURANCE COVERAGE.	H	Ref to the Com on Insurance, if favorable, Commerce and Job Development	02-22-11	
H0161	Dollar	TRANSFER STATE HEALTH PLAN TO STATE TREASURER.	*H	Re-ref Com On Appropriations	02-23-11	03-02-11
H0232	Spear	SAFE DRIVER INCENTIVE PLAN CHANGES.	*HF	Failed 3rd Reading	03-07-11	06-07-11
H0244=	Murry	STATE HEALTH PLAN/ADD SCHOOLS.	*H	Ref To Com On Insurance	03-08-11	06-07-11
H0298=	Dockham	INSURANCE AMENDMENTS.-AB	*H	Pres. To Gov. 6/15/2011	03-10-11	04-27-11
H0299=	Dockham	SURPLUS LINES/PREMIUM TAX.-AB	*H	Re-ref Com On Finance	03-10-11	04-27-11
H0373	Dockham	INSURANCE CHANGES TO PAYMENTS & GROUP LIFE.	*H	Pres. To Gov. 6/16/2011	03-17-11	05-31-11
H0453	Dockham	ALLOW SALARY PROTECTION INSURANCE.	H	Ratified	03-24-11	05-10-11
H0496	T. Moore	INSURANCE CO-PAYS FOR CHIROPRACTIC SERVICES.	*H	Ref To Com On Insurance	03-29-11	
H0501	Glazier	CREDIT UNION OWNERSHIP OF INS. CO.	*H	Pres. To Gov. 6/16/2011	03-30-11	05-18-11
75=	Dockham	SERVICE AGREEMENTS/ ALLOW RESERVE ACCOUNT.	*H	Pres. To Gov. 6/16/2011	04-04-11	05-18-11
H0578=	Murry	STATE HEALTH PLAN/ ADDITIONAL CHANGES.	*HR	Ch. SL 2011-96	04-04-11	04-27-11
H0617	Dockham	PORTABLE ELECTRONICS INSURANCE COVERAGE.	*H	Pres. To Gov. 6/16/2011	04-06-11	05-18-11
H0664	K. Alexander	DISCLOSURE/GROUP LIFE INSURANCE.	*H	Pres. To Gov. 6/16/2011	04-07-11	05-24-11
H0709=	Folwell	PROTECT AND PUT NC BACK TO WORK.	*H	Pres. To Gov. 6/14/2011	04-11-11	04-12-11
H0709=	Folwell	PROTECT AND PUT NC BACK TO WORK.	*H	Pres. To Gov. 6/14/2011	04-12-11	04-14-11
H0774	Rules, Calendar,	STUDY INSURANCE FOR CONTRACT GROWERS.	H	Ref To Com On Agriculture/ Environment/ Natural Resources	04-07-11	05-31-11
H0820	McElraft	STUDY BEACH PLAN.	H	Ref To Com On Insurance	04-07-11	
H0834=	Rhyne	REDUCE OVERPOPULATION OF REINSURANCE FACILITY.	H	Ref To Com On Insurance	04-07-11	
S0265	Tom Apodaca	STATE HEALTH PLAN/ APPROPRIATIONS AND TRANSFER.	*H	Read	03-28-11	03-29-11
S0321=	Tom Apodaca	SURPLUS LINES/PREMIUM	*HR	Ch. SL 2011-120	05-09-11	05-12-11

'$' 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.

2011-2012 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		TAX.-AB				
S0321=	Tom Apodaca	SURPLUS LINES/PREMIUM TAX.-AB	*HR	Ch. SL 2011-120	05-12-11	05-18-11
$ S0323=	**Tom Apodaca**	**STATE HLTH PLAN/ APPROPRIATIONS & TRANSFER LL.**	***HR**	**Ch. SL 2011-85**	**03-31-11**	**04-19-11**
S0608=	Neal Hunt	HEALTH CARE SHARING ORGANIZATIONS.	HR	Ch. SL 2011-103	05-03-11	05-24-11
S0647	Bob Rucho	MUTUAL INSURANCE HOLDING COMPANIES.	*H	Ref To Com On Insurance	06-09-11	
S0656	Jim Davis	RIGHT TO CHOOSE PHYSICAL THERAPIST.	*H	Ref To Com On Insurance	06-13-11	
S0702	Wesley Meredith	DIRECTOR AND OFFICER INSURANCE FOR TREASURER.	*H	Pres. To Gov. 6/ 17/2011	06-08-11	06-14-11
S0738	Thom Goolsby	LIABILITY INSURANCE REQUIRED FOR ABC PERMITS.	*H	Ref To Com On Insurance	06-13-11	
S0744	Thom Goolsby	TRANSPARENCY IN THE COST OF HEALTH CARE.	*H	Ref To Com On Insurance	06-13-11	

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

MINUTES
HOUSE COMMITTEE ON INSURANCE

February 15, 2011

The House Committee on Insurance met in Room 1228 of the Legislative Building on February 15, 2011, at 1:00 pm. The following members were present: Representatives Dockham, Chair, Blust, Bryant, Burr, Crawford, Current, Faison, Floyd, Folwell, Gibson, Hamilton, Howard, Hurley, Insko, Johnson, Mills, Murry, Pierce, Shepard, Steen, Stevens, Warren, and Wilkins. A Visitor Registration list is attached and made part of these minutes.

Representative Dockham, Chair, called the meeting to order at 1:05 pm; and indicated this was to be an introductory meeting. Chairman Dockham introduced the pages and the Sergeant of Arms Staff (see Attachment I). He recognized Tim Hovis, Bill Patterson, and Kory Goldsmith, Research Staff; and Regina Irwin, Committee Clerk.

Chairman Dockham then recognized the Commissioner of Insurance & State Fire Marshall, Wayne Goodwin. Commissioner Goodwin introduced himself and gave a PowerPoint overview of the NC Department of Insurance history and duties (see Attachment II).

Representative Dockham also recognized Ms. Rose Vaughn Williams, Legislative Counsel with the NC Department of Insurance. Ms. Williams introduced herself, briefed the committee on her role and duties of the Department of Insurance. She also gave a brief overview of issues/bills that will come before the committee this session (see Attachment III)

Addressing the Frank-Dodd Act, Representative Folwell posed a question to Ms. Williams, inquiring which states stood to benefit the most from the change in law regarding the surplus lines tax. Ms. Williams did not have the information, but promised to get the information to him as soon as possible.

There being no further business, the Chair adjourned the meeting at 1:35 pm.

Respectfully submitted,

Jerry C. Dockham

Representative Jerry C. Dockham, Chair

Regina Irwin

Regina Irwin, Committee Assistant

Attachments

AGENDA

HOUSE COMMITTEE ON INSURANCE

February 15, 2011
1:00 pm
Room 1228/1327

OPENING REMARKS

Representative Jerry Dockham, Chairman

DISCUSSION ITEMS

Briefing and Update from the NC Department of Insurance

- **Commissioner of Insurance & State Fire Marshal, Wayne Goodwin**
- **Legislative Counsel, Ms. Rose Vaughn Williams**

ADJOURNMENT

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

FEB. 15, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tony Rapp	MWC
Elizabeth Robinson	NCRMA
Gary Salandro	GSA
Tommy Suter	Novartis
Virginia Ufchez	Harell & Assoc.
Cody Thomas	NCAR
David McGowan	NCAR
[illegible]	MWC
Paul Pulk	NCAJ
Doug Heron	Wilson Mutter
[illegible]	Commissioner Jones LMAC Ins

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

FEB. 15, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Louis Belo	NCDOI
Jean Holliday	NCDOI
Bob Mack	NCDOI
Ben Popkin	NCDOI
Peggie Butler	NCDS & NCPNA
Mike Mann	NCBA
Robert Pascal	Young Moore
David Rice	Manning Fulton
David Barnes	PS
[illegible]	NCPC / NCBCA
[illegible]	NCOH
Joe Lanier	Nelson Mullins

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

FEB. 15, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Franklin Freeman	MWC

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

FEB. 15, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amy Whited	NC Med Soc
Alex O'Connor	National MS Society
Bo Heath	MWC
Kerri Bond	MWC
[illegible]	BCBSNC
Matthew Eisley	Smith A
Tom Cooper	UMRS
Andrew Meehan	Capstrat
Sherman McCoy	Nationwide
Mark Fleming	BCBSNC
Jamie Hodgdon	MLA

ATTACHMENT I

PLEASE PRINT

HOUSE PAGES

NAME OF COMMITTEE: INSURANCE **DATE: FEB. 15, 2011**

1. Name: Megan Langdon
   County: Johnston
   Sponsor: James Langdon
2. Name: Tanner Barnett
   County: Mecklenburg
   Sponsor: Bill Brawley
3. Name:
   County:
   Sponsor:
4. Name:
   County:
   Sponsor:
5. Name:
   County:
   Sponsor:

SERGEANTS-AT-ARMS

1. Name:
2. Name: LARRY ECCIOTT
3. Name: Garland S. Shepheard
4. Name: Martha H. Madison
5: Name:

An Overview of the NC Department of Insurance

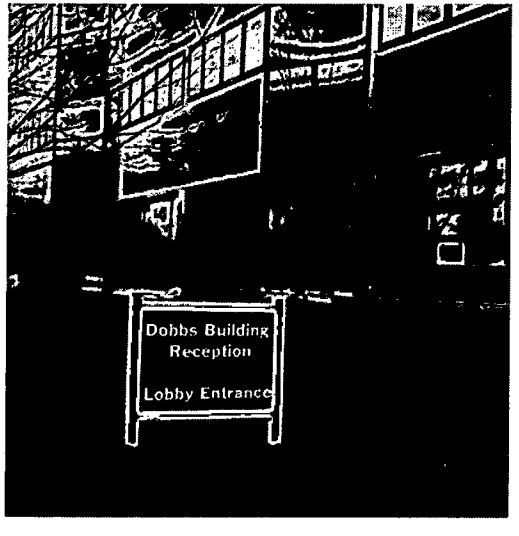
Presented by:
Wayne Goodwin
Commissioner of Insurance

ATTACHMENT II

NCDOI: History

Created in 1899

- Elected Insurance Commissioner
- Council of State Agency
- 400+ employees, 20 divisions
- Office of State Fire Marshal



NC Department of Insurance

- Serves North Carolina through consumer protection and education, safety training and promotion and regulation of specified activities and industries.

The NC Commissioner of Insurance must:

- Protect consumers from excessive, inadequate and unfairly discriminatory insurance rates.
- Ensure a solvent, accessible, well-regulated insurance market in North Carolina.

Other Responsibilities

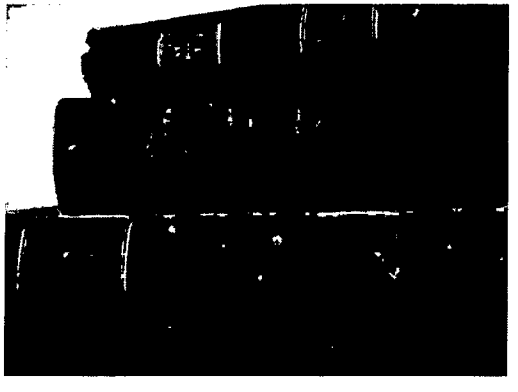
- Regulate manufactured building industry
- License bail bond companies and agents
- License collection agencies, motor clubs and premium finance companies
- Coordinate and interpret State Building Codes
- License building and home inspectors
- Insure state property
- Regulate continuing care retirement communities
- Training for fire, rescue and EMS personnel
- Inspect fire departments

NC Department of Insurance

- Administration Services
- Company Services Group
- Technical Services Group
- Public Services Group
- Ombudsman Services
- Office of State Fire Marshal

Administration Services

- Commissioner's Office
  - Commissioner of Insurance
  - Senior Staff
  - Legislative Services
  - Public Information Office
- General Counsel's Office
- Controller's Office
- Personnel Office
- Information Systems Division
- Eastern Regional Office
- Western Regional Office

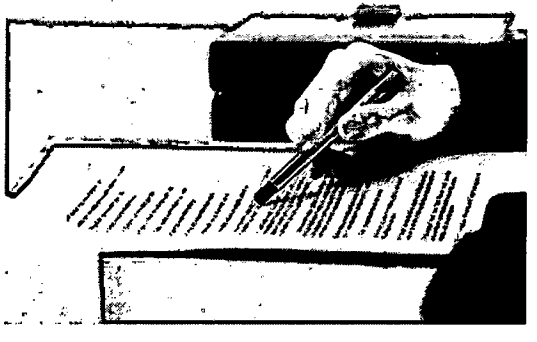


Company Services Group

- Actuarial Services Division
- Financial Evaluation Division
- Regulatory Actions Division
- RAD Trust

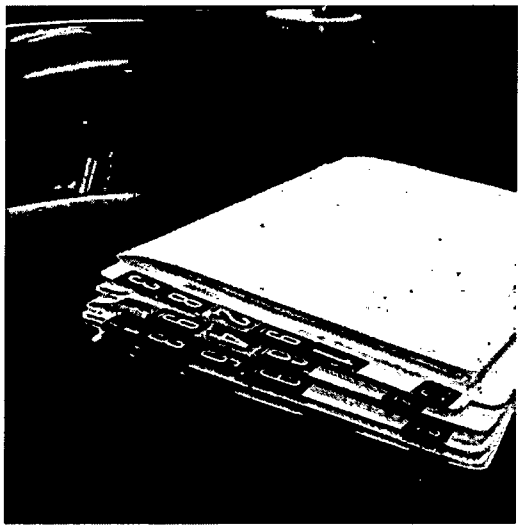
Actuarial Division

- Assists in review of rate, form and statistical filings
- Conducts actuarial studies for financial evaluation
- Involved in special projects



Financial Evaluation Division

- Oversees companies for solvency
- Ensure fair treatment of policyholders
- Review quarterly and annual statements
- Conduct regular audits
- Company admissions



Regulatory Actions & RAD Trust

- Supervision of financially troubled companies
- Rehabilitation
- Liquidation

Technical Services Group

- Life & Health Division
- Market Regulation Division
- Property & Casualty Division

Life & Health Division



- Review and approve rates, rule and policy form filings
- Monitor and analyze local, state and national trends
- Regulate third party administrators, MEWAs, HMOs, PPOs, and viatical settlement providers

Market Regulation Division

- Monitors market conduct activity of foreign and domestic companies
- Perform both in-house reviews and examinations of company records and operations

Property & Casualty Division

- Reviews rates, rules and policy form filings for NC Rate Bureau (auto, homeowners, workers comp.)
- Reviews rates, rules and policy form filings for property and casualty companies (commercial, title, specialty & misc. lines)
- Surplus Lines Administration

Ombudsman Services

- SHIIP
- Healthcare Review
- NC Consumer Assistance Program

SHIIP

- Seniors' Health Insurance Information Program
- Created in 1986
- Volunteer based program in all 100 counties (800+ volunteers)
- Unbiased, free information about Medicare and related issues
- Model program for entire country
- One-on-one counseling
- Not just for seniors!



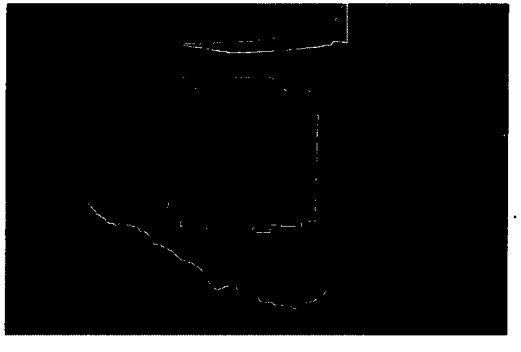
Healthcare Review Program

- Consumer counseling for insurers' appeals and grievances procedure
- Coordinate External Review, an independent medical review for health claim denials where the medical necessity is in dispute.



North Carolina Consumer Assistance Program

- Assists Consumers with the filing of Complaints and Appeals
- Provides information and assistance with the external review process
- Educates consumers on their rights and responsibilities with respect to group health plans and health insurance coverage
- Assist with enrollment for health insurance coverage
- Will collect and report data to the Secretary of US DHHS on the types of problems encountered by consumers



Public Services Group

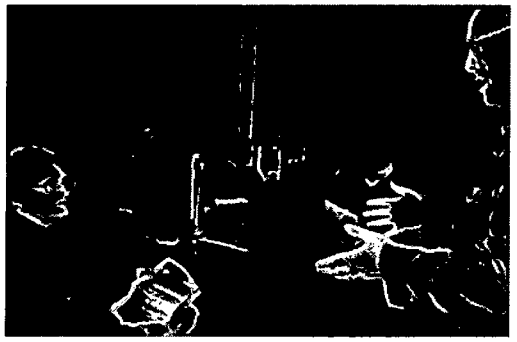
- Agent Services Division
- Consumer Services Division
- Criminal Investigations Division

Agent Services Division

- Licenses agents, brokers, limited representatives, appraisers, adjusters, bail bondsmen, surety agents and bail bond runners
- Licenses collection agencies and motor clubs
- Administers pre-licensing, continuing education, agency examinations and administrative actions

Consumer Services

- Provides assistance to the public about insurance issues and complaints
- In 2009, Consumer Services handled nearly 9,000 complaints and recovered more than $9.2 million for consumers.



Criminal Investigations

- Criminal Investigations Division founded in 1945.
- 20 sworn law enforcement officers
- Statewide jurisdiction to investigate insurance fraud
- In 2009, the division accomplished:
  - 413 cases closed
  - $10.5 million in restitution & recoveries
  - 89 criminal convictions & 175 arrests

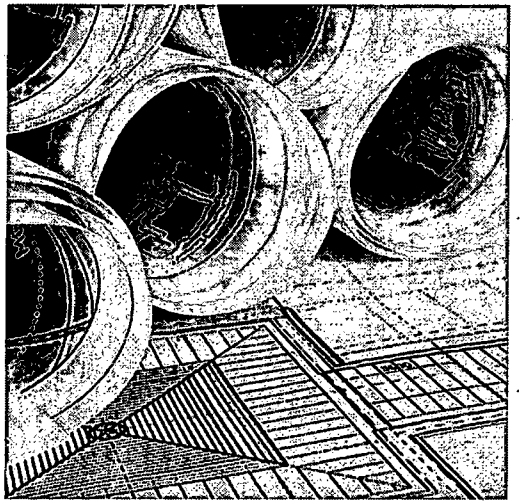


Office of State Fire Marshal

- Engineering Division
- Manufactured Building Division
- Risk Management Division
- Prevention, Programs & Grants Division
- Fire & Rescue Training & Inspections Division
- State Fire & Rescue Commission

Engineering Division

- Interpretations Section – staffs NC Building Code Council and interprets state building codes
- Enforcement Services – staffs NC Code Officials Qualification Board, licenses and provides continuing education for building inspectors
- Private Plan Review – reviews and approves plans for city/county-owned buildings larger than 20,000 square feet



Engineering Division

- Evaluation Services – provides staff to address complex projects encountered by code officials.
- Home Inspector Licensure Board – coordinates continuing education and handles complaints for/against home inspectors and associate inspectors



Manufactured Building Division

- Assure construction standards for manufactured and modular buildings
- Licenses manufactured building manufacturers, dealers, set-up contractors and sales representatives



Risk Management Division

- Insures state-owned property
- Coordinates coverage for other types of insurance for state agencies
- Inspect state-owned buildings for fire and life safety
- Provides interpretations and responds to questions on the State Electrical Code and provides support , education, and training to local electrical inspection departments

Risk Management Division

- Administers School Maintenance Electricians certification program
- Assists local governments with risk management assessments for optimizing their property and casualty insurance programs
- Serves as staff to the Public Officers and Employees Liability Insurance Commission through which professional liability insurance is made available for law enforcement officers and public employees and officials.

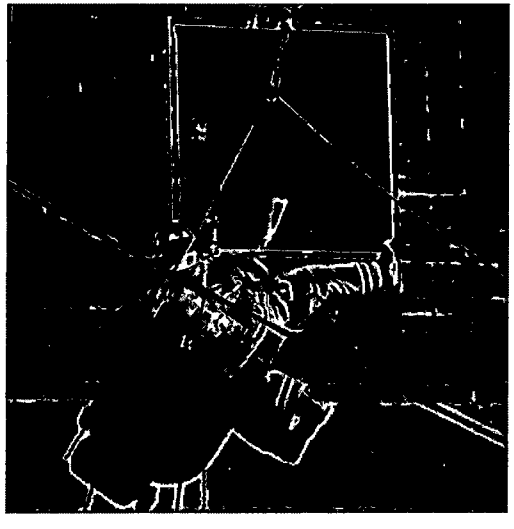
Prevention, Programs & Grants

- Offers fire prevention education to public schools and fire departments
- Firemen's & Rescue Relief Funds
- Administers Volunteer Fire Department & Rescue/EMS grant programs
- Houses Safe Kids North Carolina
- Houses Fire Safety Programs (fire safe cigarettes, novelty lighters, etc.)



Fire & Rescue Training & Inspections

- Train and certify fire and rescue personnel
- Teach specialized training schools (high angle rescue, collapsed building rescue, swift water rescue, HazMat, etc.)
- Inspects most fire departments across the state



Contact Us:

NC Department of Insurance

Consumer Helpline: 1-800-546-5664

Agent Services: 919-807-6800

Website: www.ncdoi.com

Office of State Fire Marshal

Phone: 919-661-5880

Website: www.ncdoi.com/osfm

Questions?

ATTACHMENT III

Thank Chairman

The NC General Statutes require the Department to report to the General Assembly on **changes to the laws that should be made relating to insurance and other subjects** pertaining to the Department.

Usually the Department brings many many mostly technical changes to the attention of the legislature---usuaslly non controversial and beneficial to the solvency of insurers and for the good of consumers.

Usually, many of the changes come from the **"NAIC"**

-help companies ease in doing business in other states

-carefully scrutinized in detail...subcommittees

-all states and territories represented...insurance industry and consumer groups lobby and are heard.

-result is model law

-MODEL LAW brought to you means already in place in many states.

-IMPORTANT FOR ACCREDITATION

-What accreditation means—domestics

This year is different-

Risk-Based Capital Trend Test

-One small part of a NAIC model

-Necessary for accreditation- must be in place by Jan 1, 2012

-Allow Dept. to use a "trend test" which will help us find out earlier if a company is in danger of not being solvent...

-Domestics should support

-Other states already have in place. Companies used to it.

Exchange (not an Agency bill)

-a bill that will come before you:

-prevent federal government from coming into NC and opening the Exchange

-preserve state based regulation.

-Leadership we have met with feel strongly we need to preserve state based regulation

-BY Jan 1 2014 federal health care reform requires...this is a place to buy health ins...the only place to get subsidies and tax credits for health insurane coverage for small businesses and individuals. (family of four may get subsidies if income is $80,000 or less)

-Expedia.com

-If state does not open, feds will...dk regs....this means:

-Feds would decide: What companies can sell to NC citizens, what policies, whether there will be one exchange for small businesses and another for indis., what the governance structure should be...(who is going to run it) etc.

-State must commit by Jan 1 2013, but need commitment before that so can start work.

-fully funded by federal grants right now...when it opens will have to be self-funding.

-Part of what ins. Commissioners (Rep and Dem) lobbied for across country was role for the states if health care reform passed.

-This is one of the items Commissioners fought for the states to be able to decide

Self-Insured Guaranty Association

-This is a group of 117 companies operating in NC who self-insure for Workers Comp.

-Purpose of the group

-Companies who are part of this Assoc. include Del Haize, Butterball, Federal Express, Guilford Mills, Cumberland County Hospital etc.

-When this Association formed they worked with the Department to establish the regulation that runs them. That included the Department of Insurance reviewing the Associations Plan of Operation...and long and arduous process for the Department...and for the Board of the Association.

-So...COI proposal to get them out of plan of operation review.

-This is in the WC statutes...this is NOT controversial

-Support of the companies and all consumer protections there are remain in place

More authority over small group health insurance Rates.

-Ask you to give the Department more authority to reject a health insurance rate in the small group market we believe is excessive.

-Fed. Gov regs of December 23rd, 2010.

-State based regulation

Privatize some licensing duties.

-have this authority for existing licensees...not for applicants.

Frank- Dodd Act

-premium tax paid by surplus lines carriers.

-loss of revenue to GF of 10-12 million beginning in July of 2011.

-Hope states can reach agreement by then...or get delayed effective date of fed bill

Open Enrollment period for child only policies

-survey, get them back in...will last us until Jan 1 2014

Certificates of Insurance

-what it is

-pressure on agents

NC DEPARTMENT OF INSURANCE

TRIENNIAL REPORT (2007-2009)

Wayne Goodwin
Insurance Commissioner
State Fire Marshal

North Carolina
DEPARTMENT OF INSURANCE

TRIENNIAL REPORT 2007-2009

No state dollars were used to publish this report; this item was paid for with N.C. Association of Insurance Agents, Inc. Surplus Grant monies. This report was printed by Correction Enterprises for a total cost of $545.73.

Table of Contents

Department of Insurance Mission Statement **3**
Company Services Group **5**
Actuarial Services Division 6
Financial Evaluation Division 10
Regulatory Actions Division 14
RAD Trust 15
Technical Services Group **16**
Property and Casualty Division 17
Life and Health Division 32
Seniors' Health Insurance Information Program 40
Market Regulation Division 46
Healthcare Review Program 48
Public Services Group **51**
Consumer Services Division 52
Agent Services Division 56
Criminal Investigations Division 60
Office of the General Counsel **63**
Regional Offices **65**
Office of State Fire Marshal **66**
Engineering Division 68
North Carolina Building Code Council 72
North Carolina Code Officials Qualification Board 74
North Carolina Home Inspectors Licensure Board 76
Manufactured Building Division 77
North Carolina Manufactured Housing Board 79
Risk Management Division 81
Public Officers and Employees Liability Insurance Commission 83
Fire and Rescue Commission 84
North Carolina Fire and Rescue Commission Members 86
Fire and Rescue Training and Inspection Division 87
Prevention, Programs and Grants Division 92

Department of Insurance Mission Statement

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



Wayne Goodwin
Insurance Commissioner
State Fire Marshal

This is accomplished by:

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

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

Company Services Group

The Company Services Group is comprised of the Actuarial Services, Financial Evaluation and the Regulatory Actions divisions and the RAD Trust.

The Actuarial Services Division assists in the review of company and North Carolina Rate Bureau rate filings and rate related issues. The division also conducts actuarial studies and special projects to support financial analysis and examination work as well as supporting other areas of the Department.

The Financial Evaluation Division is comprised of the Company Admissions, Financial Analysis, Financial Examinations and Special Entities sections. The Financial Evaluation Division regulates all authorized insurers, entities that self-insure for workers compensation, certain third party administrators, managing general agents, accredited reinsurers, professional employer organizations and continuing care retirement communities for compliance with the solvency laws of this state. The ultimate objective of this regulation is to reduce the likelihood of any of these entities failing and/or to mitigate the effect of any of these entities' insolvency on the insurance consumers of this state.

The Regulatory Actions Division administers the estates of all insurance entities placed into rehabilitation or liquidation in North Carolina. The Division is also responsible for closely monitoring all troubled insurance entities, including supervisions and work-outs.

The RAD Trust works with the Regulatory Actions Division in administering the estates of all insurance entities placed into rehabilitation or liquidation in North Carolina.

Actuarial Services Division

Actuarial Services assists other Department of Insurance divisions in regard to all aspects of actuarial science. Divisions that receive actuarial assistance include the:

- Consumer Services Division in regard to consumer complaints on rate increases and with general questions concerning insurance;
- Property and Casualty Division in reviewing rate filings, loss cost filings, form filings and statistical filings;
- Rate counsel when preparing for and conducting rate hearings. The division also provides actuarial assistance in the preparation of briefs during the appeals process up to and including the North Carolina Supreme Court.
- Financial Analysis Section with reviewing Actuarial Opinions and Memorandums, reviewing of HMO claim reserves and various other projects;
- Financial Examination Section with analysis of claim reserves and the proper accounting of reserve items;
- Life and Health and Financial Evaluation Divisions in regard to the licensing of new Health Maintenance Organizations (HMOs) and the review of expansion and material modification requests, and the annual licensing of Multiple Employer Welfare Arrangements (MEWAs) and Professional Employer Organizations (PEOs);
- Life and Health Division with reviewing individual accident and health insurance and HMO rate revisions, review of unusual life, annuity and health insurance products, and review of actuarial aspects of proposed rules and legislation pertaining to life and health insurance;
- Other government agencies that have received actuarial assistance including the General Assembly's Research Division with cost estimates on proposed legislation that involves insurance pricing in some way, or with various other projects that require actuarial science for proper evaluation.

Life and Health Section

This division's review of individual accident and health rate change requests saved consumers covered under such policies $11.5 million in 2007, $31.2 million in 2008 and $16.4 million in 2009. Since the division's review of rates began, consumers have realized savings of approximately $221.9 million as of December 2009.

During 2007-2009, Actuarial Services collected data and evaluated the impact of mandated reductions in the credit life and accident and health insurance prima facie rates. The combined

savings to consumers purchasing credit insurance is approximately $31.8million in 2007, $29.4 million in 2008 and $24.3 million in 2009. Since 1988, the first year of an evaluation of a prima facie rate reduction, consumers have realized savings of approximately $802.9 million as of December 2009.

Actuarial Services annually reviews the Medicare supplement insurance refund calculations submitted by insurance carriers. These forms were reviewed for calendar years 2007, 2008 and 2009 and all carriers were correctly performing the calculations. For calendar year 2007, one company made refunds which totaled to $26,536. For calendar year 2008, two companies made refunds which totaled to $124,612. For calendar year 2009, two companies made refunds which totaled to $116,091.

The division continues to review all Small Employer Group actuarial rate certifications to assure compliance with the Small Employer Group Health Coverage Reform Act.

Actuarial Services also assists in the review of licensing Multiple Employee Welfare Arrangements (MEWAs) and Professional Employer Organizations (PEOs) and the review of their specific and aggregate maximum net retention level. During 2007-2009, Actuarial Services' review of renewal licensing applications resulted in some MEWAs either increasing their surplus to accommodate their specific maximum net retention levels or lowering their specific maximum net retention level.

Actuarial Services acts as the life and health risk assessment division for the Department and works closely with the Department's Financial Evaluation Divisions concerning claim reserve, policy reserve and premium rate analyses and solvency issues for HMOs and MEWAs and PEOs. On an as-needed basis Actuarial Services also acts as an actuarial consulting division for other state agencies.

Property and Casualty Section

Actuarial Services works closely with the Property and Casualty Division and the Financial Evaluation Division in reviewing rate filings, loss cost filings, form filings and statistical filings. The division has lent its expertise to rate filings for private passenger automobile, homeowners, dwelling fire and extended coverage, workers compensation, and medical malpractice. Its actuaries also review the rate filings of the self-insured compensation funds. The division assists Department counsel to prepare and present the Department's case in the public rate hearings. Its actuaries strive to ascertain that rates are not excessive to policyholders, yet adequate so as to provide a reasonable profit to companies and to protect their solvency.

Private Passenger Auto

In 2006, the North Carolina Rate Bureau (NCRB) filed for a 7.4% rate increase in private passenger automobile rates. After an extensive public hearing, a settlement was reached and the NCRB implemented a 2.9% rate decrease, potentially saving the public as much as $349 million dollars in 2007 and $350 million dollars in 2008.

In 2008, the NCRB filed for a 12.9% rate increase for private passenger automobile rates. After the Department's review, a settlement was reached and a rate decrease of 0.5% was implemented by the NCRB, potentially saving the public as much as $391 million dollars.

In 2009, the NCRB filed for a 1.4% rate increase for private passenger automobile rates. After an extensive review by the Department, a settlement was reached and no rate change was implemented by the NCRB until 2011. This potentially saves the public as much as $13 million dollars in 2009. (The combined potential savings for drivers in North Carolina through 2011 as a result of the 2008 and 2009 is $545 million.)

Workers' Compensation

In 2007, the NCRB filed for an average 5.9% increase for workers' compensation insurance to be effective in 2008. After Department review, a settlement was reached and the NCRB implemented a 1.85% increase, potentially saving North Carolina companies as much as $56 million dollars.

In 2008, the NCRB filed for an average 4.3% decrease for workers' compensation insurance to be effective in 2009. After Department review, a settlement was reached and the NCRB implemented this rate decrease, potentially saving North Carolina companies as much as $65 million dollars.

In 2009, the NCRB filed for an average 8.5% decrease for workers' compensation insurance to be effective in 2010. After Department review, a settlement was reached and the NCRB implemented an 8.6% decrease, potentially saving North Carolina companies as much as $121 million dollars.

The division reviews the rates for the self-insured workers compensation funds domiciled in North Carolina and assists the Financial Evaluation Division in the financial review and examination of these funds.

Homeowners

In 2005 the NCRB filed for a 12.1% rate increase in homeowners rates. After Department review, a settlement was reached and the NCRB implemented a 2.2% rate increase, potentially saving the public as much as $37 million dollars in 2007.

In 2006 the NCRB filed for a 21.9% rate increase in homeowners rates. After Department review, a settlement was reached and the NCRB implemented a 5.4% rate increase, potentially saving the public as much as $144 million dollars in 2007, $214 million dollars in 2008 and $71 million dollars in 2009.

In 2008 the NCRB filed for a 19.5% rate increase in homeowners rates. After Department review, a settlement was reached and the NCRB implemented a 3.9% rate increase, potentially saving the public as much as $160 million dollars in 2009.

Dwelling Fire and Extended Coverage

In 2006, the North Carolina Rate Bureau filed for a 32.9% increase to Dwelling Fire and Extended Coverages rates. After review by the Department, a settlement was reached and the NCRB implemented a 12.1% rate increase, potentially saving the public as much as $40 million dollars a year.

Medical Malpractice

There was not much rate filing activity in the medical malpractice market during the 2007-2009 period, but the Actuarial Services Division did receive two filings for rate decreases in which it negotiated even larger decreases based on its own analysis, with an estimated total savings of $1.6 million.

Other

In addition to these activities, the division has reviewed 1,327 individual company rate filings for various lines of insurance for the years 2007, 2008 and 2009.

Financial Evaluation Division

The Financial Evaluation Division is part of the Company Services Group and is comprised of the Company Admissions, Financial Analysis, Financial Examinations, and Special Entities sections. The Financial Evaluation Division regulates all authorized insurers, entities that self-insure for workers compensation, certain third party administrators, managing general agents, accredited reinsurers, professional employer organizations and continuing care retirement communities, for compliance with the solvency laws of this state. The ultimate objective of this regulation is to reduce the likelihood of any of these entities failing and/or to mitigate the effect of any of these entities' insolvency on the insurance consumers of this state.

Company Admissions Section

The Company Admissions Section evaluates the operations and financial condition of out-of-state insurance companies (foreign insurance companies) applying to transact insurance business in North Carolina to determine compliance with admissions requirements. This section also reviews and evaluates the proposed operations of new insurance companies proposing to incorporate in North Carolina (domestic insurance companies) to determine compliance with state laws. In addition, this section evaluates and registers the following entities: risk retention groups, risk purchasing groups, surplus lines insurance companies and companies seeking accredited reinsurer status in North Carolina.

Insurance companies continue to demonstrate considerable interest in establishing business in North Carolina. During the last three years, 149 new applications were received. A total of 122 insurance entities were found to satisfy North Carolina admission requirements and received initial certificates of authority during this period. This number includes the formation of three North Carolina domestic insurance companies.

The section is also responsible for the initial review of insurance companies applying for eligibility for the placement of surplus lines business. The surplus lines market is for insurance products that are not readily available to consumers through licensed companies. During the past three years, the section received and reviewed 46 filings for surplus lines eligibility. Thirty-seven new companies were found to qualify.

Additionally, the section is responsible for reviewing applications for accredited reinsurer status in North Carolina. During the past three years, 12 filings were received and 11 companies satisfied the statutory requirements.

The section is responsible for the financial review of risk retention groups and risk purchasing groups filing for initial registration. These entities operate under the authority of the Federal Risk Retention Act and North Carolina Insurance Statutes governing liability risk retention. The federal act permits risk retention groups and purchasing groups to provide certain types of liability insurance coverage to their members if the group is properly licensed in at least one state and files certain minimal financial information with each state in which it desires to do business. We have required as much information as allowed under the federal act in order to

evaluate the merits of risk retention group filings. North Carolina statutes require a purchasing group to buy its coverage from an insurance company that is either licensed or eligible for surplus lines business in this state. During the past three years, 19 filings for initial registration were received from risk retention groups and 72 initial filings were received from risk purchasing groups. Twenty-seven risk retention groups and 72 purchasing groups received initial registration during the period. As of December 31, 2009, there were 97 risk purchasing groups in North Carolina.

Financial Analysis Section

The Financial Analysis Section of the Financial Evaluation Division is primarily responsible for the continuous monitoring, through financial analysis, of all insurers authorized to transact business in North Carolina. Upon the identification of issues, the section is responsible for taking timely and appropriate action to protect the interests of North Carolina insurance consumers.

Monitoring of insurance companies is accomplished by analyzing annual and interim financial statements and other financial data for each company using financial analysis programs and systems, including the database and programs of the National Association of Insurance Commissioners as well as systems developed by the Department. Compliance with a wide variety of statutory requirements by insurance companies is also determined and a conclusion is reached on the financial health of each insurance company. As necessary, Department action to address financial or compliance issues is taken. Review of filings submitted by insurance companies to the section for prior approval as required by law is accomplished by analyzing the proposed transaction, determining the financial impact of the transaction, determining the compliance of the transaction with applicable laws, and concluding on the overall impact to the insurance companies and its policyholders. The section will not approve any transactions that may subject the insurance company to a hazardous financial condition or that may harm policyholders.

The section is also responsible for the review of initial and renewal reinsurance intermediary license or exemption applications, and rendering a decision on those applications. Upon licensure or exemption, the intermediaries are monitored by this section for compliance with the applicable insurance laws, and action is taken as appropriate to address any failure by an intermediary to comply with the applicable insurance laws.

The section processes insurance company and other regulated entity corporate record changes (such as acquisitions, mergers, dissolutions, charter changes, bylaw changes, and other changes affecting an entity's license or authority) and is responsible for the accuracy of the corporate records database, in which this information is maintained for the use by the entire Department.

Finally, this section administers the Department's Collateral Security Program, which holds deposits of regulated entities as required by law for the protection of policyholders. The securities are maintained by U.S. Bank, N.A. under a safekeeping agreement and totaled over $861 million at year end 2007, 2008, and 2009. Most of the functions to administer the

Collateral Security Program are computerized, allowing rapid processing of transactions and better monitoring of the quality of securities on deposit.

Performance Indicators	2007	2008	2009
Insurance organizations regulated	1,579	1,629	1,693
Financial statements analyzed	6,208	6,390	6,672
Domestic audited financial statements and Form Bs reviewed	103	105	110
Insurer licenses suspended	1	1	0
Insurer licensed revoked	0	0	0
Administrative actions	1	10	17
Securities on deposit for policyholder protection	$878,000,000	$861,000,000	$866,000,000

Financial Examination Section

The Financial Examination Section conducts on-site examinations of insurance companies and other similar or related entities under North Carolina jurisdiction to determine financial condition, legality and propriety of operations and fair and equitable treatment of all policyholders. An examination report is prepared based on the results of the field examination. The work is guided by state laws and regulations, Departmental policies and procedures, and the National Association of Insurance Commissioners.

The primary responsibility of the section is to conduct risk focused examinations (i.e. audits) of financial statement data reported by various regulated insurance entities to determine compliance with the laws of this state and statutory accounting principles. Full-scope examinations of domestic insurers are required, by law, to be performed no later than every five years in order to effectively monitor their operations and overall financial condition. Limited-scope examinations are conducted on an as-needed basis in order to address more significant issues and concerns which require immediate attention and usually involve the resolution of issues that cannot be resolved during the financial analysis process. Practices and procedures have been developed by this section, the Financial Evaluation Division and the National Association of Insurance Commissioners (NAIC).

Examinations require appropriate knowledge and application of the theories and practices of Generally Accepted Accounting Principles (GAAP), Statements of Statutory Accounting Principles (SSAP), Statements on Auditing Standards (SAS), and related information technology frameworks. Application software and automated work papers are used to perform and document the procedures performed on all examinations. Therefore, automation is critical to the examination process and technological advances and the development of various software used by examiners daily require the section's commitment to maintaining current hardware equipment and software programs.

Effective communication with Department personnel, other state regulators, the NAIC and external parties is an important part of the examination process. Section staff is required to communicate major and/or complex issues, interpret rules and regulations, and document the findings and conclusions reached based on examination procedures performed.

Examiners have electronic access to the financial information of insurance entities through a secure remote access program. The ability to communicate effectively is critical to conducting an efficient and effective examination.

Special Entities Section

The Special Entities Section is responsible is for the licensing of non-traditional insurance related entities that consists of Professional Employer Organizations, Continuing Care Retirement Communities, and Group and Individual Employers who desire to self-insure their workers compensation liabilities. The section also performs financial and regulatory reviews on these entities to ensure financial continuity and statutory oversight.

As of December 31, 2009, there were 58 licensed CCRCs in North Carolina and four under development. Currently, there are over 19,000 senior adults residing in North Carolina CCRCs.

On an annual basis, the section reviews the disclosure statements, contracts, and audited financial statements for each licensed CCRC. The section also works with providers/sponsors who are currently expanding existing licensed CCRCs, or are interested in developing, new CCRCs in North Carolina for compliance with all applicable statutes and rules.

Professional Employer Organizations are entities that offer and provide professional employer services. Professional employer services is an arrangement by which a PEO assigns employees to work at a client company and in which employment responsibilities are in fact shared by the PEO and the client company, the employee's assignment is intended to be of a long-term or continuing nature, rather than temporary or seasonal in nature, and a majority of the workforce at a client company work site or a majority of the personnel of a specialized group within that workforce consists of assigned employees of the PEO.

Effective Jan. 1, 2005, all persons engaged in professional employer services in North Carolina were required to become licensed by the North Carolina Department of Insurance. Prior to this requirement, all persons engaged in professional employer services in North Carolina had to be registered by the North Carolina Department of Insurance. Effective July 1, 2005, a de minimis registration provision was added to the licensing law for PEOs with less than 50 assigned employees in North Carolina. As of December 31, 2009, there were 93 PEOs licensed, 59 PEOs with de minimis registrations, and 14 licenses and two registrations pending in North Carolina.

The section is responsible for the financial regulation of all PEOs and for the continued monitoring of the financial condition of the PEOs through the annual review of audited financial statements. On an ongoing basis the section monitors changes in controlling persons, changes in client company relationships, and changes in workers' compensation and benefit plans offered by the PEOs.

Regulatory Actions Division

The primary responsibilities of the Regulatory Actions Division are to work closely with troubled companies and to administer the financial and regulatory functions associated with companies in receivership.

The Division closely monitors the financial condition and operations of domestic insurance entities deemed to be troubled or in a hazardous financial condition. For these insurance entities, the ultimate goal of the Division is to determine whether the insurance entity can be prevented from going into formal delinquency proceedings and returned to sound financial condition and good business practices. Examples of close monitoring procedures performed by this Division include:

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

For those insurance entities requiring formal delinquency proceedings, the Regulatory Actions Division's ultimate goal is to rehabilitate and/or liquidate troubled and insolvent entities in order to protect and preserve, to the maximum extent possible, the remaining assets of an insurance entity for the benefit of the entity's policyholders, creditors and the public. Examples of specific duties performed include:

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

During 2007-2009, the division was involved with six receiverships. No receiverships were initiated during this period, one was closed, and five remained open at December 31, 2009.

RAD Trust

The establishment of the Regulatory Actions Division Group Master Trust (RAD Trust) was approved by the Superior Court of Wake County, North Carolina on July 5, 1995. The Commissioner of Insurance was named as the Grantor. Oversight of the RAD Trust is provided by the Company Services Group.

The RAD Trust was created to provide resources for administrative and accounting functions to help administer and manage insurance entities placed in liquidation.

Technical Services Group

The Technical Services Group is comprised of the Property and Casualty Division, Market Regulation Division, Life and Health Division, Seniors' Health Insurance Information Program, and the Healthcare Review Program.

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

The Life and Health Division is responsible for the review and approval of rate, rule and policy form filings submitted by life and health insurance companies and issuance of licenses for third party administrators. This division plays a pivotal role for the Department in the monitoring and analysis of local, state, and national life and health insurance trends. The division also monitors and regulates certain activities of managed care entities such as health maintenance organizations (HMOs) and managed care indemnity health insurers, including their arrangements with Preferred Provider Organizations (PPOs) with an emphasis on assuring company procedure and operational policy meet compliance requirements in North Carolina. Oversight of Multiple Employer Welfare Arrangements (MEWAs) with an emphasis on assuring company procedure and operational policy meet compliance requirements in North Carolina. The Division accomplishes its work through several types of activities such as review of document filings required of companies, data collection, review collaboration with actuarial division and the financial division, analysis, and reporting; meeting with industry representatives, health care providers, legislative representatives, and other interested parties.

The Market Regulation Division conducts field examinations, and analysis of the market practices of domestic and foreign insurers and their representatives.

The Seniors' Health Insurance Information Program's (SHIIP) primary function is to train adult volunteers to help older adults through the maze of Medicare regulations, Medicare Part D, Medicare supplement insurance, long-term care insurance and claims procedures. In recent years, Medicare's move toward managed care options has led SHIIP to develop new training courses. SHIIP's ability to increase its activities and effectiveness depends on collaboration with numerous state, county and federal agencies, as well as with community organizations.

The Healthcare Review Program (HCR Program) offers external review services, which consist of the independent medical review of a health plan denial and offers another option for resolving coverage disputes between a covered person and their insurer.

The work performed by divisions in this group work with centers on policy issues, taking into consideration how they are implemented in insurance products and day-to-day company operations.

Property and Casualty Division

This division reviews the rates, rules and forms for the North Carolina Rate Bureau, North Carolina Reinsurance Facility, NCIUA (Coastal Property Insurance Pool), NCJUA (Fair Plan) and licensed property and casualty insurance companies. In addition, the Property and Casualty Division licenses statistical organizations (formerly rating and advisory organizations) and joint underwriting and joint reinsurance organizations, along with reviewing rate, rule and policy form filings made by these entities.

State law permits insurance companies that are unlicensed to write insurance on risks in this state as "surplus lines" companies provided there is compliance with applicable statutes and rules. Surplus lines taxes are the responsibility of specially licensed agents. This division receives and reviews the tax forms and collects and processes the premium taxes submitted by these agents.

Surplus Lines Review

The following chart reflects surplus lines activity for the years 2005 through 2009 with tax reported at 5% of gross premiums charged.

Premium Taxes			
	No. of Policies	Premium	Tax Generated
2005	71,771	$516,807,630.50	$25,842,686.14
2006	77,102	$508,249,065.46	$25,389,359.89
2007	72,855	$523,549,177.60	$26,511,259.99
2008	72,959	$492,998,121.06	$24,921,563.32
2009	79,729	$504,454,716.75	$25,185,969.65

Filings Review

A key function of the Property and Casualty Division is the review of forms, rules and rate filings. These filings must be carefully analyzed. During 2005-2009, a total of 53,856 filings were reviewed.

Forms, Rates and Rules Reviewed	
	Companies and Organizations
2005	11,095
2006	11,167
2007	11,725
2008	13,145
2009	6,724
Total	53,856

As part of the speed to market initiative, the National Association of Insurance Commissioners (NAIC) established goals of having all form and rate filings completed within 60 days of receipt. For the five year period ending December 31, 2009, the Property and Casualty Division completed the review of 96% of all approved files within 60 days of receipt. Speed to market results are reflected in the following chart:

SPEED TO MARKET						
Time to Approval	**NAIC Goal**	**2005 Total**	**2006 Total**	**2007 Total**	**2008 Total**	**2009 Total**
<=20 Days	50%	92%	90%	92%	92%	89%
21-25 Days	70%	93%	92%	94%	93%	90%
26-30 Days	95%	94%	93%	94%	95%	91%
31-60 Days	100%	96%	96%	98%	98%	95%
61+ Days	n/a	3.6%	3.4%	2.5%	2.2%	4.1%

Rate Deviations

Under the jurisdiction of the North Carolina Rate Bureau, state law allows companies to file rate deviations (discounts) on coverage such as private passenger automobile, homeowners, mobile homeowners and dwelling fire. An example of a typical deviation would be lower insurance premiums for policies offering multi-policy discounts. Deviations reviewed from 2005 through 2009 are reflected in the following chart:

	Homeowners	**Dwelling Fire**	**Auto**
2005	145	4	112
2006	69	8	131
2007	171	73	185
2008	177	73	191
2009	179	74	179

Workers Compensation

The North Carolina Rate Bureau files prospective loss costs, classification plans, rating plans, and rating systems with the Department on behalf of its member companies. The insurance companies then file loss cost multipliers with the Department to determine the final rate they will charge. The companies are required to justify their filed loss cost multipliers with supporting documentation before obtaining approval. Workers Compensation filings reviewed from 2005 through 2009 are reflected in the following chart.

	NC Rate Bureau	Residual Market	Individual Company
2005	1	1	478
2006	1	1	392
2007	1	1	432
2008	1	1	669
2009	1	1	326

North Carolina Rate Bureau Rate Filings

The North Carolina Rate Bureau is responsible for making rate filings for insurance companies licensed to write workers compensation, private passenger automobile, homeowners, and dwelling fire insurance coverage in North Carolina. The following charts reflect rate filing histories and estimated savings to North Carolina consumers for these lines of business.

North Carolina Department of Insurance
North Carolina Workers Compensation Rate Changes
1985-2010

(1) Filing Year	(2) Effective Year	(3) Percent Requested	(4) Percent Approved	(5) Premium	(6) Estimated Savings	(7) = (4) * (5) Premium Change
1985	1986	12.9%	7.5%	228,937,000	12,362,598	17,170,275
1986	1987	12.8%	5.8%	344,346,000	24,104,220	19,972,068
1987	1988	16.8%	15.9%	391,308,000	3,521,772	62,217,972
1988	1989	0.0%	0.0%	453,879,000	0	0
1989	1990	16.8%	9.0%	504,204,000	39,327,912	45,378,360
1990	1991	29.3%	18.9%	557,950,000	58,026,800	105,452,550
1991	1992	41.8%	15.8%	635,173,000	165,144,980	100,357,334
1992	1993	40.3%	33.0%	635,200,000	46,369,600	209,616,000
1993	1994	15.5%	9.3%	633,461,000	39,274,582	58,911,873
1994	1995	0.0%	0.0%	633,181,437	0	0
1995	1996	-15.4%	-15.4%	587,024,256	90,401,735	-90,401,735
1996	1997	-13.7%	-13.7%	591,203,889	80,994,933	-80,994,933
1997	1998	-1.1%	-1.1%	658,153,267	7,239,686	-7,239,686
1998	1999	0.0%	0.0%	675,624,668	0	0
1999	2000	3.4%	0.0%	719,538,435	24,464,307	0
2000	2001	4.6%	4.6%	719,538,435	0	33,098,768
2001	2002	-1.2%	-1.2%	766,822,301	8,898,441	-8,898,441
2002	2003	0.25%	0.0%	836,258,595	2,090,646	0
2003	2004	9.1%	-0.5%	959,561,074	92,147,074	-5,217,359
2004	2005	8.7%	2.2%	1,057,916,982	68,764,604	23,274,174
2005	2006	16.1%	9.3%	1,140,857,125	77,578,285	106,099,713
2006	2007	12.1%	7.3%	1,262,660,703	60,607,714	92,174,231
2007	2008	5.9%	1.85%	1,385,661,358	56,119,285	25,634,735
2008	2009	-4.3%	-4.3%	1,522,624,651	65,472,860	-65,472,860
2009	2010	-8.5%	-8.6%	1,405,033,814	120,832,908	-120,832,908
Total					**1,143,744,942**	

Notes: 1) Filings are submitted on or by September 1st, with effective date of April 1st of the following year;

2) For Filing Years 2004-2008, Percent Requested and Percent Approved equal 10% of Assigned Risk rate change plus 90% Voluntary Loss Cost rate change;

3) The premium figures come from different sources depending on the filing year.
For 1985-1987, from NCCI Annual Statistical Bulletin, Earned Standard Premium.
For 1988-2002, from the NAIC Annual Statement Direct Earned Premium for that year.
For 2003-2008, from the NAIC Annual Statement Direct Written Premium of the previous year;

4) Estimated Savings equals Percent Requested minus Percent Approved times Premium for all years in which an increase was requested. Estimated Savings equals Percent Requested times Premium when a decrease was requested.

NORTH CAROLINA DEPARTMENT OF INSURANCE							
History of Voluntary Private Passenger Automobile Rate Changes							
	Overall		COI	Rate Bureau	Actual		
Filed	Filed/Proposed	Effective	Ordered	Implemented	Years	Savings to	Subject to
Date	Change	Date	Change	Change	Effective	Consumers *	Escrow **
29-Nov-1984	4.1%	01-Mar-1985	0.0%	0.0%	0.838	$19,621,579	$0
19-Jul-1985	20.8%	01-Jan-1986	10.4%	10.4%	1.534	107,041,089	0
26-Nov-1986	12.2%	15-Jul-1987	1.0%	1.0%	0.715	70,084,004	0
01-Jul-1987	4.1%	01-Apr-1988	0.7%	0.7%	0.753	27,519,059	0
01-Jul-1988	6.4%	01-Jan-1989	4.3%	4.3%	1.162	27,784,097	0
30-Jun-1989	4.2%	01-Mar-1990	-5.9%	3.4%	1.000	127,768,279	0
29-Jun-1990	9.6%	01-Mar-1991	4.1%	4.1%	1.255	97,121,492	0
01-Jul-1991	9.4%	01-Jun-1992	4.4%	4.4%	0.671	55,623,900	0
17-Aug-1992	-4.2%	01-Feb-1993	-6.0%	-6.0%	1.000	28,537,120	0
		01-Feb-1994	-6.0%	-6.0%	0.915	26,113,419	0
01-Feb-1994	17.7%	01-Jan-1995	-8.5%	4.4%	1.000	486,800,438	0
	13.8%	01-Jan-1996	-8.5%	4.4%	0.918	378,559,212	0
01-May-1995 Amended 01-Apr-1996	6.1%	01-Dec-1996	5.5%	5.5%	0.918	3,907,391	0
28-Feb-1997	5.5%	01-Nov-1997	0.0%	0.0%	1.000	140,349,969	0
10-Feb-1998	7.2%	01-Nov-1998	0.0%	0.0%	1.000	195,001,681	0
		01-Nov-1999	0.0%	0.0%	0.836	162,946,610	0
05-Mar-1999 Amended 20-Aug-1999	-5.0%	01-Sep-2000	-9.3%	-9.3%	1.000	124,369,047	0
		01-Sep-2001	-9.3%	-9.3%	0.581	72,236,268	0
01-May-2001	10.6%	01-Apr-2002	-13.0%	5.0%	0.825	573,392,774	0
01-Feb-2002	5.9%	27-Jan-2003	-11.6%	5.9%	0.425	244,512,988	0
31-Jan-2003	-10.0%	01-Jul-2003	-15.0%	-15.0%	1.507	254,622,206	0
02-Feb-2004	12.2%	01-Jan-2005	0.0%	0.0%	1.367	532,767,242	0
01-Feb-2005 Revised 29-July-2005	9.6%	15-May-2006	-2.5%	-2.5%	0.504	203,323,357	0
01-Feb-2006 Revised 10-March-2006	7.4%	15-Nov-2006	-2.9%	-2.9%	0.129	44,992,715	0
		01-Jan-2007			1.000	349,411,508	0
		01-Jan-2008			1.003	350,368,800	
01-Feb-2008	12.9%	01-Jan-2009	-0.5%	-0.5%	0.833	391,312,977	0
30-Jan-2009	1.4%	01-Nov-2009	0.0%	0.0%	0.167	12,845,019	0
		01-Jan-2010	0.0%	0.0%	1.748	134,346,259	0
		01-Oct-2011					
Total						**$5,243,280,496**	

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

** Difference in total manual premium dollars between Rate Bureau implemented and COI ordered rates.

NORTH CAROLINA DEPARTMENT OF INSURANCE

History of Homeowners Insurance Rate Changes

Filed Date	Overall Filed/Proposed Rate Change	Effective Date	COI Ordered Rate Change	NCRB Implemented Rate Change	Actual Years Effective	Savings*	Subject to Escrow**
18-Jun-1993	13.5%	01-Oct-1994	2.0%	2.0%	1.00	$55,012,318	$0
		01-Oct-1995			1.00	55,012,318	0
		01-Oct-1996			1.00	55,012,318	0
		01-Oct-1997			1.00	55,012,318	0
		01-Oct-1998			0.67	36,858,253	0
03-Dec-1998	15.6%	01-Jun-1999	4.3%	4.3%	1.00	78,460,465	0
		01-Jun-2000			1.00	78,460,465	0
		01-Jun-2001			1.21	94,937,163	0
22-Mar-2002	20.0%	15-Aug-2002	5.0%	5.0%	1.00	142,154,939	0
		15-Aug-2003			1.00	142,154,939	0
		15-Aug-2004			0.96	136,468,741	0
25-Feb-2005	12.1%	01-Aug-2005	2.2%	2.2%	1.00	110,728,419	0
		01-Aug-2006			0.42	46,505,936	0
		01-Jan-2007			0.33	36,540,378	0
29-Dec-2006	21.9%	01-May-2007	5.4%	5.4%	0.67	143,547,113	0
		01-Jan-2008			1.00	214,249,423	0
		01-Jan-2009			0.33	70,702,310	0
08-Dec-2008	19.5%	01-May-2009	3.9%	3.9%	0.67	160,114,048	0
							0
Total						**$1,711,931,864**	**$0**

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

** Difference in total manual premium dollars between Rate Bureau implemented and COI ordered rates.

North Carolina Department of Insurance Dwelling Fire and Extended Coverage Rate Changes					
Filed Date	Filed Change	Effective Date	COI Ordered Change	Actual Years Effective	Savings
18-Jun-1993	9.5%	1-Jun-1994	2.0%	1.000	$3,977,831
		1-Jun-1995		1.003	3,988,730
		1-Jun-1996		1.000	3,977,831
		1-Jun-1997		1.000	3,977,831
		1-Jun-1998		1.000	3,977,831
		1-Jun-1999		0.501	1,994,365
18-Aug-1999	12.8%	1-Dec-1999	5.2%	1.003	5,580,855
		1-Dec-2000		1.000	5,565,606
		1-Dec-2001		1.000	5,565,606
		1-Dec-2002		0.918	5,108,159
26-Jun-2003	42.8%	1-Nov-2003	13.6%	1.003	34,883,288
		1-Nov-2004		1.000	34,787,979
		1-Nov-2005		0.833	28,974,097
31-Mar-2006	32.9%	1-Sep-2006	12.1%	1.000	40,048,099
Total					**$182,408,111**

North Carolina Insurance Underwriting Association and North Carolina Joint Underwriting Association

The following charts are reflective of premium writings and policies issued by the North Carolina Insurance Underwriting Association (Coastal Property Insurance Pool/Beach Plan) and the North Carolina Joint Underwriters Association (Fair Plan) for its last nine fiscal years (10/1/00-9/30/09). Premium growth has currently pushed premium writings in the Coastal Property Insurance Pool over $295 million dollars and premium writings in the Fair Plan to over $25 million dollars.

(See next page for charts)

NORTH CAROLINA INSURANCE UNDERWRITING ASSOCIATION
Coastal Property Insurance Pool (CPIP) or formerly known as the Beach Plan

DWELLING FIRE AND WIND POLICIES - FULL COVERAGE (BEACH AREA)				
YEAR	PREMIUMS	% OF CHANGE	POLICIES ISSUED	% OF CHANGE
10/01/00 - 09/30/01	$ 25,895,253	N/A	27,156	N/A
10/01/01 - 09/30/02	$ 27,413,490	6%	28,444	5%
10/01/02 - 09/30/03	$ 30,303,491	11%	30,838	8%
10/01/03 - 09/30/04	$ 37,717,107	24%	31,761	3%
10/01/04 - 09/30/05	$ 40,834,170	8%	34,140	7%
10/01/05 - 09/30/06	$ 45,191,962	11%	34,796	2%
10/01/06 - 09/30/07	$ 53,979,982	19%	36,237	4%
10/01/07 - 09/30/08	$ 54,678,811	1%	37,956	5%
10/01/08 - 09/30/09	$ 51,720,829	(5%)	37,696	(1%)
DWELLING AND COMMERCIAL WIND AND HAIL POLICIES ONLY (BEACH AREA)				
YEAR	PREMIUMS	% OF CHANGE	POLICIES ISSUED	% OF CHANGE
10/01/00 - 09/30/01	$ 18,836,985	N/A	14,338	N/A
10/01/01 - 09/30/02	$ 23,000,641	22%	15,550	8%
10/01/02 - 09/30/03	$ 27,699,721	20%	27,472	77%
10/01/03 - 09/30/04	$ 12,697,796	(54%)	2,693	(90%)
10/01/04 - 09/30/05	$ 14,886,968	17%	2,444	(9%)
10/01/05 - 09/30/06	$ 18,381,267	23%	2,466	1%
10/01/06 - 09/30/07	$ 20,660,854	12%	2,583	5%
10/01/07 - 09/30/08	$ 25,600,649	24%	2,693	4%
10/01/08 - 09/30/09	$ 25,047,262	(2%)	2,771	3%
DWELLING AND COMMERCIAL WIND AND HAIL POLICIES ONLY (COASTAL AREA)				
YEAR	PREMIUMS	% OF CHANGE	POLICIES ISSUED	% OF CHANGE
10/01/00 - 09/30/01	$ 7,983,602	N/A	11,346	N/A
10/01/01 - 09/30/02	$ 10,903,841	37%	14,090	24%
10/01/02 - 09/30/03	$ 16,817,787	54%	20,159	43%
10/01/03 - 09/30/04	$ 7,695,717	(54%)	3,763	(81%)
10/01/04 - 09/30/05	$ 10,984,803	43%	5,446	45%
10/01/05 - 09/30/06	$ 15,792,766	44%	7,980	47%

10/01/06 - 09/30/07	$ 22,005,057	39%	10,490	31%
10/01/07 - 09/30/08	$ 28,749,107	31%	14,040	34%
10/01/08 - 09/30/09	$ 29,362,946	2%	16,092	15%
HOMEOWNERS WIND AND HAIL POLICIES ONLY (BEACH AREA)				
YEAR	**PREMIUMS**	**% OF CHANGE**	**POLICIES ISSUED**	**% OF CHANGE**
10/01/00 - 09/30/01	$ -	N/A	-	N/A
10/01/01 - 09/30/02	$ -	N/A	-	N/A
10/01/02 - 09/30/03	$ -	N/A	-	N/A
10/01/03 - 09/30/04	$ 22,690,418	N/A	30,300	N/A
10/01/04 - 09/30/05	$ 26,931,502	19%	19,104	(37%)
10/01/05 - 09/30/06	$ 37,702,627	40%	19,939	4%
10/01/06 - 09/30/07	$ 47,247,265	25%	21,498	8%
10/01/07 - 09/30/08	$ 53,876,622	14%	21,962	2%
10/01/08 - 09/30/09	$ 55,684,639	3%	21,462	(2%)
HOMEOWNERS WIND AND HAIL POLICIES ONLY (COASTAL AREA)				
YEAR	**PREMIUMS**	**% OF CHANGE**	**POLICIES ISSUED**	**% OF CHANGE**
10/01/00 - 09/30/01	$ -	N/A	-	N/A
10/01/01 - 09/30/02	$ -	N/A	-	N/A
10/01/02 - 09/30/03	$ -	N/A	-	N/A
10/01/03 - 09/30/04	$ 14,408,421	N/A	41,473	N/A
10/01/04 - 09/30/05	$ 29,231,532	103%	53,008	28%
10/01/05 - 09/30/06	$ 45,580,183	56%	63,398	20%
10/01/06 - 09/30/07	$ 70,460,407	55%	80,262	27%
10/01/07 - 09/30/08	$ 101,703,854	44%	99,707	24%
10/01/08 - 09/30/09	$ 120,718,961	19%	102,949	3%
HOMEOWNERS POLICIES ONLY (BEACH AREA)				
YEAR	**PREMIUMS**	**% OF CHANGE**	**POLICIES ISSUED**	**% OF CHANGE**
10/01/00 - 09/30/01	$ -	N/A	-	N/A
10/01/01 - 09/30/02	$ -	N/A	-	N/A
10/01/02 - 09/30/03	$ 178,245	N/A	114	N/A
10/01/03 - 09/30/04	$ 1,623,801	811%	1,020	795%
10/01/04 - 09/30/05	$ 2,614,121	61%	1,679	65%
10/01/05 - 09/30/06	$ 3,534,671	35%	1,988	18%

10/01/06 - 09/30/07	$ 4,218,860	19%	2,133	7%
10/01/07 - 09/30/08	$ 4,368,224	4%	2,040	(4%)
10/01/08 - 09/30/09	$ 3,947,041	(10%)	1,843	(10%)
HOMEOWNERS POLICIES ONLY (COASTAL AREA)				
YEAR	**PREMIUMS**	**% OF CHANGE**	**POLICIES ISSUED**	**% OF CHANGE**
10/01/00 - 09/30/01	$ -	N/A	-	N/A
10/01/01 - 09/30/02	$ -	N/A	-	N/A
10/01/02 - 09/30/03	$ 340,605	N/A	392	N/A
10/01/03 - 09/30/04	$ 2,550,532	649%	3,648	831%
10/01/04 - 09/30/05	$ 4,934,751	93%	6,396	75%
10/01/05 - 09/30/06	$ 6,722,177	36%	8,168	28%
10/01/06 - 09/30/07	$ 8,280,511	23%	8,898	9%
10/01/07 - 09/30/08	$ 8,979,280	8%	8,791	(1%)
10/01/08 - 09/30/09	$ 8,912,504	(1%)	7,730	(12%)
TOTAL BEACH PLAN				
YEAR	**PREMIUMS**	**% OF CHANGE**	**POLICIES ISSUED**	**% OF CHANGE**
10/01/00 - 09/30/01	$ 52,715,840	N/A	52,840	N/A
10/01/01 - 09/30/02	$ 61,317,972	16%	58,084	10%
10/01/02 - 09/30/03	$ 75,339,849	23%	78,975	36%
10/01/03 - 09/30/04	$ 99,383,792	32%	114,658	45%
10/01/04 - 09/30/05	$ 130,417,847	31%	122,217	7%
10/01/05 - 09/30/06	$ 172,905,653	33%	138,735	14%
10/01/06 - 09/30/07	$ 226,852,936	31%	162,101	17%
10/01/07 - 09/30/08	$ 277,956,547	23%	187,189	15%
10/01/08 - 09/30/09	$ 295,394,182	6%	190,543	2%

NORTH CAROLINA JOINT UNDERWRITING ASSOCIATION (FAIR PLAN)

FAIR PLAN - DWELLING ONLY				
YEAR	PREMIUMS	% OF CHANGE	POLICIES ISSUED	% OF CHANGE
10/01/00 - 09/30/01	$ 13,893,438	N/A	48,930	N/A
10/01/01 - 09/30/02	$ 15,649,944	13%	51,624	6%
10/01/02 - 09/30/03	$ 18,272,841	17%	62,119	20%
10/01/03 - 09/30/04	$ 21,831,871	19%	64,856	4%
10/01/04 - 09/30/05	$ 23,822,085	9%	63,324	(2%)
10/01/05 - 09/30/06	$ 23,824,906	0%	69,028	9%
10/01/06 - 09/30/07	$ 26,056,150	9%	67,201	(3%)
10/01/07 - 09/30/08	$ 25,397,739	(3%)	63,558	(5%)
10/01/08 - 09/30/09	$ 24,245,785	(5%)	64,662	2%
FAIR PLAN - COMMERCIAL ONLY				
YEAR	PREMIUMS	% OF CHANGE	POLICIES ISSUED	% OF CHANGE
10/01/00 - 09/30/01	$ 1,474,086	N/A	2,116	N/A
10/01/01 - 09/30/02	$ 2,019,644	37%	2,146	1%
10/01/02 - 09/30/03	$ 2,308,315	14%	2,215	3%
10/01/03 - 09/30/04	$ 1,876,781	(19%)	2,055	(7%)
10/01/04 - 09/30/05	$ 1,787,200	(5%)	1,900	(8%)
10/01/05 - 09/30/06	$ 1,814,916	2%	1,897	(0%)
10/01/06 - 09/30/07	$ 1,624,141	(11%)	1,774	(6%)
10/01/07 - 09/30/08	$ 1,605,222	(1%)	1,695	(4%)
10/01/08 - 09/30/09	$ 1,420,301	(12%)	1,588	(6%)
TOTAL FAIR PLAN				
YEAR	PREMIUMS	% OF CHANGE	POLICIES ISSUED	% OF CHANGE
10/01/00 - 09/30/01	$ 15,367,524	N/A	51,046	N/A
10/01/01 - 09/30/02	$ 17,669,588	15%	53,770	5%
10/01/02 - 09/30/03	$ 20,581,156	16%	64,334	20%
10/01/03 - 09/30/04	$ 23,708,652	15%	66,911	4%
10/01/04 - 09/30/05	$ 25,609,285	8%	65,224	(3%)
10/01/05 - 09/30/06	$ 25,639,822	0%	70,925	9%
10/01/06 - 09/30/07	$ 27,680,291	8%	68,975	(3%)
10/01/07 - 09/30/08	$ 27,002,961	(2%)	65,253	(5%)
10/01/08 - 09/30/09	$ 25,666,086	(5%)	66,250	2%

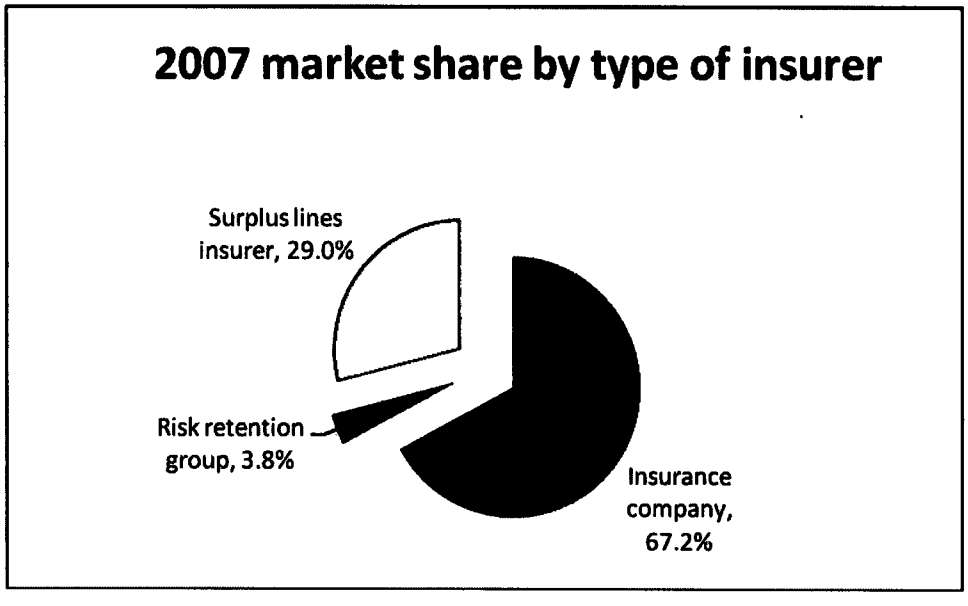
Medical Malpractice in North Carolina

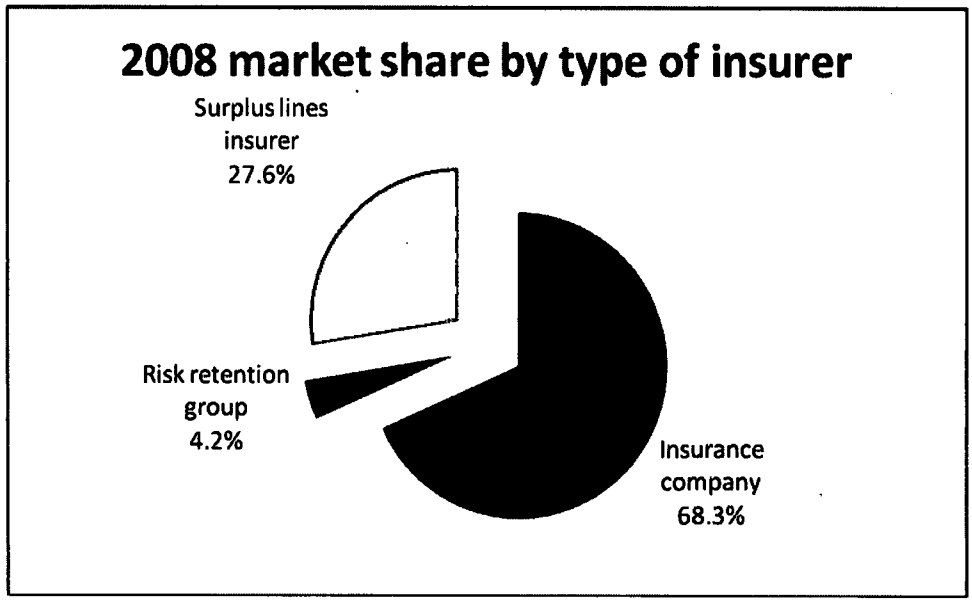
The Property and Casualty Division reviews the filings for premiums and policy forms submitted by medical malpractice insurers. The division works closely with the Actuarial Services Division which performs statistical analysis of premiums by doctor class, for over 100 classes for the leading insurers. The following charts reflect writings for the calendar years 2007 through 2009 for the largest medical malpractice writers in North Carolina.

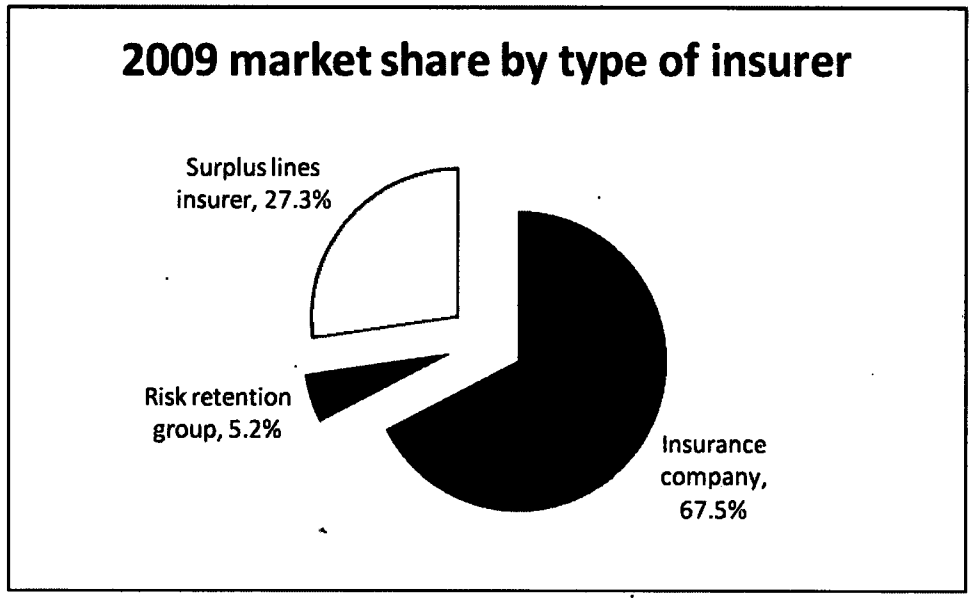
COMPANY NAME	2007 DIRECT PREMIUM WRITTEN	2007 POLICYHOLDER DIVIDENDS	MARKET SHARE
Medical Mut Ins Co Of NC	$94,979,366	0	32.4%
MAG Mut Ins Co	$59,155,357	1,362,454	20.1%
Lexington Ins Co	$25,746,872	0	8.8%
Steadfast Ins Co	$18,831,411	0	6.4%
National Fire & Marine Ins Co	$14,825,879	0	5.0%
Doctors Co An Interins Exch	$10,288,783	216,053	3.5%
Medical Protective Co	$10,149,308	0	3.5%
Hudson Specialty Ins Co	$4,736,473	0	1.6%
American Cas Co Of Reading PA	$4,711,630	0	1.6%
Columbia Cas Co	$3,294,326	0	1.1%
All other insurers	$46,866,301	235,578	16.0%
TOTAL	**$293,585,706**	**1,814,085**	**100.0%**

COMPANY NAME	2008 DIRECT PREMIUM WRITTEN	2008 POLICYHOLDER DIVIDENDS	MARKET SHARE
Medical Mut Ins Co Of NC	89,317,686	2,886,883	32.3%
MAG Mut Ins Co	55,487,252	2,695,288	20.1%
Lexington Ins Co	18,080,808	0	6.5%
Steadfast Ins Co	16,596,418	0	6.0%
National Fire & Marine Ins Co	13,102,034	0	4.7%
Doctors Co An Interins Exch	11,660,911	412,708	4.2%
Medical Protective Co	9,169,895	0	3.3%
American Cas Co Of Reading PA	4,890,686	0	1.8%
Hudson Specialty Ins Co	3,751,142	0	1.4%
Columbia Cas Co	3,456,911	0	1.3%
All other insurers	50,939,696	373,324	18.4%
TOTAL	**276,453,439**	**6,368,203**	**100.0%**

COMPANY NAME	2009 DIRECT PREMIUM WRITTEN	2009 POLICYHOLDER DIVIDENDS	MARKET SHARE
Medical Mut Ins Co Of NC	$83,753,371	113,117	33.2%
MAG Mut Ins Co	$46,224,842	2,006,877	18.3%
Lexington Ins Co	$15,361,239	0	6.1%
Steadfast Ins Co	$14,302,951	0	5.7%
Doctors Co An Interins Exch	$10,390,515	447,653	4.1%
Medical Protective Co	$7,992,532	0	3.2%
Darwin Select Ins Co	$7,238,571	0	2.9%
National Fire & Marine Ins Co	$7,103,259	0	2.8%
American Cas Co Of Reading PA	$5,052,407	0	2.0%
Columbia Cas Co	$4,025,796	0	1.6%
All other insurers	$50,917,880	261,959	20.2%
TOTAL	**$252,363,363**	**2,829,606**	**100.0%**







The following chart is reflective of the most recent filings for the largest medical malpractice insurers in North Carolina and the estimated savings for North Carolina policyholders.

NORTH CAROLINA DEPARTMENT OF INSURANCE

Estimated Savings on Medical Malpractice Premiums for North Carolina Doctors

Insurer	Filing Number	Effective Date	Filed For	Agreed To	2009 Annual Premium	Est. 2009 Savings for NC Doctors
Medical Mutual Ins. Co. of North Carolina	PC085555	1/1/2006	6.40%	4.10%	$81,109,214	$1,865,512
MAG Mutual Insurance Company	PC115211	9/1/2008	-6.90%	-10.00%	$45,980,915	$1,425,408
Doctors Co. Interinsurance Exchange	PC094517	11/1/2006	-9.00%	-9.90%	$10,254,975	$92,295
Medical Protective Company	PC118471	2/1/2009	-6.80%	-8.50%	$7,413,696	$126,033
Total savings						**$3,509,248**

Note: the above represents rate filings for doctors (physicians and surgeons) only

The "Filed For" column shows the percent change that the company originally requested

The "Agreed To" column shows the percent change that the company agreed to after being challenged by statistical analysis from the DOI's Actuarial Services Division

e "Annual Premium" is the 2009 calendar year premium, for doctors only, from Schedule T of the nual Statement

Life and Health Division

The 2007-2009 period has been a period of change and steady activity for this division. The Life and Health Division is responsible for the review and approval of rate, rule and policy form filings submitted by life and health insurance companies and issuance of licenses for third party administrators and viatical settlement and life settlement providers. This division plays a pivotal role for the Department in the monitoring and analysis of local, state, and national life and health insurance trends. The division also monitors and regulates certain activities of managed care entities such as health maintenance organizations (HMOs) and managed care indemnity health insurers, including their arrangements with Preferred Provider Organizations (PPOs) with an emphasis on assuring company procedure and operational policy meet compliance requirements in North Carolina. Oversight of Multiple Employer Welfare Arrangements (MEWAs) and Professional Employer Organizations (PEOs) with an emphasis on assuring company procedure and operational policy meet compliance requirements in North Carolina. The division accomplishes its work through several types of activities such as review of document filings required of companies, data collection, review collaboration with the Actuarial Services Division, the Market Regulation Division, the Consumer Services Division, the Financial Evaluation Division, analysis, and reporting, meeting with industry representatives, health care providers, legislative representatives, and other interested parties. The division is also the primary source for the development of proposed legislation related to life and health insurance products and rates. Federal health care reform implementation has and will continue for years to come necessitate heavy involvement and leadership from the division.

Interstate Insurance Product Regulation Commission

Since meeting its operational threshold in May 2006, the IIPRC now has 36 member states representing over half of the premium volume nationwide. The Management Committee of the IIPRC manages the affairs of the Commission. The Management Committee Members currently include the six largest compacting states according to premium volume: Massachusetts, Michigan, North Carolina, Ohio, Pennsylvania and Texas; four mid-sized states, Georgia, Indiana, Virginia, and Wisconsin; and one additional state from each of four regional zones, Idaho, Oklahoma, Vermont and West Virginia. Additional Members of the Compact include: Alaska, Colorado, Hawaii, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Mexico, Puerto Rico, Rhode Island, South Carolina, Tennessee, Utah, Washington, and Wyoming.

IIPRC Product Filing Statistics between June 2007 and August 3, 2010:

	YTD Aug 2010	% of Growth (09/10)	2009	% of Growth (08/09)	2008	2007
Companies Registered	100	105%	74	195%	38	N/A
Filings received	195		244	230%	106	36
Products Approved	154		279	221%	126	29
Transactions *	4022		7,494	245%	3053	552
Approval Time (average) **	36		28	-	25	35
Average # of states/filing	28		28	-	25	25
Mix & Match %	65%		75%	-	75%	100%
State filing fees collected	$ 398,696		$499,942	357%	$139,910	$62,965
IIPRC filing fees	$ 116,500		$107,900	157%	$68,730	$18,050

The IIPRC has adopted 57 Uniform Standards of which the 13 TOI and 64 various sub-TOIs available. Of the companies registered in 2009, 63 have re-registered demonstrating a retention rate of 85%. Of the 100 companies registered to date 38% of the national premium volume is represented. Further, 559 products have been approved by the IIPRC which equates to 14,569 SERFF transactions.

Adopted August 2010, the individual long-term care uniform standards only apply to new products filed with the IIPRC and will not affect existing long-term care products approved by a state or closed blocks of business. These uniform standards will now undergo a promulgation period and are expected to become available for filing before the end of 2010.

The IIPRC also adopted a non-binding resolution to request the NAIC review the feasibility of a national program to protect all long-term care consumers, including individuals who own existing, pre-rate stabilized long-term care insurance products.

Health Insurance Issues

The Life and Health Division oversaw health insurers' implementation of significant legislation, since numerous new and revised laws required insurers in major medical market to submit revised forms for approval.

The individual health insurance market lost three insurers during the 2007-2009 period, and six insurers joined the market during that time. The trend of insurers exiting the individual major medical health insurance market that was noted in previous reports appears to have leveled. The entry of six new insurers since 2007 shows more insurers taking interest in this marketplace and spells more choice for North Carolina citizens who do not obtain insurance coverage through their employer.

People in North Carolina and across the nation are being faced with significant rate increases on their Long-Term Care insurance (LTC) policies. Recently, the Department approved LTC insurance increases for MetLife, MedAmerica, John Hancock, Medico, Bankers Life and Casualty, Seniors Health Insurance Company of Pennsylvania, Monumental Life, and Southern Farm Bureau Life.

LTC insurance has proven to be a product line extremely difficult to price because projections are based on what we know from past events. Also, LTC insurance policyholders are living longer than expected and cancelling fewer policies than expected when the original rates were set, leading to higher claims. Many experts explain the increases as a result of actuaries "missing the mark." In fact, increases are also affecting states that adopted rate stabilization. North Carolina adopted rate stabilization in 2003.

We will continue to monitor the situation and do everything we can to keep the rate increases at a minimum while still making sure the company stays solvent. This is not only a North Carolina problem! The increases are occurring across the country and there is activity on a national level to address national LTC insurance rating issues. A proposal to protect consumers who own existing pre-rate stabilization LTC insurance products has been brought to the National Association of Insurance Commissioners. Commissioner Goodwin has expressed support for any proposal that would serve as a precautionary measure in the interest of protecting all LTC insurance consumers.

For all companies combined North Carolina residents are paying a lower percentage of increase than has been requested. In part, this is because the division conducts an independent analysis of the long-term care data submitted with each rate increase request, and recommends an adjustment when the full amount of the requested increase does not appear to be justified.

Currently North Carolina has licensed and renewed five MEWAs to operate employer health benefit plan trusts. In 2009 filing activity included 10 PPO expansions, 17 initial PPO operations, one HMO expansion, one initial HMO operations, 43 provider agreements, and 14 intermediary network agreements.

The division has seen a decrease in approval of limited health plans, sometimes referred to as "mini-med" plans during the 2007-2009 time period. These plans may only pay specified dollar amount for a covered service and generally do not provide coverage for a percentage of covered expenses. They may also have low annual or lifetime limits and generally are not considered comprehensive coverage. In 2007-2009, the division approved 62 filings containing a form identified as a limited health plan. That is a 62% decrease from 2005-2006 time period, where the division approved 163 of such filings. The division believes that the decrease may be attributed to the adoption of a standard definition for "health benefit plan" in our statutes which along with federal HIPAA regulation clearly defines when a limited health plan must comply with HIPAA as well as many of our mandated benefits. Insurers have chosen to withdraw filings rather than amend the plans to comply with the laws.

During the 2007-2009 time period the state established a high risk health insurance pool for individuals unable to qualify or purchase health insurance due to their health status. The pool was also established as an alternative mechanism under the federal HIPAA laws to provide coverage to HIPAA eligible individuals and as a qualifying health plan for individuals qualifying for premium assistance through the Trade Adjustment Act of 2002. The Pool, called Inclusive Health, become operational in January of 2009.

Other new initiatives from 2007-2009 impacting health insurance include a mental illness parity statute for group health plans, coverage for hearing aids, and several federal provisions relating to mental health and substance addiction coverage, continued eligibility for coverage for children who take a leave of absence from an institution of higher learning due to a medical condition, and discrimination based on genetic background. Lastly, the Department adopted a rule prohibiting discrimination based on an individual's domestic abuse status in health insurance.

Association Activity

The division, along with other divisions and the Attorney General's office, has been monitoring activity of associations and the controls or monitoring insurers engage in when they contract with an association to market an insurance product. The regulatory industry has been concerned with rogue associations and the deceptive marketing practices and type of policies that are being sold that may be misleading to consumers with regard to either benefits or premium vs. association dues.

Life Insurance Issues

New life insurance products continued to be developed during this biennium as this product is increasingly being sold as an investment, rather than strictly as a method of protecting beneficiaries. Life insurance companies are developing policies, which can compete with other investment vehicles, including annuities. The marketing of flexible premium annuity products to the senior population, with interest features determined by various stock market indices, has seen a significant increase during 2007-2009. As a result, new standards for disclosure were adopted by the legislature for the annuity market and small face amount policies to provide

better information to the consumer for their decision making. The division continues to be involved in the market trend analysis as it relates to improper sales activity, working with other divisions in the Department and other state agencies. Additional legislative activity regarding the suitability of annuity products was adopted during the 2007-2009 period. Additionally, protections were adopted to address issues of marketing abuse in the sale of life insurance products and annuities to military personnel.

Credit Insurance Issues

In 2007, credit insurance statutes (58-57-5 and 58-57-35) were revised to require that rates for critical period benefits shall be adjusted by a critical period conversion ratio to reflect the limited benefit period.

In 2009, 58-57-100 was revised to require that credit property auto physical damage insurance may only be written on vehicles that comply with the safety and emission inspection requirements of Part 2 of Article 3A of Chapter 20 of the General Statutes.

Form and Rate Filings

Effective January 1, 2009, the division discontinued the API link between OTIS and SERFF making SERFF its sole application for the review of forms and rates. The division added work unit types to SERFF allowing management agreements, non-form / non-rate annual reports, and other product types to be processed in SERFF. As of January 1, 2009, both electronic email and paper work units were added to SERFF thus making SERFF the primary tool for the processing of forms and rates. In 2007 there were 34 Interstate Compact Filings, and in 2009 there were 187 Interstate Compact filings.

Life & Health	Work Units Received/Created Non-Rate	Work Units Rate Received/Created	Total Work Units
2007	3,741	849	4,590
2008	3,725	981	4,706
2009	3,914	729	4,643

Speed to Market

	NAIC IS3 Goals	2007 Total	2008 Total	2009 Total
20 days or less	50%	57%	54%	65%
21 to 25 days	70%	63%	60%	70%
26 to 30 days	95%	69%	66%	75%
31 to 60 days	100%	91%	89%	93%
More than 60 days		9%	11%	7%

Third Party Administrators

The division responsible for the regulation of Third Party Administrators (TPAs), the Life & Health Division assisted the Consumer Services Division (CSD) in various investigations of unauthorized insurance activity in the State of North Carolina during the 2007-2009 time period. Frequently these situations have involved TPAs, who may have been licensed or registered by the Department. Life and Health provided technical assistance to CSD regarding our procedures and regulations of TPAs, participated in meetings about or with entities under investigation, and took action against a TPA as appropriate.

Third Party Administrator Licenses/Registrations

	Issued Licenses	Registered
2007	233	107
2008	233	135
2009	241	106

Viatical Settlement Providers

Activity in the life settlement industry remained active in 2007 and 2008. There were few new providers in 2009. There is a national concern with stranger owned life insurance and annuities that is under review presently at the National Association of Insurance Commissioners which could have an impact on the number of providers in the future.

Viatical Settlement Provider Licenses

	Issued Licenses	Active
2007	9	34
2008	8	44
2009	1	42

Managed Care Activity

The division also monitors and regulates certain activities of managed care entities, including health maintenance organizations (HMOs); preferred provider organization benefit plans (PPOs); managed care indemnity health insurers and multiple employer welfare arrangements (MEWAs). The division focuses on the company compliance non-financial policies and procedures and the impact of those policies and procedures on consumers.

In order to deliver the cost controls demanded by purchasers and consumers, managed care organizations apply a broad array of policies and techniques that have tremendous impact on consumers. These include requirements relating to provider networks, as well as programs and policies that consumers and their treating providers must follow as a condition of coverage for services.

The techniques employed by managed care plans to promote quality care and eliminate unnecessary care can also result in disputes over coverage for services promised under a consumer's policy. Thus, the Department's traditional regulatory oversight of company marketing practices, treatment of policyholders and solvency are expanded to include those systems that are unique to managed care plans.

The division accomplishes its work through several types of activities, including coordination of the Department's review of certificate of authority and license modifications of HMOs, reviewing initial filings of PPO benefit plans, approving provider and intermediary template form contracts, and providing information and guidance on managed care laws to industry and interested parties.

The review of template form health care provider contracts used by HMOs and indemnity health insurers with preferred provider benefit plans is performed to establish compliance with regulations pertaining to carriers' responsibilities for arranging the provider networks to which insureds are directed and to determine compliance with regulations governing the utilization review process and the member appeal process. The reviews of these policies and procedures are included in the division Speed to Market numbers reflected above.

Managed Care Work Unit Types have been incorporated into SERFF for review and processing.

Multiple Employer Welfare Arrangements (MEWAs)

Since laws were enacted to license multiple employer welfare arrangements (MEWAs), 11 licenses have been issued. The division reviews MEWA initial and annual license applications, coordinating their approval with other divisions, similar to the coordinated review of HMO certificates of authority. During 2007-2009, two MEWAs have discontinued their plans.

MEWAs Licensed

Year	New Licenses	Terminated Licenses
1993	3	-
1994	2	-
1995	0	-
1996	1	-
1997	0	-
1998	1	1
1999	1	3
2000	2	-
2001	0	-
2002	1	1
2003	0	0
2004	0	0
2005	0	0
2006	0	2
2007	0	0
2008	0	0
2009	0	0
Total Currently Licensed:		5

Seniors' Health Insurance Information Program

The Seniors' Health Insurance Information Program (SHIIP) provides health insurance information counseling and assistance to Medicare beneficiaries and/or family members in North Carolina. The program is coordinated in each county through an existing human service agency such as a Council on Aging office, a Senior Center, or a Cooperative Extension office. These agencies serve as sponsors and provide important continuity, an available point of access, and are models for interagency cooperation. Currently there are 110 SHIIP sponsors in our state. SHIIP was established in 1986 in response to an increased number of calls, letters and complaints from older North Carolinians confused by their health insurance options. Those persons who utilize the program most frequently are typically seniors, disabled individuals and caregivers or adult children.

The activities and duties performed by SHIIP provide a valuable service to the state's senior population. SHIIP's primary objective is to educate the public on seniors' health insurance concentrating on Medicare, Medicare supplements, Medicare Advantage and Long-Term Care insurance. The services offered by SHIIP are accomplished by training volunteer counselors in all 100 counties of North Carolina to educate and counsel their peers on seniors' health insurance, operation of a statewide toll-free line from the Raleigh SHIIP office and developing educational materials to consumers.

Because of the implementation of the Medicare Modernization Act (MMA) of 2005, which includes the new Medicare Part D Prescription Drug benefit, SHIIP was chosen to play a key role in North Carolina's educational campaign for consumers to understand the changes. The goal is to educate, counsel and assist Medicare beneficiaries, family members and the general public to help them understand the Medicare Part D benefit as well as the Medicare Part D subsidy program.

Major Initiatives and Accomplishments

Currently SHIIP has 20 fulltime employees, 836 volunteer counselors and 122 volunteer county coordinators. From January 2007 to December 2009, SHIIP staff trained 304 volunteers representing 86 counties in the basic curriculum.

There are 110 SHIIP coordinating sites in the state. These sites set up regular counseling schedules and clinics manned by SHIIP volunteers for persons needing information and assistance on Medicare Part D prescription drug coverage.

The SHIIP toll free counseling service answered 129,862 calls from 2007-2009, averaging 3,607 calls a month.

SHIIP counselors spent 107,115 hours in volunteer counseling sessions and held 194,562 individual counseling sessions during the period.

SHIIP staff conducted and/or participated in 3,280 educational seminars, health fairs and speaking engagements during this period. In addition SHIIP participated in 95 radio interviews and 50 television appearances.

SHIIP sent 25,316 mailings to individuals based on their request for materials. These requests included informational brochures, Prescription Drug Plan Finder Tool, NCRx applications, *Medicare Supplement Comparison Guides* and the National Association of Insurance Commissioners' (NAIC's) *Guide to Long-Term Care Insurance Information*.

SHIIP creates a number of consumer publications on a yearly basis including the *Medicare Supplement Comparison Guide,* the *Guide to Long-Term Care Insurance in North Carolina* and the *Road to Medicare: Planning Your Drive Toward 65*. The division also serves as a clearinghouse for Centers for Medicare and Medicaid Services (CMS) publications.

SHIIP serves as a partner and chair of the Statewide Medicare Partners Committee. This committee is a statewide initiative to inform and educate older adults, their caregivers, aging and health care service providers and others in the state on the Medicare Prescription Drug Program, Medicare Part D and the State Prescription Drug Assistance Program (SPAP) along with the North Carolina Division of Aging and Adult Services, North Carolina AARP Office, North Carolina Division of Medical Assistance, North Carolina Office of Minority Health and Health Disparities, Social Security Administration, North Carolina Office of Research, Demonstrations and Rural Health Development which administers NCRx, North Carolina Association of Area Agencies on Aging and The Office of the Governor. Monthly meetings are attended by partners to coordinate efforts and link websites and communicate regularly by email to share information.

Each year SHIIP staff members appear on "OPEN/Net," the statewide call-in television program produced by the N.C. Agency for Public Telecommunications.

The North Carolina SHIIP was one of the recipients of the CMS Beneficiary Services Certificate of Merit award.

SHIIP's website, www.ncshiip.com, provides access to an interactive Medicare Supplement insurance premium database. This database provides consumers with up-to-date information about Medicare supplement policy choices, premium costs, rate history and coverage. There were approximately 252,678 hits to this site during the period and 248,094 hits to the SHIIP home page.

SHIIP administers the North Carolina Senior Medicare Patrol Project (NC SMP) funded by the federal Administration on Aging (AOA). SHIIP initially received the grant award in 2003 and has implemented various outreach efforts to help fight Medicare/Medicaid waste, fraud and abuse.

SHIIP began operation of the NCRx call center in September 2006. SHIIP continues to partner with the Office of Rural Health and Community Care to provide an information hotline for the state prescription assistance program (SPAP) or NCRx. NCRx provides a Medicare Part D

premium subsidy for persons on Medicare who qualify based on income and assets. In addition SHIIP provides information and assistance to persons who have questions regarding the CheckMeds program in the state which provides medication management to Medicare beneficiaries age 65 and over at participating providers. NCRx and CheckMeds give SHIIP exposure to more Medicare beneficiaries.

In May 2007, SHIIP began meeting with staff at the N.C. Hospital Association to discuss a possible Medicare Advantage Educations Campaign for the state. Additional partners were invited to participate which included the N.C. Medical Society, N.C. Department of Health and Human Services and N.C. Care Facilities Association. The concern was a result of the mass confusion, marketing and sales abuse, and misunderstandings regarding Medicare Advantage products in our state. The group launched its new partnership "Partnership for Medicare Education in N.C." with a campaign slogan informing the consumer to Stop; Question; Call. Posters and flyers have been distributed by all parties across the state in their respective networks.

In October 2007, SHIIP started a Coordinators' Steering Committee. This committee is made up of eight members and includes a chairperson and vice-chair. The committee helps to promote program development at the state level along with helping develop partnerships in each of the regional manager territories. This committee also plans the annual SHIIP Coordinators' Training Conference.

SHIIP enters complaints into the CMS's Complaint Tracking Module (CTM). Reports from CMS indicate that NC enters in more complaints than any of the other participants.

In May 2009, SHIIP created a Facebook page to enable our program to reach out to individuals through the social media network. Facebook has been a great tool for SHIIP in reaching not only Medicare beneficiaries but their family members and caregivers as well.

SHIIP produces the NC SHIIP News that we provide to SHIIP Coordinators and Volunteers to provide them with updates from the SHIIP office on recent changes to Medicare.

SHIIP has received performance awards from CMS during this period. For our efforts in 2007 SHIIP received $58,101. For efforts in 2008 SHIIP received 168,559 and for efforts in 2009 SHIIP received $74,850.

Major Activities and/or Goals

SHIIP will make every effort to inform the citizens of North Carolina about the program's services. This includes Medicare beneficiaries, caregivers, adult children of aging parents, aging network professionals, medical providers, etc.

Through counseling, education and outreach SHIIP will continue to help beneficiaries identify, understand and enroll in programs and plans, when eligible and appropriate, including

Medicare Prescription Drug Plans, Medicare Advantage Plans, Medicare supplement insurance, Medicare Savings Programs and Long-Term Care insurance.

Efforts will continue to inform the public about Long-Term Care funding and payment options. Employers and baby boomers are among the groups identified as important to reach.

SHIIP will stand ready to respond to Medicare beneficiaries on Medicare Advantage or employer group health plan terminations and provide materials and information, if necessary.

SHIIP plans to continue efforts with regard to the NCSMP.

SHIIP will focus on strategies to reach the Hispanic, African American and disabled populations with a particular focus on the mental health community. Our office has a Communication Specialist that is fluent in Spanish. SHIIP has also hired an individual dedicated to reaching out to minority populations. SHIIP will focus efforts on development of partnership with mental health community in North Carolina. Since the implementation of the Technical Assistance Program (TAP) pilot in North Carolina SHIIP has worked continuously to establish new partners in the mental health community. The Mental Health Association of North Carolina has provided ongoing support to the program in identifying key agencies and organizations in the state. As a result, local mental health providers are becoming involved with SHIIP at the local level. In addition SHIIP has launched an effort to establish SHIIP sites at Psychosocial Rehabilitation Centers (PSRs) in the state. These PSRs operate similarly to senior centers but offer services to persons who are physically and mentally disabled. The center directors at six sites have completed SHIIP Basic Training, therefore they are certified to provide counseling at their centers.

SHIIP has begun partnering with the NC Community Resource Connections, (CRCs) through local SHIIP programs as well as the NCSMP. As the CRCs expand SHIIP has committed to working with them in local communities.

SHIIP agreed to co-sponsor along with the Medicare Access Network of NC (MANNC) four counseling enrollment events in Wake, Harnett, Orange, and Lee counties.

SHIIP will continue to partner with the Social Security Administration Offices in the state in order to reach increased targeted populations. SHIIP and SSA offices work together in many outreach events, particularly those geared to reaching LIS potentials. SHIIP provides regular information and training to SSA and a representative sits on the N.C. Medicare Partners Committee. Each SHIIP regional manager has met and knows each SSA office manager in their territories. They make regular visits to these offices and provide materials and assistance when requested.

SHIIP held a Congressional briefing on July 21, 2008. There were approximately 30 people in attendance including speakers and participants. The CMS RO was represented by Deputy Regional Administrator Gloria Parker. Other speakers representing Medicare A, B, and DME were in attendance along with the SHIIP Director and Technical Assistance Manager. Staff from

eight congressional offices attended the meeting. This event helped solidify relationships between congressional offices and SHIIP staff.

SHIIP launched a media campaign in February 2009 airing two :30 second commercials developed for SHIIP. These spots raised awareness of SHIIP among people who had not previously heard of the program. We will utilize these ads again once grant funding is available and will continue to target specific LIS zip codes.

SHIIP will continue efforts to promote computer use and Internet access by seniors.

Special efforts will be made to respond to persons who have specific needs or concerns; in particular, those who have high prescription drug costs as well as disabilities.

With the availability of the Medicare Prescription Drug Plans and the NCRx Program, SHIIP will focus on assisting beneficiaries in gaining insurance protection for prescription drug costs and help them receive the coverage needed with an emphasis on assisting low income beneficiaries and beneficiaries who lack insurance coverage for drug expenses.

The Governor's Office of Citizen Affairs operates a statewide careline. Careline and SHIIP signed an agreement between the agencies to transfer consumer calls directly to the SHIIP office in situations where the caller needs Medicare assistance.

In June 2009, SHIIP received federal funds to reach out to low income individuals on Medicare to help pay for prescription drug cost. This funding came from AOA and each grant recipient must work in partnership with the Area Agencies on Aging (AAA) and the Aging and Disability Resource Centers (ADRC) in order to receive the grant. The 17 Area Agencies on Aging are important partners for SHIIP and during this period. Special activities and events were co-sponsored with the AAAs as a result of the MIPPA funding. Through this partnership a MIPPA campaign slogan was developed to help spread the message. The MIPPA campaign, "Relay for Extra Help," was co sponsored by SHIIP, DAAS, ADRCs, and AAAs statewide. Through this campaign 7,239 Extra Help applications have been submitted to the Social Security Administration on behalf of SHIIP volunteers and our partners.

SHIIP provides ongoing training and support to the N.C. Division of Aging and Adult Services. This includes maintaining a strong connection to the Senior Tar Heel Legislature (STHL) which consists of senior delegates representing all 100 counties. The SHIIP director speaks to the entire delegation each quarter and in October 2009 the STHL delegation agreed to serve as ambassadors for the MIPPA initiative to spread the word about LIS in each of their communities.

SHIIP presented at Senior Scene of Charlotte in October 2009.

SHIIP spoke to 55 congregational Parrish nurses at Moses Cone Hospital in Greensboro.

SHIIP presented at the "Aging with Gusto" reaching a four county region: Chowan County, Currituck County, Camden County, and Pasquotank County. There were over 150 attendees in this rural region.

SHIIP exhibited at North Carolina Indian Senior Citizens Conference in Fayetteville.

A press kit regarding SHIIP and the LIS campaign was mailed to all congressional offices in December 2009.

Market Regulation Division

The Market Regulation Division monitors insurance company market practices, especially as they affect consumers. The examination methods employed by the division are based on a program developed by the National Association of Insurance Commissioners. By agreeing to pilot the program over 28 years ago, North Carolina became the first state in the nation to conduct market conduct examinations along the lines promulgated by the NAIC.

The division places a priority on automating examination processes. The division uses Audit Command Language (ACL) and the Microsoft Office Suite product software for 100 % of the testing on property and casualty, life and health, and HMO/PPO examinations. These combined automation efforts result in an increased review of company operations, allowing examiners to spend more time on potential problem areas rather than "routine" tasks, and also result in substantial savings to the public since more work can be done in our offices rather than at company offices.

The division monitors the activities of domestic and foreign Property and Casualty (P&C) insurance companies, Life and Health (L&H) insurance companies, Premium Finance companies, Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Multiple Employer Welfare Arrangement (MEWA) operating in North Carolina and is capable of responding to special problems or concerns related to company practices.

Examinations are conducted on a regular rotation so that all insurance companies domiciled in North Carolina are examined on a five-year cycle.

Examinations fall under several categories, including comprehensive (general), target, compliance, multistate cooperative and specialized. The examinations require distinct protocols to ensure that companies are treated fairly and without prejudice or unfair discrimination. In addition to "target" and "follow-up" exams, we utilize the Self Critical Analysis approach which allows entities to conduct a self audit on specific problem areas identified via a "target" or "follow-up" exam that would have minimal to no impact on the consumer and report their findings to the Department. This has also aided in the reduction of additional "follow-up" or "target" exams. The market analysis team (referenced later) has also resolved issues with entities via communication (e.g. correspondence, conference calls) thus preventing the need to call an examination to resolve the matter.

The division reviews managed care annual filings pursuant to NCGS 58-3-191, which requires that all insurers offering managed care products submit an annual report by July 1 of each year detailing insurers' activities for the previous year with regards to grievances received, number of participants and groups who terminated coverage, provider network size, utilization review, quality, availability and accessibility of services, performance targets and monitoring of the same, and provider compensation models. The filings are reviewed for compliance with all applicable statutes and regulations and insurers are required to correct any deficiencies noted on the review. All data submitted by insurers is located by year and type of company on the

Department's website at www.ncdoi.com/me, under the Resource Information, Managed Care Annual Data Filings menu.

Year	Filing
2007	63
2008	66
2009	73

Market Analysis Activities

Market analysis plays a major role in the identification and selection of insurers that will undergo a market conduct examination. Market analysis involves continuous surveillance of the marketplace to determine potential problem areas. The Market Analysis team performs market conduct analysis by collecting and analyzing data on domestic insurance entities and, as appropriate and/or required, that are licensed to do business in North Carolina in order to proactively identify general market disruptions early and to eliminate or limit harm to consumers, policyholders and/or claimants. The purpose of market analysis is to identify companies operating in each state's market that are potentially harming consumers due to non compliance with state laws/regulations. Market analysis review assists in narrowing the scope of any regulatory action that a state determines it must use to address those companies that are having issues with compliance.

Year	Activities
2007	168
2008	129
2009	233

In addition to regularly scheduled market conduct examinations, the division also takes other regulatory actions in response to market activities that are determined to be in violation of state laws. In 2007, the Department collected $491,526 in administrative penalty, $130,000 in 2008, and $75,252 in 2009 resulting from noncompliance with applicable laws. In 2007 a total of $1,954,024 was recovered and refunded to consumers as a result of a market conduct examination; the amount recovered and refunded in 2008 was $2,079,033 and in 2009 $981,300.81.

Year	Life & Health Exams	Property & Casualty Exams	General Exams	Compliance Exams	Target Exams
2007	7	25	7	12	16
2008	9	22	14	13	4
2009	4	20	11	7	5

Healthcare Review Program

The Healthcare Review Program (HCR Program) administers the Health Benefit Plan External Review statutes, NCGS 58-50-75 through 95. External review is the independent medical review of a health plan denial and offers another option for resolving coverage disputes between a covered person and his or her insurer. In North Carolina, external review is available to covered persons when their insurer denies coverage for services on the grounds that they are not medically necessary. This type of denial is referred to as a "noncertification decision." Denials for cosmetic or experimental services may be eligible for external review, depending on the specific circumstances of a case. The law applies to persons covered under fully-insured health benefit plans, the North Carolina State Health Plan, the North Carolina Health Choice for Children plan, and Inclusive Health (the North Carolina High Risk Pool).

To be accepted for external review, a covered person must meet eligibility requirements. A request is made directly to the HCR Program, where program staff is required to review each request for completeness and eligibility. In order to do this, information is received from the insurer within statutorily required time frames and, if needed, additional information is requested from the covered person. Once accepted for external review, the case is assigned to an independent review organization (IRO) for clinical review. The IRO issues a determination within the statutorily required time frame for the specific request (within 45 days of the HCR Program's receipt of a request for a standard review and four business days for an expedited review). The Program monitors compliance with the statutory and contractual requirements of the parties involved in external review.

The HCR Program also provides consumer counseling on utilization review and internal appeals and grievance issues. Consumers speak with professional registered nurses who are clinically experienced and knowledgeable regarding medical denials. HCR Program staff provides information to consumers on their appeal process and suggest approaches to accessing the process specific to their case. Employees advise the consumer of the availability of external review services, should that be necessary.

HCR Program Initiatives and Achievements

The Healthcare Review Program (Program) completed a number of innovative and highly successful outreach initiatives over the past three years. The Program produced a web-based video to inform and education consumers and providers about external review services. A Facebook page was established, which has provided another vehicle for consumers to access information about the Program and provides comments. A targeted mailing was sent to home health agencies, cardiac rehabilitation centers and skilled nursing facilities around the state. The Program received excellent feedback from the recipients who requested additional printed materials be sent to them. During this period, the Program staff participated in health benefit fairs and the North Carolina State Fair in order to have face-to-face contact with consumers and explain to them about the services available through the Program. HCR staff also participated in

radio interviews, made group presentations and utilized email to communicate information about the Program to state agencies.

The Program receives inquiries and requests for assistance from legislative staff when they have a constituent who has received a health claim denial from their insurance company. Legislative assistants contact the Program seeking guidance and assistance in resolving the constituent's concern. In 2009, a letter from the Commissioner of Insurance was sent to members of the North Carolina Senate and House of Representatives highlighting Program services and how these services can help them to assist their constituents. As a service to their constituents, we encourage legislative staff to include a link to the Program on their home web page. The Program also sent an electronic letter about Program services to state agency health benefit representatives informing them of the availability of Program services should an employee receive a health claim denial from their insurer.

Consumer information is continually updated and provided in a "user-friendly" format through the Department's website. Consumers can access consumer counseling information on appeal and grievance issues, as well as the External Review Request Form, instructions for completing a request form, FAQ's and a brochure entitled "A Consumer's Guide to External Review" are available for consumers on the website.

Beginning in 2007 through 2008, the Department and Healthcare Review Program provided input to members of the National Association of Insurance Commissioner's (NAIC) Regulatory Framework (B) Task Force in the development of the Uniform Health Carrier External Review Model Act. The Model was drafted to achieve a national standard and uniform approach for processing, conducting, and making external review determinations and provides the basis for national uniformity as it relates to the external review process. The Model was adopted by NAIC in 2008. During the 2009 Legislative Session, the Department proposed technical changes to North Carolina's External Review law based on the adopted Model.

In late 2008, Program staff began working with the NAIC's State Based Systems (SBS) team to design and develop an SBS External Review database to accommodate the NAIC Model law, and that would be used by all interested states. SBS chose to use the database of North Carolina's Healthcare Review Program as its model for this new service. Program staff is collaborating with the SBS team in developing this product and service which will offer improved efficiencies of SBS states' workflow, project tracking, reporting, correspondence, and allow for relationships of data.

External Review Activity during 2007-2009

During this three-year period, the HCR Program received 618 requests for external review. Three hundred cases were eligible and accepted for review. In 15 cases, the insurer reversed their denial prior to the review of the case by an IRO, 181 cases had the insurer's decision upheld by the IRO and 104 cases were overturned. Since the Program began on July 1, 2002, the cumulative total of services provided to consumers as a result of external review is $3,306,771.84.

Consumer Counseling Activity

During the 2007-2009 timeframe, the HCR Program received 3,678 telephone calls from consumers with questions relating to appeals, grievances or external review. The Program provided detailed consumer counseling to 912 consumers in the period from 2007 to 2009. The volume of call activity from consumers seeking assistance with insurer appeal and grievance issues remains steady.

Program Activity Measure	2007	2008	2009
External Review			
Number Received & Evaluated for Eligibility	264	188	166
Number Accepted for External Review	133	89	78
Consumer Counseling			
Number of Cases	295	296	321
Consumer Calls			
Total Calls Answered (External Review and Consumer Counseling)	1,344	1,083	1,251

Public Services Group

The Public Services Group is comprised of the Consumer Services, Agent Services and Criminal Investigations Divisions. The primary mission of the group is to assist consumers, companies, agents and other licensees in resolving matters associated with understanding insurance policy contracts, licensing and marketing concerns, and resolving matters associated with insurance fraud.

The Consumer Services Division assists North Carolina consumers by responding to insurance questions and resolving matters associated with premium calculations, cancellations, claims and changes in terms and conditions of insurance policies. A staff of consumer specialists advises and acquaints consumers with courses of action they may pursue to resolve their particular insurance problem.

The Agent Services Division is responsible for the regulation of all agents, brokers, limited representatives, appraisers, adjusters, premium finance companies, collection agencies, motor clubs, bail bondsmen, surety agents and bail bond runners authorized to do business in North Carolina. This includes pre-licensing education, continuing education, agency examinations and administrative actions.

The Criminal Investigations Division conducts criminal investigations of insurance-related crimes committed by policyholders, claimants, insurance producers and insurance companies. The division also conducts criminal investigations involving bail bonding, collection agency and premium finance activities.

Consumer Services Division

The technical and complex nature of insurance generates a multitude of questions from North Carolina consumers, employers, health care providers and even insurance professionals. Every year, the Department's Consumer Services Division provides (as shown below) several types of assistance to North Carolina citizens, in relation to virtually all varieties of insurance. In addition, the division built (via 2006 legislation) a disaster mediation program to assist consumers with post-disaster claim settlement disputes stemming from disaster-related residential property damage.

Complaints and Inquiries

During 2007-2009, division staff handled more than 183,000 telephone inquiries from consumers and 24,000 written consumer complaints. All written complaints (and related documentation) are stored electronically, allowing the division to continuously monitor data for significant trends, and to act accordingly. The division also shares information with other divisions on a regular basis, to facilitate and coordinate regulatory activity. During 2007-2009, division staff handled the following volume of telephone inquiries and written complaints from consumers:

	2007	2008	2009
Inquiries:	**63,545**	**58,582**	**61,474**
Life & Health	30,569	28,976	30,533
Property & Casualty	32,976	29,606	30,941
Complaints:	**7,517**	**8,230**	**8,827**
Life & Health	3,846	4,180	4,038
Property & Casualty	3,671	4,050	4,789

By general coverage type, the breakdown of 2007-2009 complaints is as follows:

Life & Health:	2007	2008	2009
Life & Annuity	31%	29%	30%
Accident & Health	68%	71%	69%
HMOs*	5%	4%	2%

**Percentages for HMOs are sub-percentages of the Accident and Health complaints.*

Property & Casualty:	2007	2008	2009
Automobile	66%	68%	65%
Homeowner	19%	19%	23%
Other	15%	13%	12%

	2007	2008	2009
Complaints Submitted via Internet:	**2,647**	**3,175**	**3,320**
Life & Health	997	1,260	1,154
Property & Casualty	1,650	1,915	2,166
Receptionist/Switchboard Encounters:	**33,430**	**30,657**	**30,659**
Walk-in Visitors	164	153	147
Calls through the Switchboard	33,266	30,642	30,512

Complaint-Driven Recoveries

During 2007-2009, the division assisted North Carolina consumers in recovering more than $26.5 million worth of insurance benefits, via the investigation and resolution of consumer complaints:

2007	2008	2009
$7,074,345	$9,695,276	$9,765,445

Publications Distributed

The division distributed 22,004 consumer publications in 2007; the top four publications were:

Publication Name	Quantity
It Pays to be a Safe Driver	11,997
Consumer's Guide to Auto Insurance	2,769
Consumer's Guide to Homeowner's Insurance	1,708
Consumer's Guide to Health Insurance	1,477

The division distributed 20,078 consumer publications in 2008; the top four publications were:

Publication Name	Quantity
It Pays to be a Safe Driver	8,947
Consumer's Guide to Auto Insurance	4,067
Consumer's Guide to Homeowner's Insurance	2,111
Consumer's Guide to Health Insurance	1,310

The division distributed 5,168 consumer publications in 2009. Distribution was limited because of budgetary cutbacks, which resulted in a decreased printing cycle; all publications were available for download on the Department's website. The top four publications mailed out were:

Publication Name	Quantity
It Pays to be a Safe Driver	2,347
Consumer's Guide to Auto Insurance	421
Consumer's Guide to Health Insurance	496
List of Individual Health Insurers	388

Website Utilization

The Consumer Services Division also seeks to reach consumers via its section of the Department's website. Below are statistics for "page hits" and "downloads" during the fourth quarter of 2009, for Consumer Services Division resources on the website.

CSD Web Page	Page Hits (Q4 2009)
Consumer Services Division Home Page	22,188
What We Can and Cannot Do	7,346
Health Insurance Main Page	5,857
Complaint Ratios Main Page	4,898
Consumer Complaint Form	4,756
Auto Insurance Main Page	4,188
Rate Calculator Home Page	3,260
Businesses Main Page	2,396
Homeowners Main Page	2,359
Consumer Alerts	2,067

CSD Publication/Document	Downloads (Q4 2009)
Consumer Guide to Auto Insurance	2,941
Consumer Guide to Surplus Lines Insurance	2,003
Consumer Guide to Health Insurance	1,850
Safe Driver Incentive Plan	1,682
Insurance Fraud in North Carolina	1,607
Consumer Guide to Homeowners Insurance	1,591
Consumer Guide to Cancer Insurance	1,113
Consumer Guide to Life Insurance	894
List of Individual Health Insurers	878
What Happens To My Coverage If My Job Status Changes?	776

Summary

The Consumer Services Division serves as a significant front-line provider of assistance to North Carolina citizens, including consumers and health care providers. The division receives visitors, handles a large number of incoming phone calls and written complaints, mails hard-copy publications, and maintains an information-rich section of the Department's website. Consumer Services staff continually strive to improve the quality and scope of their service to consumers through professional training and continuing education.

Agent Services Division

The Agent Services Division's (ASD) main function is to regulate all licensed agents, insurance business entities, brokers, limited representatives, appraisers, adjusters, insurance premium finance companies, collection agencies, professional bail bondsmen, surety bondsmen, runners, and motor clubs authorized to do business in North Carolina. This regulation includes pre-licensing and continuing education (where applicable), issuance of the license, agency examinations, informal conferences, and administrative hearings. ASD assures that individuals and entities engaged in the solicitation and negotiation of insurance meet and maintain statutory requirements and are properly licensed and appointed to represent insurance companies; the division performs similar functions for the bail bonding, premium finance, motor club, and collection agency industries.

This division is designed to protect the general public of North Carolina and is a service center for applicants and licensees. Consumers are protected when the individuals and entities licensed and regulated by ASD have an adequate knowledge of the industry and possess the moral and ethical characteristics necessary to operate in a fiduciary capacity. In addition ASD ensures that licensees comply with the requirements of state law pertaining to their industry. Citizens have a need for the products and services these individuals and entities offer.

The division operates in two separate and distinct sections. The Licensing Section establishes and administers minimum standards for licensing of all individuals/entities licensed by the division as well as appointing agents to represent various insurance companies licensed in North Carolina. The Licensing Section is also responsible for the billing/collection of fees paid to the division and operates a call center which handles telephone calls from industry and applicants seeking licensure.

The Compliance Section of the Agent Services Division is responsible for assuring compliance by all licensees with North Carolina General Statutes and Rules. The section handles complaints registered by consumers and other interested parties relative to business activities of licensees and performs insurance agency examinations to determine compliance with North Carolina statutes and rules. This section also administers continuing education requirements for insurance agents, adjusters, professional bail bondsmen, surety agents and runners.

ASD has been on the forefront of uniformity initiatives since the Gramm-Leach-Biley Act (GLBA) in 1999. This Act required that certain uniformity licensing initiatives be enacted by a majority of states to stave off federal regulation of licensing. Since this Act, ASD has enacted several major changes to the licensing structure for agents and insurance agencies beginning with the Producer Licensing Model Act (PLMA) adopted by statute in North Carolina in 2002. PLMA serves as the uniform template for agent licensure in 46 states. This template continually changes and requires massive changes to the licensee database and licensing structure.

In 2008, ASD adopted more statutory changes relative to uniformity driven by the PLMA and National Association of Insurance Commissioners (NAIC) such that all states issue and regulate

licenses in same manner and require renewal in same month and year. The 2008 changes include biennial structure for continuing education requirements and introduction of six major lines of authority for agent licensure in lieu of dual licenses. A statute change was made in 2010 such that ASD implemented another uniform standard which requires insurance applicants to submit fingerprints for a criminal background review prior to licensure. In addition, ASD adopted a number of desk procedures relative to licensing for insurance producers, adjusters and insurance business entities to achieve uniformity pursuant to NAIC models. ASD continues to make statutory changes and administrative rule changes to achieve greater uniformity with NAIC standards.

ASD also regulates non-insurance individual and entity licenses. Since 2006 there have been statute changes relative to bail licensure requirements for both the initial and renewal license application process. One major change made in 2009 required all bail bond licensees to submit fingerprints every even-year renewal period for ASD to review the criminal history to qualify the bondsmen for licensure. In 2009, a statute change was made via the Attorney General Consumer Protection Act requiring debt buyers operating in North Carolina to obtain a collection agency license. Debt buyer qualification necessitated an increased number of referrals for legal assistance in that these entities do not fit the normal collection agency model.

ASD initiated several modernization initiatives beginning 2007/2008 to leverage electronic processes for insurance and bail bond application and license fee submission, electronic fingerprinting for bail bondsmen, renewal license fee collection and enhance continuing education services. There continues to be a gap in electronic processing for 10% of the insurance applications and for all non-insurance licenses. ASD has adopted business rules to increase electronic transactions and information transfers on the insurance side. ASD has modified systems and business rules to reduce manual processing for non-insurance licensing but has done so on a limited basis.

Revenue collected by ASD in the past three years totaled $ 118 million:

Revenue Collected	2007	2008	2009
CE Administrator (Prometric)	n/a	$629,154.00	$847,319.00
Examination Vendor (Pearson Vue)	$342,450.00	$736,085.00	$732,175.00
Licensing Fees (NIPR)	$323,490.00	$1,839,185.00	$28,787,155.00
Licensing Fees (SunTrust)	$634,548.44	$1,871,534.45	$468,990.00
Insurance Licensing Fees (In-house)	$24,859,273.16	$46,104,199.44	$7,379,055.96
Non-Insurance Licensing Fees (In-house)	$328,569.00	$744,111.93	$424,235.00
CE Fees (In-house)	$926,141.55	$146,918.67	$18,341.65
Monetary Penalties	$462,350.00	$33,250.00	$36,400.00
Securities Liquidated	$181,791.78	$247,266.67	$201,565.14

Licensing statistics are listed below:

License Type	2007	2008	2009
✯Major Lines Licenses	147,369	498,103	568,392
Limited Representatives	47,714	51,636	39,666
Brokers	4,828	4,853	5,148
Viatical Settlement Brokers	222	276	312
Adjuster/Appraiser	26,135	32,863	35,748
Professional Bail Bondsmen	161	156	155
Bail Bond Runners	306	306	309
Surety Bail Bondsmen	1,053	1,103	1,097
Surplus Lines/Purchasing Groups	1,316	1,537	1,682
Insurance Corporations/Partnerships	8,208	8,986	9,881
Motor Clubs (B/O)	24	26	29
Collection Agencies	884	955	1,016
Premium Finance Companies	126	143	150

✯ -In 2008, major lines were converted from combined license types to single lines of authority.

The Compliance statistics are listed below:

Compliance	2007	2008	2009
Agency Examinations Conducted	182	168	312
CE Course Monitored	102	76	129
Complaints Opened	532	646	798
Closed Complaints	456	548	888
Special Review Cases	188	41	76

The Regulatory statistics are listed below:

Regulatory	2007	2008	2009
Informal Conferences	136	89	150
Settlement Agreement Executed	18	14	28
Consent Orders Executed	12	3	0
Monetary Penalties	$ 456,050.00	$ 40,850.00	$ 36,400.00
License Surrenders	20	23	46
Administrative Hearings	16	4	8
License Revocations	21	4	4

The division receives telephone inquiries from licensees, insurance company representatives, industry associations and the public.

Inquiries	2007	2008	2009
Telephone Calls	137,524	100,167	128,067
In Person	1,475	1,218	984

Criminal Investigations Division

The Criminal Investigations Division conducts criminal investigations of insurance-related crimes committed by medical providers, policyholders, claimants, insurance producers and insurance companies. The division also conducts criminal investigations of bail bonding industry, motor clubs, collection agencies and premium finance companies.

During 2007-2010, case referrals and allegations of fraud submitted for investigation by this division have remained at a consistently high level. This of course, is a reflection of the problem of insurance fraud itself, as well as an indication of the steady increase of fraud awareness on the part of both the consumer and the industry. In addition, over the last two years, the division has made a concerted effort to continually assure that quality investigations are being pursued so that the North Carolina consumer is most effectively served. This commitment to quality has resulted not only in impressive statistical achievement, but also in a more efficient and effective operation.

	2007	2008	2009	1/1/10 – 9/30/10
Incoming Referrals:				
Industry / NICB	**3,130**	**2,726**	**2,920**	**2,405**
Government Agencies/Law Enforcement	**45**	**34**	**28**	**26**
Citizen Complaints	**203**	**138**	**95**	**99**
Department Divisions	**60**	**82**	**29**	**49**
Outgoing Referrals:				
Law Enforcement	**34**	**13**	**6**	**13**
Administrative Agencies	**57**	**71**	**27**	**28**
Department Divisions	**100**	**37**	**86**	**99**
Investigations Assigned:	**422**	**286**	**334**	**385**
Investigations Closed:	**2,825**	**2,573**	**2,619**	**2,054**

In 2009, 89 convictions were achieved, a substantial increase from previous years. The 89 convictions are the most ever for the Criminal Investigations Division. To date, in 2010, the division saw 68 convictions. Cases worked involved Professional Employer Organizations (PEOs), unauthorized insurance, healthcare fraud, chiropractor fraud, staged accidents, embezzlement

and fraud associated with insurance activity (claim adjudication), and certain bail bonding related matters. In addition there are 101 cases currently pending court.

Successful case resolutions for 2007-2010 are substantially higher than in prior years. Listed below are the arrests, monetary recovery numbers, and convictions for 2007-2010.

	2007	2008	2009	As of Sept. 2010
Arrests	109	130	175	103
Monetary Recoveries	$14.5 million	$5.8 million	$10.5 million	$18.5 million
Convictions	53	60	89	68

The division head was responsible for fraud training activity associated with regulators and the industry, both in North Carolina and elsewhere. Fraud Director's roundtables, viatical fraud, rate evasion, PEO fraud, unauthorized entities, healthcare fraud, agent embezzlement, and other topics have been taught by the division head and certain investigators at meetings and training sessions hosted by the National Association of Insurance Commissioners, North Carolina Association of Special Investigators, and North Carolina Insurance Crime Information Exchange, and National Insurance Crime Bureau.

Insurance fraud related cases have been and are being addressed in the areas of health care, workers' compensation, unauthorized insurers, Multiple Employers Welfare Arrangements, employee leasing companies, surety bonds, rate evasion and the traditional claimant and agent fraud covering all lines of insurance.

The division remains a vital entity of the North Carolina Department of Insurance, often assisting other internal regulatory divisions in the identification of subjects, schemes and entities requiring attention. Investigators regularly testify at departmental hearings and assist in the preparation of new or amended anti-fraud legislation.

Personnel of this division are active and respected members of industry anti-fraud organizations, law enforcement related organizations and task forces throughout the state. Memberships include the North Carolina Insurance and Health Care Fraud Task Force, the Federal Western District of North Carolina Health Care Task Force, the North Carolina Insurance Crime Information Exchange, North Carolina Police Executives Association, the National Association of Insurance Commissioners Anti-Fraud Task Force, the International Association of Special Investigations Units and the North Carolina Sheriff's Association. Personnel regularly receive insurance and law enforcement related training and often are called upon to represent the Department by giving presentations and training to various groups in North Carolina and across the nation. Division personnel are also members of the State Emergency Response Team (SERT).

Criminal Investigations Division stands ready to meet the many challenges that the future holds to include implementation of the new Healthcare Reform Legislation. As the infrastructure of insurance methods and operations radically change, so will the methods and operations of the insurance fraudster. Internet-based insurance transactions and electronic licensing/appointing functions unveil an entire universe of illicit opportunities to those intent on cheating the system. Banks and other financial institutions are entering the insurance market and insurance companies are diversifying as well. This will broaden the scope of potential fraud into a multitude of areas and will require a coordinated and uniform response from regulators, law enforcement and the industry. The Criminal Investigations Division is committed to meeting these challenges now and in the future.

Office of the General Counsel

The General Counsel's Office gives legal advice and counsel to the Commissioner and all members of the Department in areas of law relating to the entities regulated by the Department, which include: the insurance industry, the bail bond industry, collection agencies, premium finance companies, professional employer organizations and building inspectors. The General Counsel also provides advice to the Department on a wide variety of procedural matters, including the Administrative Procedures Act and Rules of Civil Procedure. Additionally, the General Counsel provides legal advice pertinent to the running of the Department itself, such as advice on personnel matters, contracts, ethics laws and public records laws. The attorneys in the General Counsel's Office also serve as the Department's hearing officers for a wide variety of administrative hearings under Article 3A of Chapter 150B of the North Carolina General Statutes.

Ratemaking Litigation

During 2007-2009, Rate Counsel worked on a wide range of rate matters and other regulatory issues. Rate Counsel also continued to litigate contested rate cases involving personal lines of insurance under the jurisdiction of the North Carolina Rate Bureau ("Rate Bureau"). Rate cases of significance during this Biennium are detailed below.

1. 2007 Workers' Compensation Insurance Filing

On August 31, 2007, the Rate Bureau filed the 2007 Workers' Compensation Advisory Loss Costs and Residual Market Filings proposing an overall rate level increase of 5.9% in residual market rates and 5.9% for loss costs. On October 26, 2007, the filings were settled for an increase in loss costs of 1.6% and an increase in residual market rates of 4.1%. The potential savings to the consumers as a result of the settlement was approximately $78 million.

2. 2008 and 2009 Private Passenger Automobile Insurance Filing

On February 1, 2008, the Rate Bureau filed the 2008 Private Passenger Automobile Filing proposing an overall rate level increase of 13.0% for private passenger cars. On June 30, 2008, the Department convened a public hearing on the filing. Following the conclusion of the public hearing a month later in July 29, 2008, the Commissioner issued his order on September 11, 2008 disapproving the Rate Bureau's filing and ordering an overall decrease in rate levels of -16.1% for cars and -11.2% for motorcycles. The Bureau appealed the Commissioner's order, and, as required by statute, the companies implemented the Bureau rates and began to escrow the difference between the implemented rates and the Commissioner's ordered rates until the resolution of the case. While the appeal of the 2008 case was pending before the Court of Appeals the Rate Bureau, as required by statute, filed the 2009 automobile filing on January 30, 2009 seeking an increase in the overall rate level of 1.4% (including a 5.4% overall increase in automobile liability rates). After lengthy negotiations, on July 15, 2009 the Rate Bureau and the Commissioner agreed to settle the 2008 and 2009 auto rate cases as follows:

a) The 2008 auto case was settled for an overall decrease in the rate level of -0.5% with refunds to the policyholders from escrow to occur in 2010.

b) The 2009 auto case was settled for an overall 0.0% change.

c) The settlement of the 2008 case at a decrease of -0.5% pushed the manual rates down to 2006 levels, and, the Rate Bureau and the Commissioner agreed that the rates would remain at those levels until October 1, 2011.

3. 2008 Workers' Compensation Insurance Filing

On August 29, 2008, the Rate Bureau filed the 2008 Workers' Compensation Insurance Filings proposing an overall rate level decrease of 4.4% for loss costs and overall rate level decrease of 3.8% for residual market rates. Both filings were approved subject to disclaimer on October 22, 2008.

4. 2008 Homeowners' Insurance Rate Filing

On December 8, 2008, the Rate Bureau filed the 2008 Homeowners' Insurance Rate Filing proposing an overall increase in rates of 19.5% with proposed increases in certain coastal communities of up to 50%. On December 11, 2008, the Rate Bureau filed for revised Homeowners' Territory Definitions. The proposals submitted with both of these filings had been discussed with the Department for several months. Thus, on December 23, 2008, the Department was able to approve the filed territory definitions and to settle the rate filing at an overall increase of 3.9%. The settlement represented a potential savings to consumers of $247 million.

5. 2009 Workers' Compensation Filing

On September 1, 2009 the Rate Bureau filed the 2009 Workers' Compensation Insurance Filing proposing an overall decrease in loss costs of -9.6% and an overall increase in residual market rates of 1.3%. On October 30, 2009 the Commissioner and the Rate Bureau entered into a settlement agreement wherein the filing for revised loss costs was approved and the filing for residual market rates was settled at an overall rate level change of 0.0%.

Regional Offices

The North Carolina Department of Insurance has two regional offices: the Western Regional Office (WRO) in Asheville and the Eastern Regional Office (ERO) in New Bern. The purpose of the Regional Offices is to provide local access to serve the citizens, regulated entities and governmental officials and staff of the Eastern and Western most part of the state in any and all matters related to any and all divisions of the Department.

While in constant communication and liaison with the Department's Raleigh headquarters, the regional offices serve as the primary link between Raleigh and the regions they handle. (The WRO serves the 29 westernmost counties of North Carolina while the ERO serves the 32 easternmost.) The regional offices receive, evaluate and process consumer complaints and questions regarding insurance industry inquiries and requests for assistance. The regional offices also provide staffing facilities for field personnel of other divisions within the Department including Manufactured Housing, Investigations, and Office of the State Fire Marshal, Risk Management, Agent Services, Consumer Services, Bail Bond Agents, Premium Finance Companies, Building Codes and the Seniors Health Insurance Program (SHIIP), which includes serving as their counseling centers. In addition, the regional offices serve as the Commissioner of Insurance's primary liaison with area federal, state and local government officials, regional legislators, civic groups and regulated entities.

Of particular note during the 2007-2009 period, the regional offices were closely involved with resolving consumer inquiries and serving as the point of contact for formal insurance complaints. Further, during this period, the regional offices were very active in the administration of the North Carolina Fire and Rescue Matching Grant Program, wherein numerous grant checks were delivered with appropriate audits conducted.

During the 2007-2009 period, the regional offices:

- Received 83,413 in-person and telephone contacts with citizens, including insurance industry and all Departmental regulated entities.
- Handled directly or by referral to Raleigh 7,557 cases regarding consumer complaints and other inquiries.
- Were responsible for the delivery of over $9.6 million in fire/rescue grant funds. Regional office personnel also facilitated appropriate audits of equipment/property purchased with these funds.

Office of State Fire Marshal

Since the late 1940s, the Commissioner of Insurance has served as the State Fire Marshal by North Carolina General Statute. Groundwork for this began in 1907 when the General Assembly established the "Firemen's Relief Fund," requiring the Commissioner to collect funds from insurance companies to be used for relief of distressed firefighters.

In an effort to bring more focus and visibility to this division's programs, the Office of State Fire Marshal (OSFM) was formally established within the Department of Insurance on April 1, 1998.

OSFM is comprised of the following six divisions: Engineering; Manufactured Building; Risk Management; Fire and Rescue Training, Research and Program Development and Inspections; Fire and Rescue Commission; and Prevention and Grants.

OFSM administers and enforces life safety standards throughout the state, promotes risk management practices throughout government and maintains a sound insurance program for state agencies.

The Engineering Division administers the state building code and provides staff to the North Carolina Building Code Council, the North Carolina Code Official Qualifications Board and the Home Inspectors Licensing Board.

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

The Risk Management Division administers the self-insurance funds for state-owned property and vehicles, and procures from private insurance companies other types of insurance needed by the state agencies and universities. This division inspects all state-owned facilities for fire and life safety and inspects all new state-owned facilities for Electrical Code compliance. Also, the division assists local governments with property and casualty insurance programs and makes available professional liability coverages for law enforcement officers, public officials and employees of any political subdivision in the state. This division also provides staff, administration, and research services to the Public Officers and Employees Liability Insurance Commission (POELIC).

The Fire and Rescue Commission Division serves as staff to the Fire and Rescue Commission and handles the state's voluntary certification system comprised of 25 levels and 80,000 individuals, as well as the State Fire and Rescue Incident Reporting System.

The Fire and Rescue Training, Research and Program Development and Inspection Division trains fire departments, rescue squads, and instructors to improve fire and rescue protection

statewide. Through special schools, development of training programs and teaching outlines, and specialist training directed to instructors, this division provides continuous upgrade to the training of our state's emergency workers. Fire departments' delivery capabilities are measured and upgraded by providing initial insurance ratings for fire departments, as well as coordination for the improvement of ratings to reduce insurance costs for homeowners.

The Prevention and Grants Division administers the Firemen's Relief Fund, Rescue Relief Fund, assists all divisions within the OSFM with development of programs and brochures and provides direction and support for injury prevention programs statewide. The division also administers matching dollar-for-dollar grants to volunteer fire departments and rescue squads and offers fire prevention education in the public schools.

Engineering Division

North Carolina's General Statutes give the Commissioner of Insurance the responsibility of general supervision of the administration of the North Carolina State Building Codes as well as the supervision of enforcement by city and county jurisdictions.

The North Carolina Building Codes contain minimum guidelines relating to the construction of structures, which includes plumbing, electrical, heating, air conditioning, fire protection, accessibility and energy conservation disciplines. The division meets these responsibilities by providing interpretations of code requirements, education of code provisions, assisting local government authorities with the application of the codes and hearing code appeals. Department staff carries out the provisions of the code developed by the North Carolina Building Code Council.

The division reviews plans and specifications of new buildings specified by General Statute 58-31-40 for code compliance. Reviews also include meetings with designers, developers, contractors and code officials when difficulties regarding code compliance occur.

The division develops code-related educational programs for code officials and design professionals. In addition in classroom training, the division produces research reports to simplify complex code issues.

The division administers state examinations required certification of city, county and state code enforcement officials working as staff to the North Carolina Code Officials Qualification Board. This includes the development and psychometric evaluation of exams, tracking required continued education for all active inspectors, verifying that inspections are being carried out in all North Carolina jurisdictions and the investigation of complaints against inspectors.

The division administers required licensure for private home inspectors in North Carolina working as staff to the North Carolina Home Inspector Licensure Board. This includes the development and psychometric evaluation of exams, tracking required continued education for all active inspectors, and the investigation of complaints against inspectors.

The division administers training, testing and certification of pyrotechnic operators.

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

State Building Code Council Support

The Building Code Council consists of 17 members appointed by the governor. The Council is empowered to adopt and amend the state building code, hear appeals on the interpretation of the code and approve local building regulations which are different from the state code.

When the N.C. Building Code Council (BCC) promulgates a new code, it is based on the previous cycle of the International Codes with the Board's amendments. Those amendments are developed by committees appointed by the Chairman of the BCC. After completion by the respective committee, the board votes on the revised code and it is sent to the Office of Administrative Hearing for final adoption.

The staff's role is to facilitate all of the operations, from assisting in the development of the code changes in the respective committees to teaching the code intent after adoption. Staff's role is also the interpretation of code, using the context of the original code language to real world applications.

State law permits the Building Code Council to provide, in circumstances deemed appropriate, programs to certify independent testing laboratories as state-accredited third-party agencies to evaluate, inspect and label factory-built manufactured buildings, and electrical and mechanical building components. Division staff administers this program.

Code Interpretations Section

Consisting of professionals with extensive construction background, this section is responsible for expertise of the N.C. State Building Codes which include the Administrative, Plumbing, Mechanical, Electrical, Fire, Residential, Fuel Gas, Energy Conservation, Accessibility and Building Codes regarding questions related to N.C. Building Codes.

Summary			
Actions	**2007**	**2008**	**2009**
Telephone Information Request	7,726	9,936	14,912
Letters of Interpretation	215	227	97
Informal E-mail Interpretation	769	2,992	5,266
Other E-Mails	3,130	4,875	8,173
Office Conference	22	40	66
Schools, seminar and conference participation	24	49	56
On-site conferences and investigations	0	9	49
Building Code Council and committee meetings	0	8	56

Private Plan Review Section

Dedicated to the review of construction documents for compliance with the Code, this section is responsible for a partial plan review performed by the Department in accordance with GS 58-41-30. Concentrated primarily for city and county owned buildings and school districts, this section verifies that the most important elements of safety comply with the building codes, leaving the local jurisdictions to conclude the plan review and field inspection.

Plan Review Section Statistics			
	2007	2008	2009*
Plans Reviewed	912	750	494
Office Conferences (Express Reviews w/designers)	235	185	132
Information Requests* (Phone calls)	8679	7,999	5,279
Written Interpretations (mostly email)**	759	939	730
State Property Plan Review Statistics			
	2007	2008	2009*
Plans Reviewed	1,408	2,037	1,454
Meetings, Classes, Seminars	422	719	413
Contacts (Phone and Email)	19,370	22,626	8,075

*In September 2009, the N.C. General Assembly transferred state property plan review responsibilities to the N.C. Department of Administration, State Construction Office. Data represents 1/1/09 – 9/30/09.

Enforcement Services Section

Primarily dedicated to the support of the North Carolina Code Officials Qualification Board, the Enforcement Services Section staff administers a certification program for approximately 4,000 code enforcement officials across the state. The staff oversees 15 different state examinations to all code enforcement officials. Exam administration includes development of exam content and questions, standard application evaluation for approval or denial, and examination proctoring. The staff also maintains 16 technical code courses taught through the North Carolina Community College System. These courses are attended by all licensees as well as contractors, engineers and architects. Additional responsibilities include approving continuing education sponsors and courses, probationary application evaluation, performing investigations upon receipt of complaints against code enforcement officials, and providing technical code interpretations.

The Enforcement Services Section is also responsible for investigating complaints against inspectors to be reported back to the Board.

Engineering Division Activities	2007	2008	2009
Qualification Board Meetings	4	4	6
Qualification Board complaint investigations	20	19	12
Inspection certification schools coordinated	148	124	198
Inspection certification exams administered	1,519	1,542	*1047
Inspection certification applications reviewed	1,006	1,315	1,039

*As of July 1, 2009, state exams administered by a third party.

Home Inspectors Licensure Board Staff

Primarily dedicated to the support of the North Carolina Home Inspector Licensure Board, the Home Inspector Licensure Board Staff administers training, examinations, issuing licenses, renewal and disciplinary procedures of individuals who perform home inspections for compensation.

North Carolina Building Code Council

NC General Statutes 143-138 authorize the N.C. Building Code Council to prepare, adopt and amend the State Building Code. The council consists of 17 members appointed by the governor for six-year terms. Statutes require that members have expertise in areas relating to construction safety. The Council meets quarterly. The members include:

Dan Tingen, Chairman, (Homebuilder)
Tingen Construction Company
8411 Garvey Drive #101
Raleigh, NC 27616-3176
(919) 875-2161
dan@tingen.com
TERM EXPIRES: 2011

John Llewellyn Hitch, AIA, Vice Chairman
(Architect)
The Smith Sinnett Associates, P.A.
4601 Lake Boone Trail
Raleigh, NC 27607
(919) 781-8582
jhitch@smithsinnett.com
TERM EXPIRES: 2010

J. Albert Bass Jr., (Mechanical Engineer)
6425 Chapman Ct.
Raleigh, NC 27612
(919) 782-4689
albasspe@aol.com
TERM EXPIRES: 2009

Kim Reitterer, PE, (Electrical Engineer)
ELM Engineering, Inc.
212 S. Tryon Street, Ste. 1050
Charlotte, NC 28281
(704) 335-0396
KReitterer@elmengr.com
TERM EXPIRES: 2013

Ralph Euchner, (Gas Industry)
PSNC Energy
PO Box 1398
Gastonia, NC 28053
(704) 810-3331
REUCHNER@SCANA.com
TERM EXPIRES: 2013

Steve L. Knight, PE, (Structural Engineer)
1507 Mt. Vernon Avenue
Statesville, NC 28677-3539
(704) 878-2996
TERM EXPIRES: 2009

Hawley Truax, (Public Representative)
Z Smith Reynolds Foundation
147 South Cherry Street, Suite 200
Winston-Salem, NC 27101
(336) 725-7541
hawleyt@zsr.org
TERM EXPIRES: 2011

Paula Strickland, (Mechanical Contractor)
Williams PH & AC
1051 Grecade Street
Greensboro, NC 27408
(336) 275-1328
wphvac@aol.com
TERM EXPIRES: 2013

Cindy Browning, PE, (State Agency)
Division of State Construction
301 N. Wilmington St.
Raleigh, NC 27601
(919) 807-4127
cindy.browning@ncmail.net
TERM EXPIRES: 2011

Jack F. Neel, PE, (Municipal-Gov't Rep)
1007 Colonial Drive
Albemarle, NC 28001
(704) 982-8434
neel@vnet.net
TERM EXPIRES: 2010

Mack Nixon, (County Government Representative)
Albemarle Home Builders
199 Mill Street
Elizabeth City, NC 27909
(252) 338-5211
ahbuilders@earthlink.net
TERM EXPIRES: 2010

Ed Moore, (Electrical Contractor)
E. Moore & Son Electric, Inc.
2708 N. Graham St., Ste. D
Charlotte, NC 28206
(704) 358-8828
edsr@emooreelectric.com
TERM EXPIRES: 2013

Lon McSwain
Mecklenburg County Engineering & Building Standards 700 North Tryon Street Charlotte, NC 28202
(704)336.4302
mcswala@co.mecklenburg.nc.us
TERM EXPIRES: 2009

Thomas P. Turner, FAIA, (Architect)
ADEP, P.A.
3225 Wickersham Road
Charlotte, NC 28211
(704) 364-0829
(704) 770-0475
tpturner13@bellsouth.net
TERM EXPIRES: 2010

Alan W. Perdue, (Fire Services)
Guilford Co. Emergency Services
1002 Meadowood Street
Greensboro, NC 27409
(336) 641 7565
aperdue@co.guilford.nc.us
TERM EXPIRES: 2009

Robert F. Ruffner, Jr., (General Contractor)
Clancy & Theys Construction Company
P.O. Box 4189
Wilmington, NC 28406
(910) 392-5220
Bruffner@ctwilmington.com
TERM EXPIRES: 2009

David Smith, (Coastal Contractor)
D. Smith Builder
905 Saltwood Lane
Wilmington, NC 28411
(910) 681-0934
dsmith16@earthlink.net
TERM EXPIRES: 2010

North Carolina Code Officials Qualification Board

The board is organized under the provisions of Chapter 143, Article 9C of the North Carolina General Statutes. The members include:

Hayden Lutterloh, III
Chairman
Assistant Fire Chief
1812 Brandons Circle
Sanford, NC 27330-8287
(919) 775-5992

William Rakatansky, FAIA, CSI, NCARB, LEED AP
Vice Chairman
Principal
R&M Group-NC, PLLC
8025 Arrowridge Blvd.
Charlotte, NC 28273
(704) 909-7081

Tim Bradley
Secretary
Senior Deputy Commissioner
NC Dept of Insurance
1202 Mail Service Center
Raleigh, NC 27699-1202
(919) 661-5880

Ronnie Bailey
Asst. Professor, Architectural Engineering
North Carolina A&T University
452 McNair Hall
Greensboro, NC 27411
(336) 334-7575

Dean Barbour
Director of Inspections
Johnston County
309 East Market Street
Smithfield, NC 27577
(919) 989-5060

Richard C. Blackburn
Ashe County Commissioner
150 Government Circle, Suite 2500
Jefferson,, NC 28640
(336) 846-5501

Jeff Curtis
700 Sunset Blvd North
Sunset Beach, NC 28468
(910) 579-0075

Richard D. Ducker
Institute of Government
CB# 3330 Knapp Building UNC
Chapel Hill, NC 27599
(919) 966-5381

Valoree Eikinas, PE
Mulkey Engineering
6750 Tryon Road
Cary, NC 27511
(919) 851-1912

Mark Hicks
Mark Hicks Builders, Inc.
221 Hillsboro Street
Oxford, NC 27565
(919) 693-1866

Charles R. Horne
Chatham County Manager
P. O. Box 87
Pittsboro, NC 27312
(919) 542-8200

James D. Kennedy, Jr.
3481 Cumberland Road
Winston-Salem, NC 27105
(336) 767-8352

John Kirkland
Mayor
Town of River Bend
45 Shoreline Drive
River Bend, NC 28562
(252) 638-3870 Ext. 201

Kenneth G. Mullen
4021 Benjamin Court
Rocky Mount, NC 27803
(252) 443-2754

Victor N. Shaw
Shaw Repair Sevices, Inc.
2050 Corinth Church Road
Monroe, NC 28112
(704) 283-9220

Bill Thunberg
Mayor, Town of Mooresville
413 N. Main Street
Mooresville, NC 28115
(704) 663-0426

Tracy McPherson
Director of Public Safety Programs
NC Community College System
5003 Mail Service Center
Raleigh, NC 27699-5003
(919) 807-7117

Robert Nunez
NC State University, Civil Engineering Department
P.O. Box 7908
Raleigh, NC 27695
(919) 515-8408

Curtis Sherrill Smith
Stanly County Commissioner
32739 Millingport Road
New London, NC 28127
(704) 463-5418

Hiram Williams
Action Construction of Surf City
825 South Greentee Road
Hampstead, NC 28443
(910) 328-1404

North Carolina Home Inspectors Licensure Board

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

Gerald W. Canipe
(Appointed by Speaker)
ARCHISPEC
P.O. Box 30
Hope Mills, NC 28348-0030
(910) 868-3086
(910) 868-7184 Fax

Theodore W. Triebel, Treasurer
(Appointed by Speaker)
6601 Sir Laddin Lane
Rougemont, NC 27572
(919) 732-6691
triebel@mindspring.com

David G. Jones Treasurer
(Appointed by Pres Pro Term)
Expert Inspection Service, Inc.
1027 Beaver Dam Rd.
Chapel Hill, NC 27517
(919) 933-6842
(919) 933-8928 Fax

Christian Noles, Secretary
(Appointed by Commissioner of Insurance)
NC Department of Insurance
322 Chapanoke Road, Suite 200
Raleigh, NC 27603
(919) 661-5880

Tony H. Jarrett
(Appointed by Governor)
717 Green Valley Road
Greensboro, NC 27408
(336) 544-1700
tony.jarrett@allentate.com

Marion Peeples, Vice Chairman
(Appointed by Governor)
Vice-Chairman
6104 Pintail Court
Oak Ridge, NC 27310
(336) 643-8657
(336) 217-8103 Fax
mkp@pillc.us

Talmadge Jones, Chairman
(Appointed by Pres Pro Term)
Cottage to Castle Home Inspections, Inc.
112 Meekins Drive
Manteo, NC 27954
(252) 256-0650
(252) 475-9809 Fax

Waverly M. Sawyer
(Appointed by Governor)
117 Havenwood Drive
Camden, NC 27921
(252) 338-1519
waverlymsawyer@hotmail.com

Manufactured Building Division

This division acts both as a State Administrative Agency under the Federal Manufactured Housing Construction and Safety Standards Act and as staff to the North Carolina Manufactured Housing Board.

The role of a State Administrative Agency is to monitor manufacturers', dealers' and set-up contractors' handling of consumer complaints to assure compliance with state and federal standards. Staff support of the Manufactured Housing Board includes receiving and resolving consumer complaints and licensing all manufacturers, dealers, set-up contractors and salespersons that do business in this state to ensure compliance with warranty requirements set forth in the general statutes. The field staff conducts dealer lot and consumer complaint inspections to assure compliance with state licensing laws and the federal HUD standards

The division is responsible for filing claims against required surety bonds in the event dealers, manufacturers or set-up contractors go out of business or cannot otherwise fulfill their warranty obligations.

The Manufactured Building Division is also responsible for developing standards for the set-up and anchoring of manufactured homes. The division assists local inspection departments in the inspection of homes for proper set-up and anchoring requirements. Training seminars are held throughout the state each year to familiarize the local inspection departments, manufacturers, dealers, set-up contractors and other interested parties with the manufactured housing standards and any recent revisions to those standards. The division has supplemented its State budget receipts by participating in a joint federal/state manufactured housing monitoring program with a contract with the Institute for Building Technology and Safety (IBTS), a HUD Subcontractor.

The Manufactured Building Division serves as staff to the North Carolina Building Code Council in the administration of the state's modular construction program. This includes receiving and resolving modular complaints and the certification and monitoring of residential and commercial modular manufacturers. As of 2009, there were 139 certified manufacturers (24 located within North Carolina) shipping modular buildings for placement in North Carolina, with plant locations ranging from Florida to Arizona to Montana. The division also certifies independent certification agencies (third party agencies) that review modular plans for compliance with the North Carolina State Building Code and monitors production in modular plants on continuing basis. There are currently eight approved third party certification agencies.

The Manufactured Building Division operates under two budgets, a state budget and a federal budget. The division's federal budget is receipt supported based upon fees received from HUD for new manufactured homes built in manufacturing facilities within the State of North Carolina and fees for new manufactured homes built by manufacturing facilities from any state, licensed by this division, placed within North Carolina for retail sale. The division's state budget is also receipt supported based upon the issuance of Modular Validation Stamps that are placed in

Code compliant modular homes and commercial buildings. Revenues are also received from certification fees for the initial review of new manufacturers' quality assurance programs, design manuals, and production processes. Other receipts for the division come from manufactured housing licensing fees charged to manufacturers, dealers, set-up contractors and salespersons. The state budget also receives receipts from continuing education fees for manufactured housing salespersons and set-up contractors. In recent years, due to the downturn in the construction industry, it is backed up with appropriations from the State's Insurance Regulatory Surcharge Fund.

Manufactured Building Division Activities - Manufactured Housing

	2007	2008	2009
Complaints Received	93	95	77
Inspections Completed	38	32	144
Manufacturers Licensed	49	46	38
Dealers Licensed	434	387	339
Set-up Contractors Licensed	326	306	289
Salespersons Licensed	1,270	1,144	986
Salespersons Temp. Licensed	302	274	169
Board Hearings Scheduled	0	0	0
Pre-Hearing Conferences Scheduled	6	5	1

Manufactured Building Division Activities - Modular Construction

	2007	2008	2009
Complaints	74	75	36
Manufacturers	146	141	139
Third Party Certification Agencies	9	8	8
Modular Stamps	7,953	5,618	3,167

North Carolina Manufactured Housing Board

The Board is empowered to issue and revoke licenses, require bonds, resolve complaints and promulgate rules as necessary to carry out these goals. The following is a list of members and the individual or industry they represent as of January 2009. Members include:

Chairman: Wayne Goodwin
Insurance Commissioner
1201 Mail Service Center
Raleigh, NC 27699

Designated Chairman: Tim Bradley
Senior Deputy Insurance Commissioner
1202 Mail Service Center
Raleigh, NC 27699-1202

INSURANCE COMMISSIONER APPOINTEES

PUBLIC REPRESENTATIVE	MS. LINDA WILLEY PO BOX 232 MANTEO, NC 27954 252-473-5273	TERM (2nd): 10-01-05 to 09-30-08 (Completing Vacant 2nd Term)
PUBLIC REPRESENTATIVE	MS. LYNN S. CARLSON 7265 SCHOONER COURT, B-2 OCEAN ISLE BEACH, NC 28469 910-754-5726	Term (2nd): 10-01-05 to 09-30-08 (Completing Vacant 2nd Term)

GOVERNOR APPOINTEES

MANUFACTURER REPRESENTATIVE	MR.JEFF MOORING CAVALIER HOME BUILDERS P O BOX 1007 NASHVILLE, NC 27856 252-459-7026 252-459-7529(FAX)	TERM (1st): 10-01-08 to 09-30-11
DEALER REPRESENTATIVE	BILLY A. GLOVER GLOVER SALES, INC. 406 EAST JACKSON BLVD ERWIN, NC 28339 910-892-4405/ 910-892-4406 (FAX)	TERM: (2nd): 10-1-05 to 9-30-11

SPEAKER APPOINTEES

FINANCE REPRESENTATIVE	MR. WAYNE CARPENTER 208 CHERRY LAUREL DRIVE CLAYTON, NC 27527 919-518-1432	TERM: (2nd): 10-01-09 to 06-30-12
INSURANCE	MR. DELL AVERETTE	TERM: (2nd):

REPRESENTATIVE	STAN TAYLOR INSURANCE AGENCY 3826 BLAND ROAD RALEIGH, NC 27609 919-781-5300	10-01-09 to 06-30-12
HUD COUNSELING AGENCY	MS. KATRINA F. BRYANT NORTHEASTERN COMMUNITY DEVELOPMENT CORPORATION PO BOX 367 154 HWY., 158 E. CAMDEN, NC 27921 252-338-5466, EXT 25 252-338-5639(FAX)	TERM: (2nd): 10-01-09 to 06-30-12

PRESIDENT PRO TEM OF SENATE APPOINTEES

SUPPLIER REPRESENTATIVE	MR. CLIFF DESPAIN BATCHELOR SUPPLY, INC. 143 HEIN DRIVE GARNER, NC 27529 919-779-0296/ 919-779-8958 (FAX)	Term (2nd): 10-01-07 to 09-30-10 (Completing Vacant Term)
SET-UP CONTRACTOR REPRESENTATIVE	MR. DAVID CRANFIELD MIDSTATE MODULAR 340 MESSICK ROAD SALISBURY, NC 28147 704/202-1791	TERM: (2nd): 01-03-09 to 06-30-12
ACCOUNTANT	MR. MICHAEL PERKINS PERKINS & LUND PLLC 2607 OBERLIN ROAD, STE. 200 RALEIGH, NC 27608 919-781-1721	TERM: (2nd): 10-01-09 to 06-30-12

Risk Management Division

This division is responsible for the operation and maintenance of the State Property Fire Insurance Fund (the Fund), the self-insurance plan for the state's property. The Fund provides insurance coverage for approximately 13,950 state-owned buildings and structures as well as the contents in these buildings and approximately 1,330 leased locations with a combined value of $29.4 billion. The Fund pays the first $2.5 million of any covered loss and purchases excess insurance from private insurance companies to pay for any loss exceeding its retention. Losses to the State's property are investigated and adjusted by this division and are paid from the Fund with the approval of the Council of State. The following claims were paid from the Fund in 2007, 2008 and 2009:

Year	Number of Claims	Total Claim Amounts
2007	54	$944,321
2008	70	$755,532
2009	114	$1,767,131

The Fund provides basic fire and lightning insurance for state-owned property and offers broader insurance including, but not limited to, coverages for wind, hail, aircraft or vehicles, riot or civil commotion, explosion, smoke, theft, sprinkler leakage, vandalism, flood, business interruption and "all risk." All General Fund facilities are insured for fire and lightning at no cost to the agency. Approximately 75% of the state's buildings receive this coverage at no charge to the agency or university. Special Fund operations are billed for the fire and lightning coverage. All agencies are charged a premium for coverages broader than the basic fire and lightning. This arrangement has saved the state millions of dollars, compared to buying commercial insurance for all state-owned property.

When the Fund was established in 1945, the General Assembly recognized that loss prevention was an essential ingredient for a successful self-insurance program. The General Statutes require an annual fire and life safety inspection of all state-owned buildings by the division's inspectors who are certified in the interpretation of codes and standards for fire protection and construction. Reports are made to agency managers for correction of deficiencies. The inspection staff also provides advice on corrective measures.

This division's electrical staff provides various support services and resources to local inspection jurisdictions in the form of Electrical Code consultation and interpretation, training assistance, continuing education, investigations of electrical equipment and installations, and participation in meetings with county associations or other groups. The Risk Management Division in conjunction with the Engineering Division provides and coordinates planning and presentation of educational programs on the State Electrical Code for the state.

Electrical staff also performs onsite inspections of DOT traffic related electrical installations and may inspect state-owned property or leased facilities for fire and life safety. Until October 1, 2009, the electrical staff inspected all new electrical systems in state-owned buildings to assure that these systems complied with the State Electrical Code. Beginning October 1, 2009, the inspection of electrical installations in new state facilities was transferred to the Department of Administration. During years 2007, 2008, and 2009, the electrical staff performed electrical inspections and responded to telephone inquiries as follows:

Year	Inspections	Telephone
2007	4,501	10,256
2008	4,518	9,684
2009	3,125	6,927

The Risk Management Division serves as a resource for state agencies, universities, and in some cases community colleges, in resolving risk issues. This division administers the state's automobile insurance program, which covers 42,487 vehicles and motorized equipment. Also, various types of insurance coverages are procured for state agencies and universities from private insurance companies. These coverages include, but are not limited to, inland marine, ocean marine, aircraft liability and physical damage, boiler and machinery, workers compensation, medical malpractice, accident and health, general liability, crime, professional liability and bonds. This division also assists local governments, when requested, with their property and casualty insurance programs. Since 1986, 173 North Carolina communities and counties have received insurance surveys and risk management services.

The division also provides staff, administration and research services to the Public Officers and Employees Liability Insurance Commission. The Commission is charged with making available a plan of professional liability coverage for all law enforcement officers, public officials and employees of any political subdivision of the state. The Commission also makes available $10 million in liability coverage on all state employees for losses resulting in bodily injury or property damage and for errors and omissions in the performance of their jobs.

Public Officers and Employees Liability Insurance Commission

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

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

NC ASSN. OF COUNTY COMMISSIONERS	**SPEAKER OF THE HOUSE**
Vacant	**CHAIRMAN**
Term Expires: 6-30-2013	**Mr. Joseph R. Kluttz, CPCU**
	Term Expires: 6-30-2011
NC LEAGUE OF MUNICIPALITIES	**PRESIDENT PRO TEMPORE**
Mr. Robert G. Haynes	**Mr. Walter Pierce**
NCLM - Risk Management Services	Term Expires: 6-30-2011
Term Expires: 6-30-2011	
	EX OFFICIO MEMBERS
NC SHERIFFS ASSOCIATION	
Sheriff Dane Mastin	**COMMISSIONER OF INSURANCE**
Wilkes County Sheriff	**Mr. J. Thomas Sutton, III**
Term Expires: 6-30-2011	
	ATTORNEY GENERAL'S OFFICE
NC POLICE CHIEFS AND NC POLICE EXECUTIVES ASSN.	**Mr. Robert T. Hargett**
Maj. Kevin Smeltzer	Dept. of Justice
Term Expires: 6-30-2013	
	CRIME CONTROL & PUBLIC SAFETY
INDEPENDENT INSURANCE AGENTS OF NC	**. Mr. Thomas Caves**
Vacant	
Term Expires: 6-30-2011	
INDEPENDENT INSURANCE AGENTS OF NC	
Vacant	
Term Expires: 6-30-2013	

Fire and Rescue Commission

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

Many of North Carolina's certification programs are accredited by the International Fire Service Accreditation Congress (IFSAC), and the National Professional Qualification Board (NPQB).

A site visit conducted by IFSAC on November 2-4, 2010, granted full re-accreditation for the following programs:

- Hazardous Materials, Awareness, NFPA 472, 2008 edition
- Hazardous Materials, Core Competencies for Operations Level, (Chapter 5), NFPA 472, 2008 edition
- Hazardous Materials, Operations, N.C.PA 472, 2008 edition
- Hazardous Materials, Technician, NFPA 472, 2008 edition
- Firefighter Levels 1, and 2, NFPA 1001, 2008 edition
- Driver/Operator – NFPA 1002, Chapter 4, 2009 edition
- Driver/Operator – Pumper, NFPA 1002, 2009 edition
- Driver/Operator – Aerial, NFPA 1002, 2009 edition
- Airport Fire Fighter, NFPA 1003, 2010 edition
- Technical Rescuer, NFPA 1006, Chapter 5, 2008 edition
- Technical Rescuer, NFPA 1006, Rope Levels 1 and 2, 2008 edition
- Technical Rescuer, NFPA 1006, Vehicle & Machinery Levels 1 and 2, 2008 edition
- Technical Rescuer, NFPA 1006, Structural Collapse, Levels 1 and 2, 2008 edition
- Technical Rescuer, NFPA 1006, Trench, Levels 1 and 2, 2008 edition
- Fire Officer, NFPA 1021, Levels 1, 2, and 3, 2009 edition
- Fire Inspector Levels 1, 2, and 3, NFPA 131, 2009 edition
- Public Fire and Life Safety Educator Levels 1, 2, and 3, NFPA 1035, 2010 edition
- Fire Service Instructor, Levels 1, and 2, NFPA 1041, 2007 edition
- Agriculture Rescue, North Carolina Standard

And full accreditation for the following new levels:

- Hazardous Materials, Competencies for Operations Level Assigned Mission
- Specific Responsibilities (Chapter 6 – Sections 6.2, 6.3, 6.4, 6.6, 6.7) NFPA 472

- Marine Fire Fighting, Levels 1, and 2, NFPA 1005, 2007 edition
- Technical Rescuer, NFPA 1006, Confined Space, Levels 1 and 2, 2008 edition
- Technical Rescuer, NFPA 1006, Surface Water, Levels 1 and 2, 2008 edition
- Technical Rescuer, NFPA 1006, Swift Water, Levels 1 and 2, 2008 edition
- Technical Rescuer, NFPA 1006, Wilderness, Levels 1 and 2, 2008 edition
- Fire Service Instructor, Level 3, NFPA 1041, 2007 edition

Out of the total membership of IFSAC, this makes North Carolina the largest system other than the U.S. Department of Defense (DOD).

Each month the Commission receives approximately 500 applications for one of the above mentioned certifications. The Commission currently maintains over 150,000 certifications.

An ongoing project of the Commission is development and dissemination of the Occupational Safety and Health Standard for Fire Departments and Rescue Squads. This was a compilation of the applicable NFPA Standards and OSHA General Industry Standards.

New programs for the Commission include Understanding Building Construction as a delivery to firefighters, Chief 101. These courses were implemented as a result of Administrative Code changes relevant to the N.C. Response Rating System.

Volunteer Safety Worker's Compensation Fund

The Fire and Rescue Commission continues to administer the Volunteer Safety Workers Comp Fund which was created by the General Assembly as a self-funded workers compensation program for non-municipal volunteer fire and rescue departments. Key Risk Corporation serves as TPA (third party administrator) of the funds, handling claims, billing and administration. The Commission appointed a nine member Board which oversees the administration of the fund and selects the TPA. Currently, 1,218 fire and rescue departments had workers compensation coverage through the fund, covering a total of 45,663 workers.

North Carolina Fire and Rescue Commission Members

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

The Commission is also responsible for developing state master plans for fire prevention and control and rescue services, increasing professional skills of fire fighters and rescue personnel.

MEMBER	REPRESENTING:
C. Harley Cook, Chair	N.C. Society of Fire Rescue Instructors
Phil Welch	N.C. Firemen's Association
Gary Whitman (pending approval of SEI by State Ethics Commission)	N.C. Association of Rescue and EMS, Inc.
Robert Poe	N.C. Association of Rescue and EMS, IN.C.
Wes Greene	N.C. Firemen's Association
Ken Briscoe	N.C. Association of Fire Chiefs
Bill Rogers	N.C. Fire Marshal's Association
Vacant	N.C. Association of County Commissioners
Walter M. Gardner, Jr.	N.C. League of Municipalities
Cloyce Anders	Public-at-Large
Garry Cooper	Speaker of House Appointee
Ronnie Griffin	President of the Senate Appointee
David Wray	Governor's Appointee
Ed Duffield	Professional Firefighters and Paramedics of N.C.
Matt Davis	County Fire Marshal's Association

Fire and Rescue Training and Inspection Division

This division helps fire departments and rescue squads stay abreast of the many dynamic changes within emergency services as they occur which includes serving as the certifying agency for qualifying fire departments and their members for several benefit programs. It also serves to provide the technical resources to help keep all programs within the Office of State Fire Marshal current. It includes fire and rescue training, research and program development and fire inspections and ratings.

The training responsibility of this group is the development and delivery of upgrades, certification and qualification courses for fire and rescue instructors. Additional responsibilities include NFA direct program deliveries, research and program development of new training and certifications, special statewide fire and rescue school deliveries and participation on the state Emergency Response Team and State All Hazard Incident Management Teams. The intent of this division is to provide the best possible service to the fire and rescue services in North Carolina. A constant review and update of all existing instructional programs is essential in providing the most current information and techniques. The Research and Program Development (RPD) section of this division assures that coursework stays current and is accredited to international standards as well as providing technical resources for other divisions.

This division participates in programs provided by the National Fire Academy and the Emergency Management Institute both on a federal and regional level. Personnel attend classes as well as receive the train-the-trainer programs to be delivered to North Carolina instructors and responders. OSFM personnel have been appointed to and are currently serving on national committees with the responsibility of creating training standards and curriculum for organizations including the National Fire Protection Agency (NFPA), the Terrorism Task Force, and local organizations such as the Autism Society of North Carolina. Personnel also sit on editorial boards for several publications and other technical books and manuals.

New coursework completed in 2010
Marine Shipboard Firefighting For Land based Firefighters
Rapid Intervention Team Training
Residential Sprinkler Installation For Plumbers

Coursework Revisions completed in 2010	
Firefighter I & II	TR: General
Agriculture Machinery Rescue	TR: Structural Collapse
TR: Surface Water Rescue	TR: Confined Space Rescue

TR: Vehicle and Machinery Rescue	TR: Trench Rescue
TR: Ropes Rescue	TR: Wilderness Rescue
Driver / Operator - Pumps	Driver Operator – Trailer Towing
Driver / Operator – Aerials	Fire & Life Safety Educator I,II, and III
Airport Firefighter	Hazardous Materials For the 1st Responder
Autism Recognition For the 1st Responder	Fire Officer I & II

New coursework proposed in 2010
Fire Officer III & IV
NFPA 1033, Standard for Professional Qualifications for Fire Investigator
NFPA 1031 Standard for Professional Qualifications for Fire Inspector and Plans Examiner
NFPA 1037 Standard for Professional Qualifications for Fire Marshal
NFPA 1061 Standard on Professional Qualifications for Public Safety Telecommunicator
NFPA 1583 Standard on Health Related Fitness Programs for Fire Fighters.

This division facilitates curriculum development and the related audio/visual materials for all fire and rescue training programs. In addition, this section designs and develops informational and educational materials for publication and distribution to the public. The OSFM Fire and Rescue Journal is published quarterly by the Research and Program Development section and as of January 2011 will be providing an online Fire and Rescue Journal with up-to-date articles and current information concerning the fire and rescue community.

This division also maintains the OSFM Facebook page that has attracted more than 2,950 fans. This site is continually monitored by RPD staff and updated with information concerning the fire and rescue community.

This division has developed and maintains the very successful training website for the fire and rescue community called Pocket Tools Training. Staff has made presentations about this site to a national audience. This site is constantly updated with small training ideas called Quick Drills. Along with the categories of Fire, Rescue, and Prevention, two new categories have been added titled Codes Review and Health and Wellness. Also within the category of Quick Drills, RPD has developed and published Quick Reference Guides that describe how to properly respond to hybrid vehicle emergencies. So far they have researched and published the guides for over 25 hybrid vehicles. There are also practicals for training, announcements, OSFM-sponsored coursework, instructional videos, and training comments by the Assistant State Fire Marshal. These comments are in the form of articles and videos. Further, there are two video programs that are updated regularly: the "Just ask Vince Show" that provides video instruction and insight into new rescue technologies and the "Matt and Carnie Show" that tackles fire and

rescue questions such as the use of Smooth vs. Fog Nozzle attack and Three Man Engine Company Response to Structure Fires. A featured video is also posted every other month that highlights what OSFM does in its training schools and conferences.

This division conducts research into important fire and rescue concerns. Currently staff is working with ATF and conducting research on the effects of smooth bore vs. fog nozzles used during a structure fire.

This division continues to build its video capabilities for applying full length informational and training videos to DVD media. Recent training videos that have been distributed include the North Carolina Highway Incident Safety Training DVD, which has gained national recognition. In addition smaller training videos include Bike Helmet Safety, Child Passenger Seat Installation, Fire Alarm Canvassing, Sprinklered vs. Unsprinklered Buildings, Pyrotechnics Legislation, Fire Safe Cigarettes, and Novelty Lighters.

A major responsibility for this division is to update and revise as necessary all North Carolina International Fire Service Accreditation Congress (IFSAC), National Professional Qualification Board (NPQB) accredited programs and North Carolina accredited coursework every five years as the NFPA standards are revised. The Research and Program Development section of this division has undertaken the task of building consistency in all its coursework delivered to the fire and rescue community. All coursework is being anchored to the national consensus standards of the National Fire Protection Association that in turn readies these courses for international accreditation through the International Fire Service Accreditation Congress. Each course is tracked to the NFPA standard revision cycles so that the information delivered and the training that takes place is up-to-date. This division also houses and maintains the entire set of question banks for all accredited coursework and keeps them secure, validated, and up-to-date.

This division also provides valuable assistance to fire departments and rescue squads in case of an in-line-of-duty death, a death in which a member dies while performing duties for his/her fire or rescue department. OSFM assists their department, spouse and children in securing all the funds available to them after an in-line-of-duty death. OSFM was instrumental in getting federal legislation passed to extend coverage to death events that include heart attack and stroke occurring within 24 hours of a related emergency services incident.

The review of technical specifications for emergency apparatus is also conducted by the Fire and Rescue Training and Inspection Division. Each year millions of dollars are invested in emergency apparatus. These highly complex and expensive investments have highly detailed and technical specifications. Staff reviews these specifications when requested to make sure the vehicles meet minimum nationally recognized standards.

The Department of Insurance has responsibility for conducting inspections of fire departments in areas with a population less than 100,000. These inspections serve to determine the rate classification for property insurance.

The inspection program is designed to help improve fire protection for the citizens of North Carolina and increase the safety of our state's firefighters. Oftentimes it results in lower property insurance rates. This section continues to assist local governments with fire district mapping and setting up tax districts. Staff travel to rural counties to prepare fire departments for NCRRS surveys and provide information on benefit programs. The section also serves as an information resource on rural fire protection for local government officials.

The division also inspected 1,541 fire insurance districts serviced by 1,273 fire departments in North Carolina. The results of these inspections are reported to the North Carolina Fire Rate Bureau and are used by them in filing future rates for fire insurance costs. The fire departments are re-inspected on a three to five-year cycle in order to maintain a current picture of the quality of fire protection in North Carolina and to assist the departments in making improvements.

Rating Classification						
	Rural Fire Districts			Municipal Fire Districts		
ISO Class	2000	2005	2010	2000	2005	2010
1	0	0	2	1	1	1
2	0	1	2	5	5	6
3	2	0	7	19	28	29
4	6	7	47	30	56	72
5	10	23	216	118	117	115
6	59	61	324	90	92	97
7	51	47	162	58	48	39
8	19	2	8	12	8	6
9S	1,054	579	117	12	12	2
9E	0	459	289	0	0	0

Fire Department Statistics As of January 1, 2007	
Fire Departments in North Carolina	1,284
Municipal Fire Departments	241
Non-Profit Corporations	1,043
Fire Districts in North Carolina	1,546
Rural Fire Districts in North Carolina	1,179

These inspections ensure that the fire departments are maintaining the minimum rating requirements. Meeting these requirements provides for the eligibility of the department's personnel to participate in the Fireman's Pension Fund, in the Firemen's Death Benefit Act and in the Firemen's Relief Fund. Meeting these requirements also allows property owners living in the fire district to enjoy a lower fire insurance premium on their property insurance.

Fire Dept. Inspection Summary	2006 -2010	
	State Total	State Total
County Inspected	100	100
Department Inspected	1,178	1,198
Districts Inspected	1,402	1,973
NCRRS Surveys below class 9S	510	654
Class 9S Surveys Conducted	892	1,319
Class 9S Surveys Conducted		
Districts Improved (382)	75%	65%
Districts Stayed the same (113)	22%	35%
Districts Retrogressed (15)	3%	4%

Further duties of this section include providing fire protection information to local government officials, county fire marshals, local fire associations and citizens of North Carolina. Inspectors also assist with programs to educate fire departments and rescue squads on financing alternatives, record keeping, contract agreements, benefits and other administrative subjects.

This division also continues to attend and participate in state meetings and conventions and to serve on state committees where requested. Staff is working closely with the North Carolina State Firemen's Association and North Carolina Association of Fire Chief's annual conference, the winter meeting of the Fire Chief's Association, North Carolina Association of Hazardous Materials Responders, State Hazardous Materials Advisory Board, North Carolina Society of Fire/Rescue Instructors, the North Carolina Association of Rescue and EMS annual conference, EMS Today, the North Carolina Association of County Commissioners and many others.

Prevention, Programs and Grants Division

The Prevention, Programs and Grants Division administers the Firemen's Relief Fund and Rescue Relief Fund, oversees the Fire Standard Compliant Cigarette Certification as well as assists local fire, EMS, law enforcement and Safe Kids coalitions by providing resources on injury prevention programs statewide. Injury prevention specialists specialize in Child Passenger Safety, Remembering When, and Safe Kids within their region of the state. Safe Kids North Carolina focuses on reducing unintentional injuries to children 14 years of age and younger; currently, there are 36 Safe Kids coalitions covering 62 counties in North Carolina.

Grant Funds Provided to Fire and Rescue Personnel and Departments

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

The Department of Insurance was given the responsibility by the General Assembly to administer the Volunteer Fire Department Fund and the Volunteer Rescue/EMS Fund in 1988. The intent of these programs is to financially aid volunteer fire departments and rescue providers to purchase related equipment and to make capital expenditures, based on need. The Volunteer Fire Department Fund matches on a dollar-for-dollar basis up to $ $30,000. Likewise, the Volunteer Rescue/EMS Fund will match on a dollar-for-dollar basis up to $25,000. Further, the Volunteer Rescue/EMS Fund also allows rescue providers with liquid assets of less than $1,000 to apply for a $3,000 non-matching grant.

Approved monies for volunteer fire departments and volunteer rescue providers through the Volunteer Fire Department Fund and the Volunteer Rescue/EMS Fund since 1988 exceed $97,572,779.11.

Below is a breakdown of the grant funds distributed by the division from 2007-2009:

Funding Source	2007	2008	2009
Firefighters' Relief Fund	$5,711,848.38	$6,036,939.28	$5,841,436.13
Rescue Relief Fund	$820,595.66	$798,543.22	$576,792.47
Volunteer Fire Department Fund Matching Grant	$4,494,263.02	$6,798,151.36	$8,026,806.37
Volunteer Rescue/EMS Fund Matching Grant	$2,243,766.93	$2,062,207.96	$1,077,212,.44
Volunteer Rescue/EMS Fund Nonmatching Grant	$2,896,254.79	$2,078,293.43	$1,088,828.76

The Volunteer Workers Compensation Fund was established by the General Assembly to provide low cost workers compensation insurance coverage to non-municipal volunteer fire departments, rescue squads and EMS departments. It was established as a self-funded program within the Department of Insurance. Each fire, rescue or EMS department pays $50 per

individual for volunteers and $250 per individual for career personnel. The fund is supplemented each year by an appropriation from the General Assembly. Per requirements of the statutes, the fund is governed by the North Carolina Fire and Rescue Commission housed within the Department of Insurance. The Commission contracts with a third party administrator (TPA) to handle administration of the fund, as directed by statute. Currently Key Risk Management Services serves as the TPA.

Remembering When Overview

The Office of State Fire Marshal (OSFM) continues to provide incentives for Remembering When presentations. Individuals that completed the Remembering When Train the Trainer class are eligible to request incentives for fire and fall prevention programs for older adults. We had 41 requests in 2008 and 38 incentive requests in 2009.

Juvenile Fire Setters

OSFM continues to develop and expand the network for Juvenile Fire-setter Intervention (JFSI) program in North Carolina. By identifying and developing a working relationship with communities and agencies that have established intervention programs, OSFM is able to serve as a resource and make referrals when complex situations present and specialized assistance is necessary. OSFM frequently receives referrals from the N.C. Juvenile Justice System and assists with required educational sessions upon request. Juvenile Fire-setter Intervention courses from National Fire Academy are coordinated and offered annually at the N.C. Fire and Life Safety Educator's Conference. OSFM Injury Prevention staff attend national training opportunities specific to JFIS to assure accuracy and to stay current with effective intervention techniques.

Campus Fire Safety

The Office of State Fire Marshal began building a Campus Fire Safety program in 2007. One of the major goals was to assist North Carolina fire departments in building stronger relationships with the college campuses that they protected. By offering resources and train-the-trainer workshops at annual fire conferences, a network has been established that includes a partnership with the UNC Jaycee Burn Center. In 2009, a Campus Fire safety workshop at the N.C. Chiefs' Conference in Raleigh included a media event (mock dormitory side-by-side live burn) at Shaw University. This well-promoted event was attended by hundreds of students, faculty and firefighters and local television stations. This was the launch of an ongoing initiative to promote Campus Fire Safety month in North Carolina. OSFM also applied for and was awarded a FEMA fire prevention grant in 2009 to further expand the campus safety initiative.

ATV Safety

In 2007, a Safety Task Force was formed to help address the need for ATV Safety Training for youth. The task force members included representation from police, fire, Safe Kids, hospitals, Farm Bureau, ASI, 4-H, Cooperative Extension and ATV rider groups. With the help of ATV Safety Institute approximately 15 new ATV Safety Instructors were trained in North Carolina so

that more rider safety courses could be taught. Also, through a grant from N.C. DENR, three Safety Training Trailers have been purchased and outfitted with equipment necessary to hold the rider courses. The trailers are currently located regionally around the state.

Buckle Up Kids

The Buckle Up Kids program is the child passenger safety component of Safe Kids North Carolina. Local fire, EMS and rescue personnel serve as primary and secondary contacts to work to increase awareness of child passenger safety issues. There are currently 87 SKBU communities participating statewide. These programs are administered by child passenger safety technicians in each county. OSFM staff trained approximately 1,300 new child passenger safety technicians during 2007-2009. In addition, approximately 62 child passenger technician trainings, one two-day Basic Awareness Introductory class, 35 Update/Refresher courses and five Renewal courses were conducted statewide. A Child Passenger Safety Conference is held annually to provide continuing education and networking opportunities to currently certified child passenger safety technicians and instructors in North Carolina. This event is structured to bring together hundreds of technicians, instructors and industry leaders to discuss the most current occupant protection resources, technologies, products, and programs. These classes and conferences are funded through a grant from the Governor's Highway Safety program.

Bucklebear

Bucklebear is an educational tool for children aged 3-8 years old. Our Buckle Bear costume is offered to local injury prevention partners for use at the community level. The bear is a mascot for child passenger, bike, trike and pedestrian safety events including fairs, safety events and child passenger safety clinics. The Buckle Bear costume was used in 12 events during 2007-2009.

Safe Kids North Carolina

Safe Kids North Carolina works as a resource to local Safe Kids Coalitions to address unintentional injuries to children 14 and under. Currently, there are 36 coalitions of SKNC. The coalitions apply for grant funding through SKNC and participate in activities including bike rodeos, car seat clinics, pedestrian safety, water safety, fire prevention, poisoning prevention, fall prevention, and choking and strangulation risk areas. In addition, special events are focused on Child Passenger Safety Week, Safe Kids Week, and Fire Prevention Week. Safe Kids North Carolina provides a van to coalitions upon request; the van is stocked with tents, signage, cones and equipment for holding child passenger safety events. The van has been used in 129 events during 2007-2009. In 2009 SKNC obtained a third van, which is kept in the western region of the state with the same equipment and is available in the west or if the primary van is in use.

Fire Standard Compliant Cigarettes (Fire Safe Cigarettes)

Cigarettes are the leading cause of fire deaths in this state and the nation. During the 2007 session, the N.C. Legislature passed House Bill 1785 N.C. Fire Safety Standard and Fire Fighter

Protection Act (GS 58, Article 92), sometimes referred to as the "Fire Safe Cigarette Act." It requires that all cigarettes sold or offered for sale in North Carolina meet the criteria for reduced ignition propensity cigarettes. Fire-safe cigarettes have a reduced propensity to burn when left unattended and the use of such cigarettes will help prevent tens of thousands of cigarette-ignited fires each year. Fire-safe cigarettes are a proven, practical, and effective way to eliminate the risk of cigarette-ignited fires. This law went into effect January 1, 2010, and is expected to significantly reduce the number of people in North Carolina who are killed or injured from mattress or upholstered furniture fires caused by cigarettes left burning.

Since the January 2010 inception date, OSFM has certified 1,468 brand styles of fire standard compliant cigarettes.

Education and Technology Smoke Alarm Campaign

Through continued funding provided by FEMA Prevention Grants we have continued grants to participating fire departments for smoke alarm education and installation. The purpose of this continued grant is to combine education with technology and the installation of 10 year smoke alarms and battery operated carbon monoxide alarms in high risk areas. This program is not designed as a smoke alarm distribution program, but a total community canvassing project to provide both education and long-life smoke alarms as needed. The goal of this project is to reduce fire deaths and injuries to North Carolina residents by providing education and installing smoke alarms in home of residents at greatest risk. The long-term outcome will result in a total community being better prepared should a fire ever result in their residence.

In 2007, 3,000 smoke alarms were distributed. In 2008, 194 smoke alarms and 500 carbon monoxide alarms were distributed. And 2009, more than 1,200 smoke alarms and 150 carbon monoxide alarms were been installed.

Fire and Life Safety Education Conference

Each year a Fire and Life Safety Conference is held by the N.C. Fire and Life Safety Education Council. Members of our Injury Prevention staff coordinate and manage the conference planning and conference. The conference is for fire and life safety educators across the state to obtain innovative education programs, network with other educators and learn about new fire prevention technology. The conference is dedicated to educating statewide fire, rescue, and emergency service personnel on how to effectively prevent accidental injuries and deaths. The conference provides a forum that delivers common-sense solutions to today's fire and life safety problems and addresses a wide range of prevention and safety topics. Each year the conference is held in a new site and our staff coordinates the conference committee.

N.C. Home Fire Sprinkler Alliance

Advocates for home fire sprinklers have formed the Home Fire Sprinkler Alliance lead by members of our Injury Prevention staff. The Alliance is made up of members of numerous fire agencies and other agencies such as N.C. State Fireman's Association, N.C. State Fire Chiefs,

N.C. Fire Marshals Association, N.C. Jaycee Burn Center, Common Voices and others. The mission of the Alliance is to educate the public about the technology that can protect their homes from fire and the effectiveness of the home sprinklers in combination with smoke alarms. The Alliance has developed and utilized home sprinkler banners and fire timelines to use at trade shows and conferences. The Alliance has also developed a webpage and provided home sprinkler education materials to fire service agencies across North Carolina.

MINUTES

HOUSE COMMITTEE ON INSURANCE

February 22, 2011

The House Committee on Insurance met in Room 1228 of the Legislative Building on February 22, 2011, at 1:00 pm. The following members were present: Representatives Dockham, Chair, Blust, Brown, Bryant, Collins, Crawford, Current, Faison, Floyd, Folwell, Glazier, Hamilton, Hurley, Insko, Jackson, Johnson, Mills, Murry, Pierce, Shepard, Steen, Stevens, Warren, Wilkins, and Wray. Tim Hovis, Bill Patterson, Kory Goldsmith, and Amy Jo Johnson, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes.

Representative Dockham, Chair, called the meeting to order at 1:00 pm. He introduced the pages and the Sergeant of Arms Staff (see Attachment I).

Chairman Dockham then recognized Ms. Pam Silberman, Chief Executive Officer and President of the N.C. Institute of Medicine. Ms. Silberman introduced herself, and gave a PowerPoint overview of the Federal Health Reform Legislation and Required State Legislation (see Attachment II).

Representative Dockham welcomed questions from the committee and discussion followed.

There being no further business, the Chair adjourned the meeting at 1:45 pm.

Respectfully submitted,

Representative Jerry C. Dockham, Chair

Regina Irwin, Committee Assistant

Attachments

AGENDA

HOUSE COMMITTEE ON INSURANCE

February 22, 2011
1:00 pm
Room 1228/1327

WELCOME AND OPENING REMARKS

Representative Jerry Dockham, Chairman

INTRODUCTIONS

Pages & Sargent at Arms

Ms. Pam Silberman, Chief Executive Officer and President of the N.C. Institute of Medicine.

PRESENTATION

Ms. Pam Silberman, Chief Executive Officer and President of the N.C. Institute of Medicine, will Present an overview of Federal Health Reform Legislation and Required State Legislation.

ADJOURNMENT

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

FEB. 22, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Michael Keough	Inclusive Health
Robert Patchef	Young Moore
John Dennin	Governor's Office
Louis Belo	NCDOI
Ben Popkin	NCDOI
Adrian Jimenez	SEANC
[illegible]	SEANC
[illegible]	SEANC
[illegible]	[illegible]
Jennifer Cohen	IFNC
Sara Fender	IFNC

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

FEB. 22, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
SARAH OVASKA	NC Policy WATCH
	BCBSNC
Mary Fleming	BCBSNC
Bobby Lowery, RNP	NCNA - Nurse of The Day
Louis Isolbocion	NC Board of Nursing
Sarah Preston	ACLU-NC
Ashley Emanuelson	NMSS-NC
Susan Valenti	Nationwide Insurance
Ken Kinion	American General
Dirk Colton	Ally at Law

VISITOR REGISTRATION SHEET

INSURANCE — FEB. 22, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Heather Robinson	NCRMA
Fred Bone	Bone & Associates
[illegible]	BCBSNC
Ed TURLINGTON	Brooks Pierce
Gary Salamido	GSK
Joel Maynard	GPM & Assoc.
Erica Nelson	NCCCP
[illegible]	NMRS
Paula A. Wolf	March of Dimes
Martha Burk	Examiner.com (media)
Chris Fitzsimon	NC Policy Watch

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

FEB. 22, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lori Ann Harris	LAHA
Bill Rowe	NC Justice Center
Ian Piercy	Ragsdale Liggett
Suzanne Beasley	SEANC
Bill Rustin	ALP
Mike James	BCG
Ellen Beley	Visitor
Tami Fitzgerald	MLG
Peyton Maynard	GPM & Assoc
Tim Hoyer	Energy United
JOHN MIDGETTE	NCPBA

PLEASE PRINT

ATTACHMENT I

HOUSE PAGES

NAME OF COMMITTEE: INSURANCE DATE: FEB. 22, 2011

1. **NAME:** DONNA BLEKFELD-SZTRAKY
   County: CLAY
   Sponsor: ROGER WEST
2. **NAME:** Anna Pell
   County: Randolph
   Sponsor: Dockham
3. **NAME:** Sam Shumate
   County: Cumberland
   Sponsor: Parfitt
4. **NAME:**
   County:
   Sponsor:
5. **NAME:**
   County:
   Sponsor:

SERGEANTS-AT-ARMS

1. **Name:** MARTHA H. GADISON
2. **Name:** LARRY ELLIOTT
3. **Name:** GARLAND Shepherd
4. **Name:**
5. **Name:**

Patient Protection and Affordable Care Act

House Insurance Committee

Presentation by: Pam Silberman, JD, DrPH
President & CEO
North Carolina Institute of Medicine
February 22, 2011

NCIOM North Carolina Institute of Medicine
shaping policy for a healthier state

ATTACHMENT II

Agenda

- Overview
- Employer and individual coverage in the private market
- Insurance reform
- Medicaid expansion
- Other ACA provisions

NCIOM

Agenda

- **Overview**
- Employer and individual coverage in the private market
- Insurance reform
- Medicaid expansion
- Other ACA provisions

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National Health Reform Legislation

- Patient Protection and Affordable Care Act (HR 3590) (signed into law March 23, 2010)
- Health Care and Education Affordability Act of 2010 (HR 4872) (also referred to as "reconciliation")
  - **The combined bills are often referred to as the Affordable Care Act (or ACA)**

NCIOM

Health Reform Workgroups

- Public-private workgroups convened to how to best implement health reform in North Carolina
- *Overall Advisory Committee:*
  Co-Chairs: Secretary Lanier Cansler, CPA; Insurance Commissioner Wayne Goodwin, JD
- *Eight work groups:*
  Health Benefit Exchange and Insurance Oversight; Health Professional Workforce; Medicaid Provisions and Elder Law; New Models of Care; Prevention; Quality; Safety Net; Fraud and Abuse

NCIOM

Overview of Health Reform

- By 2014, the bill requires most people to have health insurance and large employers (50+ employees) to provide health insurance--or pay a penalty.
  - Builds on our current system of public coverage, employer-sponsored insurance, and individual (non-group) coverage
- New funding for prevention, expansion of the health workforce, improving quality, testing new payment and delivery models, expand long-term care services, and increase the healthcare safety net

NCIOM

Agenda

- Overview
- **Employer and individual coverage in the private market**
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- Other ACA provisions

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Employer Responsibilities

- Employers with more than 50 full-time equivalent employees are required to offer coverage or pay a penalty (Sec. 1513, amended by Sec. 1003 Reconciliation)
- Employers with 50 or fewer employees exempt from penalties (Sec. 1513(d)(2))
  - Employers with 25 or fewer employees and average annual wages of less than $50,000 can receive a tax credit (Sec. 1421, Sec. 10105)

NCIOM

Individual Mandate

- Citizens and legal immigrants will be required to pay penalty if they do not have qualified health insurance, unless exempt. (Sec. 1312(d), 1501, amended Sec. 1002 in Reconciliation)
  - Penalties: Must pay the greater of: $95/person or 1% taxable income (2014); $325 or 2.0% (2015); or $695 or 2.5% (2016), increased by cost-of living adjustment*
  - Some of the exemptions include people who are not required to file taxes, and those for whom the lowest cost plan exceeds 8% of an individual's income (Sec. 1501(d)(2)-(4),(e))

NCIOM

*Families of 3 or more will pay the greater of the percentage of income, or three times the individual penalty amount. The maximum penalty is equal to the amount the individual or family would have paid for the lowest cost bronze plan (minus any allowable subsidy).

Premium Tax Credits and Cost Sharing Subsidies for Individuals

- Refundable, advanceable premium tax credits will be available to individuals with incomes up to 400% FPL on a sliding scale basis ($43,320/yr. for one person, $58,280 for two, $73,240 for three, $88,200 for a family of four in 2010).* (Sec. 1401, as amended by Sec. 1001 of Reconciliation)
  - Individuals are generally not eligible for subsidies if they have employer-based coverage, TRICARE, VA, Medicaid, or Medicare (Sec. 1401(c)(2)(B)(C), 1501)
  - In comparison: North Carolina's median household income in 2008 was $46,574 (avg. household = 2.5 people).

NCIOM

***2010 Federal Poverty Levels are: $10,830 for an individual, $14,570 for a family of two, $18,310 for a family of three, or $22,050 for a family of four. US Census Bureau. North Carolina. Quick Facts. http://quickfacts.census.gov/qfd/states/37000.html**

Health Benefits Exchange (HBE)

- States will create a Health Benefits Exchange for individuals and small businesses (Sec. 1311, 1321)
  - Limited to citizens and lawful residents who do not have access to employer-sponsored or governmental-supported health insurance and to small businesses with 100 or fewer employees. (Sec. 1312(f))
- **If the state does not create an HBE, the federal government will do so**

NCIOM

Health Benefits Exchange

- The following individuals or groups *must* obtain coverage through the HBE:
  - Individuals seeking premium and cost-sharing subsidies
  - Small businesses seeking employer tax credit
  - Individuals given a choice voucher
- The following individuals or groups *may* obtain coverage through the HBE:
  - Any other qualified individual (ie, a citizen or lawfully present immigrant)
  - Small business (as defined by the state)

NCIOM

Health Benefit Exchange (HBE) Requirements

- Exchanges must:
  - Consult with stakeholders relevant to carrying out required activities
  - Certify and decertify qualified health plans, and enroll coops and federally approved multi-state plans
  - Operate a toll-free telephone hotline for assistance
  - Maintain a website that provides standardized comparative information on health plans that includes information on costs and quality ratings
  - Determine eligibility for the individual premium tax credits and cost sharing subsidies, and certify people who are exempt from the individual mandate
  - Inform people about eligibility for Medicaid and CHIP, and if eligible, enroll the individuals into these programs

Health Benefit Exchange (HBE) Requirements

- Exchanges must:
  - Establish a navigator program to provide information to the public about health plan choices and help them enroll
  - Establish a navigator program to provide information to the public about health plan choices and help them enroll
  - Report on all activities, receipts and expenditures annually to the Secretary of DHHS
- States must ensure that exchange are financially self-sufficient beginning January 1, 2015. Exchange can charge assessments or user fees to participating health insurance issuers or otherwise generate funding

NCIOM

Qualified Health Plans

- To be certified, a qualified health plans must: (Sec. 1301, 1311, 10104)
  - Provide essential benefits package
  - Be licensed under state law
  - Offer at least one qualified health plan in silver and gold levels in the HBE
  - Agree to charge the same premium rate for each qualified health plan, whether or not offered through the HBE
  - Operate a single risk pool for the individual market, and a single risk pool for small employers (whether or not offered through the HBE
  - Ensure sufficient choice of providers and contract with essential community providers
  - Be accredited and meet certain quality reporting and improvement requirements

NCIOM

Essential Benefits Package

- HHS Secretary will recommend an essential health care benefits package that includes a comprehensive set of services:* (Sec. 1302)
  - Hospital services; professional services; prescription drugs; rehabilitation and habilitative services; mental health and substance use disorders; and maternity care
  - Well-baby, well-child care, oral health and vision services for children under age 21 (Sec. 1001, 1302)
  - Recommended preventive services with no cost-sharing and all recommended immunizations (Sec. 1001, 10406)
  - Mental health parity law applies to qualified health plans (Sec. 1311(j))

NCIOM

* With some exceptions, existing grandfathered plans not required to meet new benefit standards or essential health benefits.

Four Levels of Coverage

- Four levels of plans, all must cover essential benefits package: (Sec. 1302(d))
  - Platinum: 90% of the benefit costs
  - Gold: 80% of the benefit costs
  - ***Silver: 70% of the benefits costs****
  - Bronze (minimum creditable coverage): must cover 60% of the benefit costs of the plan
  - Catastrophic plan (only available to people up to age 30 or if exempt from coverage mandate) (Sec. 1302(e))

NCIOM

*Subsidies tied to second lowest cost silver plan in the HBE.

State Flexibility (If State Operates HBE)

- States can:
  - Determine governance structure of the HBE: state, quasi state, or nonprofit and Board composition (Sec. 1311(d))
  - Choose whether to create two HBEs, or merge non-group and small group HBE (Sec. 1311(b)(2))
  - Determine the size of small employers allowed to purchase health insurance in the exchange
    - Initially states can decide to limit small employer groups to <50 until Jan. 2016, after which states must offer coverage to businesses with <100 employees (Sec. 1304(b)(3))
    - In 2017, states can decide whether to open the HBE to businesses with more than 100 employees (Sec. 1312(f))

NCIOM

State Flexibility (If State Operates HBE)

- HBE may certify qualified health plan if health plan meets the requirements for certification and the HBE determines making the plan available through the HBE is in the interests of qualified individuals and employers in the state (Sec. 1311(e))
  - States can add additional requirements to ensure that the plan offerings are in the best interest of individuals and employers
- HBEs may help facilitate enrollment for small employers by administering premium transactions
  - This would include monthly premium billing, collection, changes in coverage status, notices for delinquent payments, renewal notices, etc.

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Potential State Legislation

- If North Carolina wants to create its own HBE, then it must enact legislation that meets the federal requirements

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Potential State Legislation

- The General Assembly has authority over some of the benefits offered in the Health Benefit Exchange. For example:
  - States must decide whether insurers must offer state mandated benefits inside the HBE (in addition to any services required as part of the essential benefits package). If so, the state must pay the additional costs of coverage for state mandated benefits for anyone who purchases coverage through the HBE.
  - Federal law gives states the option to exclude abortion coverage in plans offered through the HBE.

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Agenda

- Overview
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- **Insurance reform**
- Medicaid expansion
- Other ACA provisions

NCIOM

Immediate Insurance-Related Provisions: 2010

- Effective for plan years that begin after September 23, 2010:
  - Prohibits insurers from imposing pre-existing condition exclusions for children (Sec. 10103(e))
  - Prohibits insurers from dropping coverage to people when they get sick (Sec. 1001)
  - Prohibits plans from imposing lifetime caps; and restricts use of annual caps (annual caps prohibited 2014) (Sec. 1001, as amended Sec. 2301 of Reconciliation)
  - Extends coverage for young people up to 26th birthday through parents coverage (Sec. 1001)
  - *New* private plans must cover preventive services with no cost sharing (Sec. 1001)

NCIOM

Immediate Insurance Provisions: 2010

- Effective July 2010, $5B to create a temporary reinsurance program for employers providing health insurance coverage to early retirees ages 55-64 (2010) (Sec. 1102)
  - 101 North Carolina employer groups certified to receive assistance as of January 27, 2011, including State Health Plan, 28 counties, and 20 municipalities
- Effective July 2010, $5 B to create a federal high risk pool
  - North Carolina share is $145 million. North Carolina had the fourth highest enrollment in federal high risk pool (Nov. 2010)
- New federal website with standardized format to help consumers identify affordable insurance (Sec. 1103) (www.healthcare.gov)

NCIOM

Other Insurance Provisions: 2011-2014

- The Secretary, in conjunction with the states, will establish a procedure to review premium rate increases to determine if they are "unreasonable"
  - The Secretary will rely on a state's determination if the Secretary determines the state has an effective rate review program
- Insurers must report on their medical loss ratio (MLR) to the Secretary beginning for reporting year 2011
  - No less than 80% for individual or small group
  - No less than 85% for large group

NCIOM

Insurance Provisions: 2014

- Insurers are prohibited from:
  - Discriminating against people or charge them more based on preexisting health problems (Effective 2014; Sec. 1201)
  - Including annual or lifetime limits for essential benefits (Sec. 1001, 10101)
- Insurers are required to:
  - Limit the differences in premiums charged to different people based on age (3:1 variation allowed), and certain other rating factors (Effective 2014; Sec. 1201)

NCIOM

Different Insurance Rules Apply to Different Plans

- Some of the new insurance provisions do not apply to grandfathered plans.
  - Grandfathered plans are group and non-group plans that were in effect on March 23, 2010 and that are maintained continuously
  - For example, grandfathered plans are not required to provide the essential health benefits, coverage of all clinical preventive services, or new rating rules
- Some of the provisions do not apply to ERISA (self-insured) plans
  - ERISA plans are not subject to MLR requirements

NCIOM

Department of Insurance

- DOI has new responsibilities:
  - Review insurance policies to comply with federal requirements (ie, no recissions, enhanced preventive benefits, dependent coverage to age 26, no lifetime limits and restricted annual limits, appeals process)
  - Review premiums to determine unreasonable rate increases, if North Carolina wants to maintain authority for rate review (Sec. 1003)
  - Increase capacity to provide consumer assistance and counseling to help with enrollment and complaints (Sec. 1002)
  - Work with the Secretary to provide consumer information about affordable insurance coverage (Sec. 1103)

NCIOM

Department of Insurance

- New responsibilities by 2014:
  - Regulatory oversight of new insurance protections (ie, no discrimination or exclusions based on preexisting conditions, no annual limits, insure payments for abortion coverage—if any—are segregated)
  - Establish rating areas (Sec. 2701)
  - Collect data from health plans (Sec. 10104(f)(2))
  - Make recommendations to the HBEs about whether particular insurers should be excluded from the exchange based on unreasonable rate increases (Sec. 1003)

NCIOM

Potential State Legislation or Implementation Steps

- NC Department of Insurance may need additional rate review authority in order to ensure that it has an effective rate review process
- Note: North Carolina Department of Insurance received three federal grants to help prepare for some of the ACA provisions.
  - Strengthen the rate review process: $1 million
  - Strengthen consumer assistance program: $850,000
  - HBE planning grant: $1 million
    - North Carolina will be eligible for additional grants if it is making progress in implementing the HBE

NCIOM

Agenda

- Overview
- Employer and individual coverage in the private market
- Insurance reform
- **Medicaid expansion**
- Other ACA provisions

NCIOM

Expansion of Public Coverage

- Beginning in January 2014, adults will be able to qualify for Medicaid if their income is no greater than 138% of the federal poverty guidelines (FPL) ($30,429/year for a family of four in 2010)*
  - Currently, childless adults who are not elderly or disabled can not qualify for Medicaid (regardless of their amount of income)
- Undocumented immigrants are not eligible for Medicaid or any other insurance coverage made available through this bill

NCIOM

* The ACA mandates that states expand coverage up to 133% FPL, but also includes a 5% income disregard, effectively raising eligibility limits to 138% FPL.

ACA Requirements for Medicaid

- Maintenance of effort for existing Medicaid and CHIP eligibility groups (Sec. 2001(b); Sec. 2101)
- Expanding coverage to all adults up to 138% FPG
  - Enhanced FMAP for newly eligibles
  - Regular FMAP for those who were previously eligible but not enrolled
- Significant changes to enrollment processes (Sec. 1411 et. seq, 2201, 3021)
  - Must allow electronic applications (and signatures), and consolidated enrollment process with health insurance exchange
  - Eliminates asset tests for most eligibles

NCIOM

ACA Requirements for Medicaid

- New service options and mandates
  - Optional services, often with enhanced FMAP, including preventive services, home and community based services, health home for people with chronic illness (Sec. 2301 et. seq, 10201-10202, 2703, 4106-4108)
  - Some new requirements for mandatory services, but North Carolina already meeting these requirements

NCIOM

ACA Requirements for Medicaid

- Demonstration opportunities: (Sec. 2701-2707,3021, 3502)
  - New models of care (ie, pediatric accountable care organizations, patient centered medical home, emergency psychiatric demonstration, global payment, all payer payment reform, dual eligibles)
  - Healthy lifestyle initiatives
- Enhanced fraud and abuse requirements, which may require state authorizing legislation (Sec. 6501 et. seq.)

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Agenda

- Overview
- Employer and individual coverage in the private market
- Insurance reform
- Medicaid expansion
- **Other ACA provisions**
  - **Prevention, workforce, quality, new models of care**

NCIOM

Prevention and Workforce

- Prevention and Public Health Fund to invest in prevention, wellness, and public health activities (Sec. 4002)
  - Appropriates $500 million in FY 2010, $750 million in FY 2011, $1 billion in FY 2012, $1.25 billion in FY 2013, $1.5 billion in FY 2014, and $2 billion in FY 2015 and each fiscal year thereafter
  - May be used to fund programs for prevention, wellness, and public health activities.
- Provisions aim to expand the health professional workforce, including primary care, nursing, long-term care, mental health/addiction specialists, dental health, public health, allied health, direct care workforce and community health workers

NCIOM

Health Care Workforce: Underserved Areas

- Expansion of National Health Service Corps: Appropriates a total of $1.5B total over 5 years, FY 2011-2015 (Sec. 5207, 10503)
  - Loan forgiveness for health professionals who agree to practice in health professional shortage areas (HPSAs) for certain length of time (to pay off loan forgiveness)
  - Includes primary care providers, dental providers, and behavioral health providers
  - North Carolina Office of Rural Health and Community Care estimates that North Carolina will be able to recruit an additional 20-25 health professionals/year into underserved areas as a result of this new funding

NCIOM

Quality and New Models of Care

- Providers and payers will be required to report data to measure quality of care
  - Data will be made available to the public
  - Increased emphasis paying for the quality and value of services provided
- The ACA includes funding to test new models of delivering and paying for health care services
  - Goal is to improve quality and health outcomes, improve efficiency, and help reduce health care cost escalation

NCIOM

Questions



NCIOM

MINUTES

HOUSE COMMITTEE ON INSURANCE

March, 1, 2011

The House Committee on Insurance met in Room 1228 of the Legislative Building on March 1, 2011, at 1:00 pm. The following members were present: Representatives Dockham, Chair, Blust, Brubaker, Bryant, Burr, Collins, Crawford, Current, Faison, Floyd, Folwell, Glazier, Graham, Hamilton, Howard, Hurley, Insko, Johnson, McElraft, Mills, Murry, Pierce, Shepard, Steen, Stevens, Warren, Wilkins, and Wray. Tim Hovis, Bill Patterson, and Kory Goldsmith, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes.

Representative Dockham, Chair, called the meeting to order at 1:00 pm. He introduced the pages and the Sergeant of Arms staff. (Attachment I)

Representative Dockham requested Representative McElraft, Vice-Chair, to preside over the first portion of the meeting since he is the primary sponsor of HB 138, first bill under consideration.

HB 138, entitled, A BILL TO BE ENTITLED AN ACT TO AMEND THE HEALTH INSURANCE RISK POOL STATUTES. Representative Dockham, bill sponsor, was recognized and he presented a proposed committee substitute. Representative Howard moved for the committee to adopt the PCS for discussion. The motion passed. Rep. McElraft recognized Representative Dockham to explain the bill.

Rep. Dockham provided background information regarding HB 138 and explained what the bill will do. (Attachment II)

After some discussion Representative Insko moved for a favorable report as to the committee substitute bill, unfavorable as to the original bill. The motion passed.

HB 161, entitled, AN ACT TO TRANSFER THE NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES TO THE DEPARTMENT OF STATE TREASURER. The Chair recognized Representative Dollar, the bill sponsor, to explain the bill. Representative Howard moved to amend the bill on page 2, line 4-19, by deleting the lines and substituting the following: (Attachment III)

Representative Dollar recognized Representatives Blackwell, Hurley, and Blust, primary sponsors, and proceeded to explained the bill. HB 161 would transfer the State Health Plan for Teachers and State Employees to the Department of State Treasurer, make the State Treasurer responsible for appointing and removing the Executive Administrator, and remove from chapter 135 all references to the Committee on Employee Hospital and Medical Benefits and the State Health Plan Administrative Commission. The Plan will be transferred as a type II transfer. Representative Insko, not objecting to the transfer of the State Health Plan to the Department of State Treasurer, expressed concerns over the lack of Legislative

oversight in the current language of the bill. She indicated that she might offer an amendment when the bill is taken up for consideration in the Committee on Appropriations. Representative Faison questioned why transferring the State Health Plan to the Department of the Treasurer and not to the Department of Insurance. Representative Dollar responded that there were conflicts of interest in the Department of Insurance running an insurance company and regulating it at the same time. He also pointed out that NCDOI facilitates the appeals process, so if someone wanted to appeal the denial of coverage for a service to the State Health Plan that appeal would go to NCDOI the same department who denied the claim.

Ardis Watkins, Director, Legislative Affairs, State Employees Association of NC; Lacey Barnes, Deputy Director, State Health Plan; and Tony Solari, Legislative Liaison, NC Department of State Treasurer, spoke in favor of HB 161.

After a lengthy discussion Representative Folwell moved for favorable report to the bill as amended, rolled into a committee substitute, unfavorable as to the original bill and re-referred to the Committee on Appropriations. The motion passed.

There being no further business, the Chair adjourned the meeting at 1:45 pm.

Respectfully submitted,

Jerry C. Dockham

Representative Jerry C. Dockham, Chair

Regina Irwin

Regina Irwin, Committee Assistant

Attachments

AGENDA

HOUSE COMMITTEE ON INSURANCE

March 1, 2011

Room 1228

1:00 pm

OPENING REMARKS

Representative Jerry Dockham, Chairman
Insurance Committee

AGENDA ITEMS

HB 138 AMEND HEALTH INSURANCE RISK POOL STATUTES
Representative Jerry Dockham, Sponsor

HB 161 TRANSFER STATE HEALTH PLAN TO STATE TREASURER
Representative Nelson Dollar, Sponsor
Representative Hugh Blackwell, Sponsor
Representative Pat Hurley, Sponsor
Representative John Blust, Sponsor

ADJOURNMENT

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

MARCH 1, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Cohen	IFNC
Sara Fender	IFNC
Yusen Valauri	Nationwide
Harry Kaplan	MWC
Emily Grimm	MWC
DAVID BARNES	
Elizabeth Robinson	NCRMA
Lacey Barnes	SHP
Carol Durrell	SHP
John Bowdish	AstraZeneca

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

MARCH 1, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ed Regan	NCRGEA
Marie Freeman	NCAE
Abby Emerson	NMSS - NC
[illegible]	NMSS - NC
Kay Parsons	NASW-NC
Forrest Gilliam	Governor's Office
Governor's Pages: Maryscott Manning, Sima Djahanbani, Hira Puetz, Teslime Cakir, Anthony Klopfer	Governor's Office
Andy Ellen	NCRMM
Jennifer Mahan	Autism Society of NC
Bob Dandrea	Autism Speaks
Bill Scoggin	TSS

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

MARCH 1, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mark Fleming	BCBSNC
BJ Miller	Moses Cone
Jason Davis	JCS
BRUCE THOMPSON	PARKER POE

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

MARCH 1, 2011
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Penny Burtt	School of Gov.
[signature]	BCBSNC
Rose Williams	NCDOI
[signature]	NMRS
[signature]	BCBSNC
Katherine Joyce	NCASA
Joanne Stevens	Nursing
[signature]	Nursing
Sarah Preston	ACLU-NC
Nicole Fisher	John Locke Foundation
Carl Hadl	OST

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

MARCH 1, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carl Dean	DSP
Andrew Holton	DST
Tony Solari	DST
Adrian Jimenez	SEANC
Suzanne Beasley	SEANC
Artis Wadkins	SEANC
Cheryl Moon	SEANC
Chuck Stone	SEANC
N Sheild	NC Med Soc.
Patrick Hannah	Liberty Mutual
Amy Jo Johnson	Research staff

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

MARCH 1, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Henry Lancaster	LCA
Lori Ann Harris	LAHA
Amy Whited	NC Med Society
Ed Turlington	Bowles Pierce
MaryBe McMillan	NC AFL-CIO
Wendy Kelly	Policy Group
Lynn Bonner	NBO

PLEASE PRINT

ATTACHMENT I

HOUSE PAGES

NAME OF COMMITTEE: INSURANCE DATE: MARCH 1, 2011

1. **NAME:** Addison McLamb
   County: Davidson
   Sponsor: Rayne Brown
2. **NAME:** Jonathan Farb
   County: Orange
   Sponsor: Bill Faison
3. **NAME:** Julia Chavis
   County: Wake
   Sponsor: Ross
4. **NAME:** Chris Haskins
   County: Cumberland
   Sponsor: Floyd
5. **NAME:** Owen Essen
   County: Chatham
   Sponsor: Joe Hackney

SERGEANTS-AT-ARMS

1. **Name:**
2. **Name:** Garland Shepherd
3. **Name:** Bill MacRae
4. **Name:** Martha Gadison
5. **Name:** Earl Baker

2011 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
HB 138 A BILL TO BE ENTITLED AN ACT TO AMEND THE HEALTH INSURANCE RISK POOL STATUTES.

☒ 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.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 138
PROPOSED COMMITTEE SUBSTITUTE H138-PCS60019-RG-2

Short Title: Amend Health Insurance Risk Pool Statutes. (Public)

Sponsors:

Referred to:

February 21, 2011

A BILL TO BE ENTITLED

AN ACT TO AMEND THE HEALTH INSURANCE RISK POOL STATUTES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-180(c) reads as rewritten:

"(c) The initial appointments by the Governor and the General Assembly upon the recommendation of the Speaker of the House of Representatives and the President Pro Tempore of the Senate shall serve a term of three years. The initial appointments by the Commissioner under sub-subdivisions a., b., and d. of subdivision (b)(3) of this section shall be for a term of two years. The initial appointments by the Commissioner under sub-subdivisions c., e., f., and g. of subdivision (b)(3) of this section shall be for a term of one year. All succeeding appointments shall be for terms of three years. Members shall not serve for more than ~~two~~ three successive terms.

A Board member's term shall continue until the member's successor is appointed by the original appointing authority. Vacancies shall be filled by the appointing authority for the unexpired portion of the term in which they occur. A Board member may be removed by the appointing authority for cause.

The Board shall meet at least quarterly upon the call of the chair. A majority of the total membership of the ~~Commission~~ Board shall constitute a quorum.

The Commissioner shall appoint a chair to serve for the initial two years of the Plan's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms. Board members shall receive travel allowances under G.S. 138-5 when traveling to and from meetings of the Board or for official business of the Pool, but shall not receive any per diem under subdivision (a)(1) of that section."

SECTION 2. G.S. 58-50-180(e)(4a) 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:

...

(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~~ where the Board deems it is fiscally prudent to do so. Premium subsidies may come from the following sources:

a. Federal grants made to the Pool for premium subsidies.

b. The Pool's own funds, not to exceed the amount of the most recent year for which the Pool received a federal grant award under sub-subdivision a. of this subdivision."

SECTION 3. G.S. 58-50-190(b) reads as rewritten:

"(b) The Pool shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for the coverage. Pool rates shall be ~~one hundred fifty percent (150%) to two hundred percent (200%)~~ one hundred thirty-five percent (135%) to one hundred seventy-five percent (175%) of rates established as applicable for individual standard rates and shall be adjusted annually, at the time of annual renewal."

SECTION 4. G.S. 58-50-195(a) is amended by adding a new subdivision to read:

"(a) Any individual who is and continues to be a resident of this State is eligible for Pool coverage if the individual provides evidence of any of the following:

...

(8) The individual is eligible for and has not exhausted current COBRA health insurance coverage at a rate exceeding the Pool rate and provides evidence of eligibility for Pool coverage under any of the subdivisions (1) through (4) of this subsection."

SECTION 5. G.S. 58-50-210(a) reads as rewritten:

"(a) Except as otherwise provided by law, Pool coverage shall exclude charges or expenses incurred during the first ~~12~~six months following the effective date of coverage as to any condition for which medical advice, care, or treatment was recommended or received as to such conditions during the 12-month period immediately preceding the effective date of coverage, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual or an individual who is eligible for the Pool because of his or her eligibility 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, pursuant to G.S. 58-50-195(a)(6)."

SECTION 6. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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HOUSE BILL 138
PROPOSED COMMITTEE SUBSTITUTE H138-CSRG-2 [v.2]

2/28/2011 4:07:45 PM

Short Title: Amend Health Insurance Risk Pool Statutes. (Public)

Sponsors:

Referred to:

February 21, 2011

A BILL TO BE ENTITLED

AN ACT TO AMEND THE HEALTH INSURANCE RISK POOL STATUTES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-180(c) reads as rewritten:

"(c) The initial appointments by the Governor and the General Assembly upon the recommendation of the Speaker of the House of Representatives and the President Pro Tempore of the Senate shall serve a term of three years. The initial appointments by the Commissioner under sub-subdivisions a., b., and d. of subdivision (b)(3) of this section shall be for a term of two years. The initial appointments by the Commissioner under sub-subdivisions c., e., f., and g. of subdivision (b)(3) of this section shall be for a term of one year. All succeeding appointments shall be for terms of three years. Members shall not serve for more than ~~two~~ three successive terms.

A Board member's term shall continue until the member's successor is appointed by the original appointing authority. Vacancies shall be filled by the appointing authority for the unexpired portion of the term in which they occur. A Board member may be removed by the appointing authority for cause.

The Board shall meet at least quarterly upon the call of the chair. A majority of the total membership of the ~~Commission~~ Board shall constitute a quorum.

The Commissioner shall appoint a chair to serve for the initial two years of the Plan's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms. Board members shall receive travel allowances under G.S. 138-5 when traveling to and from meetings of the Board or for official business of the Pool, but shall not receive any per diem under subdivision (a)(1) of that section."

SECTION 2. G.S. 58-50-180(e)(4a) 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:

...

(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~~ where the Board deems it is fiscally prudent to do so. Premium subsidies may come from the following sources:

a. Federal grants made to the Pool for premium subsidies.

b. The Pool's own funds, not to exceed the amount of the most recent year for which the Pool received a federal grant award under sub-subdivision a. of this subdivision."

SECTION 3. G.S. 55-50-190(b) is amended by adding a new subdivision to read:

"(b) The Pool shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for the coverage. Pool rates shall be ~~one hundred fifty percent (150%) to two hundred percent (200%)~~ one hundred thirty-five percent (135%) to one hundred seventy-five percent (175%) of rates established as applicable for individual standard rates and shall be adjusted annually, at the time of annual renewal."

SECTION 4. G.S. 58-50-195(a) is amended by adding a new subdivision to read:

"(a) Any individual who is and continues to be a resident of this State is eligible for Pool coverage if the individual provides evidence of any of the following:

...

(8) The individual is eligible for and has not exhausted current COBRA health insurance coverage at a rate exceeding the Pool rate and provides evidence of eligibility for Pool coverage under any of the subdivisions (1) through (4) of this subsection."

SECTION 5. G.S. 58-50-210(a) reads as rewritten:

"(a) Except as otherwise provided by law, Pool coverage shall exclude charges or expenses incurred during the first ~~12~~ six months following the effective date of coverage as to any condition for which medical advice, care, or treatment was recommended or received as to such conditions during the 12-month period immediately preceding the effective date of coverage, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual or an individual who is eligible for the Pool because of his or her eligibility 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, pursuant to G.S. 58-50-195(a)(6)."

SECTION 6. This act is effective when it becomes law.

HOUSE PCS 138:
Amend Health Insurance Risk Pool Statutes

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	February 27, 2011
Introduced by:	Rep. Dockham	**Prepared by:**	Tim Hovis
Analysis of:	PCS to First Edition H138-CSRG-2		Committee Counsel

SUMMARY: House Bill 1392 would make the following changes to the North Carolina Risk Pool:

Section 1 of the PCS increases the number of successive terms a member of the Pool's Board of Directors may serve from two to three successive terms. The NC Risk Pool will likely cease to operate if the federal Affordable Care Act (ACA) becomes fully effective in 2014. This change will allow a greater number of existing Board members to oversee the phasing out of the Pool.

Section 2 authorizes the Pool to offer premium subsidies from the Pool's own funds, not to exceed the amount of the subsidies of the most recent year the Pool received a federal grant for premium subsidies. Current law allows the Pool to offer premium subsidies only if federal grants are available.

Section 3 reduces Pool rates from a range of 150%-200% to a range of 135%-175% of standard rates for individuals charged by other insurers. Pool rates are set to ensure that the Pool does not compete with other insurers.

Section 4 provides eligibility for Pool coverage to State residents who have not exhausted current COBRA health insurance coverage at a rate exceeding the Pool rate and who, in addition, meet one of the following four conditions: (1) have been rejected by an insurer for health reasons; (2) have been offered coverage only with a conditional rider; (3) have been refused coverage except at a rate exceeding the Pool rate; or (4) have one of the medical or health conditions listed by the Board as eligible for coverage.

Section 5 reduces the time period from 12 to 6 months that Pool coverage excludes charges and conditions for preexisting conditions for which advice or care was recommended during the 12 month period preceding coverage by the Pool.

The Proposed Committee Substitute adds Section 1 noted above. In Section 3, the PCS increases the range for Pool rates from 125%-175% in the original bill to 135%-175% of standard rates. The PCS also makes the bill effective when it becomes law.

EFFECTIVE DATE: The 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]

H138-SMRG-5(CSRG-2) v5

[1] http://www.inclusivehealth.org/pages/6/About-Us/

HOUSE BILL 138

Short Title:	Amend Health Insurance Risk Pool Statutes.	(Public)
Sponsors:	Representative Dockham (Primary Sponsor). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Insurance.	

February 21, 2011

A BILL TO BE ENTITLED

AN ACT TO AMEND THE HEALTH INSURANCE RISK POOL STATUTES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-180(e)(4a) 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:

...

(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~~ where the Board deems it is fiscally prudent to do so. Premium subsidies may come from the following sources:

a. Federal grants made to the Pool for premium subsidies.

b. The Pool's own funds, not to exceed the amount of the most recent year for which the Pool received a federal grant award under sub-subdivision a. of this subdivision."

SECTION 2. G.S. 55-50-190(b) is amended by adding a new subdivision to read:

"(b) The Pool shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for the coverage. Pool rates shall be ~~one hundred fifty percent (150%) to two hundred percent (200%)~~ one hundred twenty-five percent (125%) to one hundred seventy-five percent (175%) of rates established as applicable for individual standard rates and shall be adjusted annually, at the time of annual renewal."

SECTION 3. G.S. 58-50-195(a) is amended by adding a new subdivision to read:

"(a) Any individual who is and continues to be a resident of this State is eligible for Pool coverage if the individual provides evidence of any of the following:

...

(8) The individual is eligible for and has not exhausted current COBRA health insurance coverage at a rate exceeding the Pool rate and provides evidence of eligibility for Pool coverage under any of the subdivisions (1) through (4) of this subsection."

SECTION 4. G.S. 58-50-210(a) reads as rewritten:

"(a) Except as otherwise provided by law, Pool coverage shall exclude charges or expenses incurred during the first ~~12~~ six months following the effective date of coverage as to any condition for which medical advice, care, or treatment was recommended or received as to

such conditions during the 12-month period immediately preceding the effective date of coverage, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual or an individual who is eligible for the Pool because of his or her eligibility 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, pursuant to G.S. 58-50-195(a)(6)."

SECTION 5. This act becomes effective October 1, 2011.

HB 138
Amend Health Insurance Risk Pool Statutes

Background:

The General Assembly created the North Carolina Health Insurance Risk Pool for individuals with pre-existing conditions that prevent them from purchasing affordable health insurance. First enacted as HB 265 in August 2007, it began covering its first eligibles in January 2009.

Created as the insurer of last resort, the pool guarantees coverage to eligible individuals at a standard rate that is based on the state's individual market. The enabling statute dictates a rate range that is above the market average for those without pre-existing conditions but lower than the individuals would pay for coverage given their underwriting risk, if they were able to find commercial coverage. Over 5,700 people and counting have joined the Pool to date.

What the bill does:

First, Section 1 of this bill would extend by one term the length of service of the Pool's current Board

members so that these Directors could see the Pool through the onset of federal health insurance reforms.

The goals of this bill are in Sections 2 through 5, which would enhance our citizens' access to the Pool by:

1) Broadening premium subsidy opportunities using the Pool's own resources (Section 2);
2) Permitting the Pool Board to lower premiums if it is fiscally prudent to do so (Section 3);
3) Allowing those on COBRA to join if the Pool's rates are lower than their COBRA rate (Section 4), and
4) Lowering the pre-existing condition waiting period for those who apply without continuous coverage from 12 months to 6 (Section 5).

The Pool has enjoyed widespread legislative support throughout its brief history, and these changes require no State funding to make an essential service for our citizens more affordable, more accessible and more comprehensive.

2011 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
HB 161 A BILL TO BE ENTITLED AN ACT TO TRANSFER THE NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES TO THE DEPARTMENT OF STATE TREASURER.

☒ 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.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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HOUSE BILL 161
PROPOSED COMMITTEE SUBSTITUTE H161-PCS11056-RC-3

Short Title: Transfer State Health Plan to State Treasurer. (Public)

Sponsors:

Referred to:

February 23, 2011

A BILL TO BE ENTITLED

AN ACT TO TRANSFER THE NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES TO THE DEPARTMENT OF STATE TREASURER.

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 State Treasurer. 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 State Treasurer, 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.~~State Treasurer."

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~~ The General Assembly 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 the State Treasurer or their designees and the employees of the Legislative Services Office 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 the State Treasurer or their designees and the employees of the Legislative Services Office 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 Pro Tempore of the Senate and the Speaker of the House of Representatives."

SECTION 7. 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.~~State Treasurer. 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.~~State Treasurer.

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,~~State Treasurer, 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.~~State Treasurer.

(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.~~State Treasurer.

(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 President of the Senate, the Speaker of the House of ~~Representatives and the Committee on Employee Hospital and Medical Benefits.~~Representatives."

SECTION 7.1. G.S. 135-44.4(31) reads 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:

...

(31) The Plan shall conduct a monthly review of Plan costs as compared to the same month in the immediately preceding year and a comparison of projected costs and savings to actual costs and savings. The Plan shall report the results of the review to the ~~Committee on Employee Hospital and Medical Benefits and the State Health Plan Blue Ribbon Task Force~~ State Treasurer and the General Assembly at least semiannually."

SECTION 7.2. G.S. 135-44.6(a) reads as rewritten:

"**§ 135-44.6. Premiums set.**

(a) The Executive Administrator and Board of Trustees shall, from time to time, recommend to the General Assembly the establishment or adjustment of premium rates for the Plan and based on premium rates enacted by the General Assembly shall adopt rules for payment of the premiums. Premium rates shall be established for coverages where Medicare is the primary payer of health benefits separate and apart from the rates established for coverages where Medicare is not the primary payer of health benefits. The amount of State funds contributed for optional coverage for employees and retirees on a partially contributory basis shall not be more than the Plan's total noncontributory premium for Employee Only coverage, with the person selecting the coverage paying the balance of the partially contributory premium not paid by the Plan. The amount of State funds contributed shall not exceed the Plan's cost for Employee Only coverage. The Executive Administrator and Board of Trustees shall not impose a partially contributory premium until after it has consulted on the premium and the optional coverage design with the ~~Committee on Employee Hospital and Medical Benefits.~~State Treasurer."

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. G.S. 135-45.7 reads as rewritten:

"**§ 135-45.7. Prior approval procedures.**

The Executive Administrator and Board of Trustees may establish procedures to require prior medical approval and may implement the procedures after consultation with the ~~Committee on Employee Hospital and Medical Benefits.~~State Treasurer."

SECTION 11. G.S. 135-45.10(d) reads as rewritten:

"**§ 135-45.10. Persons eligible for Medicare; optional participation in other Medicare products.**

...

(d) Notwithstanding the foregoing provisions of this section or any other provisions of the Plan, the Executive Administrator and Board of Trustees may enter into negotiations with

the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, in order to secure a more favorable coordination of the Plan's benefits with those provided by Medicare, including but not limited to, measures by which the Plan would provide Medicare benefits for all of its Medicare-eligible members in return for adequate payments from the federal government in providing such benefits. Should such negotiations result in an agreement favorable to the Plan and its Medicare-eligible members, the Executive Administrator and Board of Trustees may, after consultation with the ~~Committee on Employee Hospital and Medical Benefits,~~State Treasurer, implement such an agreement which shall supersede all other provisions of the Plan to the contrary related to its payment of claims for Medicare-eligible members."

SECTION 12. 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~~ State Treasurer for ~~its~~ 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~~State Treasurer for review."

SECTION 13. G.S. 135-45.13(b) reads as rewritten:

"**§ 135-45.13. Conversion.**

...

(b) The Executive Administrator and Board of Trustees shall provide for the continuation of conversion privilege exercised under the predecessor plan, on a fully contributory basis. The Executive Administrator and Board of Trustees shall consult with the

~~Committee on Employee Hospital and Medical Benefits~~ State Treasurer before taking action under this subsection."

SECTION 14. This act becomes effective September 1, 2011.

HOUSE BILL 161

Short Title:	Transfer State Health Plan to State Treasurer.	(Public)
Sponsors:	Representatives Dollar, Blackwell, Hurley, and Blust (Primary Sponsors). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Insurance, if favorable, Appropriations.	

February 23, 2011

A BILL TO BE ENTITLED

AN ACT TO TRANSFER THE NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES TO THE DEPARTMENT OF STATE TREASURER.

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 State Treasurer. 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 State Treasurer, 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.~~State Treasurer."

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 the State Treasurer 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 the State Treasurer 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 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.~~State Treasurer. 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.~~State Treasurer.

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,~~State Treasurer, 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.~~State Treasurer."

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 September 1, 2011.

HOUSE BILL 161:
Transfer State Health Plan to State Treasurer

2011-2012 General Assembly

Committee:	House Insurance, if favorable, Appropriations	**Date:**	February 28, 2011
Introduced by:	Reps. Dollar, Blackwell, Hurley, Blust	**Prepared by:**	Kory Goldsmith
Analysis of:	First Edition		Committee Counsel

SUMMARY: House Bill 161 would transfer the State Health Plan for Teachers and State Employees to the Department of State Treasurer, make the State Treasurer responsible for appointing and removing the Executive Administrator, and remove from Chapter 135 all references to the Committee on Employee Hospital and Medical Benefits and the State Health Plan Administrative Commission.

CURRENT LAW: Article 3A of the Chapter 135 of the General Statutes provides for the organization, governance, and benefit structure of the North Carolina State Health Plan for Teachers and State Employees (the Plan). Only the General Assembly has the authority to change the Plan's comprehensive health benefit coverage, co-payments, deductibles, out-of–pocket expenditures, lifetime maximums, and prescription drug benefits.

Part 2 of Article 3A creates the Board of Trustees of the Plan (the Board), a 9 member board that has certain powers and duties under G.S. 135-44.4. There are also provisions for an Executive Administrator (the EA) who is appointed and may be removed by the State Health Plan Administrative Commission (the Commission). The Commission consists of 3 members who are appointed by the General Assembly upon the recommendation of the Speaker of the House and the President Pro Tempore of the Senate. The Commissioner of Insurance serves as the secretary to the Commission. The Commission is administratively housed in the Department of Insurance although it exercises its statutory powers independently of the Commissioner of Insurance.

There are 3 additional legislative oversight bodies. The Committee on Employee Hospital and Medical Benefits (the Committee) is composed of 12 members who are all legislators. It has the broadest responsibilities and must meet at least quarterly. The EA and the Board are accountable to the Committee and must consult with the Committee on a number of matters before taking any action. There is also an Oversight Team composed of employees of the Legislative Services Office and the Office of State Budget and Management. The Oversight Team has access to all records of the Board, the EA, the Claims Processor and the Plan. The Oversight Team reports to the Committee. Finally, there is the Committee on Actuarial Valuation of Retired Employees' Health Benefits. It is charged with collecting data and reviewing assumptions to provide required actuarial valuation of the State supported retired employees' health benefits.

BILL ANALYSIS:

Section 1 directs that the Plan will be transferred to the Department of State Treasurer as a Type II transfer. A Type II transfer means the transferring intact of an existing agency to a principal department established by Chapter 143A. When any agency is transferred to a principal department under a Type II transfer, that agency will be administered under the direction and supervision of that principal department, but shall exercise all its prescribed statutory powers independently of the head of the principal department, except that under a Type II transfer the management functions of any transferred agency are performed under the direction and supervision of the head of the principal department.

Sections 3 and 4 repeal the statutes that created the Committee (G.S. 135-43.1) and the Commission (G.S. 135-43.2).

Sections 2 and 5 – 9 remove references to the Committee, the Commission and the Oversight Team.

Section 7 specifies that the State Treasurer will appoint and remove the EA.

EFFECTIVE DATE: This act becomes effective September 1, 2011.

BACKGROUND: During the 2010 Interim, the Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees examined issues related to governance of the Plan. The Task Force findings included the following:

1. Responsibility for broad oversight of the Plan should not primarily reside with the General Assembly.
2. The current appointment and removal process for the Plan's Executive Administrator is unclear.

The Task Force recommended, among other things, that oversight of the Plan be provided by the executive branch and a strong and independent governing board with broad policy making authority and that the appointment and removal of the Executive Administrator be one of the duties of the governing board.

H161-SMRC-3(e1) v2

ATTACHMENT III

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 161

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

H161-ARC-6 [v.4]

Comm. Sub. [NO]
Amends Title [NO]
First Edition

Date 3/1/ ,2011

Representative _____

moves to amend the bill on page 2, lines 4-19, by deleting the lines and substituting the following:

"(a) ~~The Committee on Employee Hospital and Medical Benefits~~ The General Assembly 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 the State Treasurer or their designees and the employees of the Legislative Services Office 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 the State Treasurer or their designees and the employees of the Legislative Services Office shall be entitled to attend all meetings of the Board of Trustees.";

and on page 2, lines 28-40, by deleting the lines and substituting the following:

"**SECTION 7.** 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.~~State Treasurer. 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.~~State Treasurer.

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,~~State Treasurer, 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.~~State Treasurer.

(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.~~State Treasurer.

(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 President of the Senate, the Speaker of the House of ~~Representatives and the Committee on Employee Hospital and Medical Benefits.~~Representatives."

SECTION 7.1. G.S. 135-44.4(31) reads 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:

. . .

(31) The Plan shall conduct a monthly review of Plan costs as compared to the same month in the immediately preceding year and a comparison of projected costs and savings to actual costs and savings. The Plan shall report the results of the review to the ~~Committee on Employee Hospital and~~

~~Medical Benefits and the State Health Plan Blue Ribbon Task Force~~ State Treasurer and the General Assembly at least semiannually."

SECTION 7.2. G.S. 135-44.6(a) reads as rewritten:

"§ 135-44.6. Premiums set.

(a) The Executive Administrator and Board of Trustees shall, from time to time, recommend to the General Assembly the establishment or adjustment of premium rates for the Plan and based on premium rates enacted by the General Assembly shall adopt rules for payment of the premiums. Premium rates shall be established for coverages where Medicare is the primary payer of health benefits separate and apart from the rates established for coverages where Medicare is not the primary payer of health benefits. The amount of State funds contributed for optional coverage for employees and retirees on a partially contributory basis shall not be more than the Plan's total noncontributory premium for Employee Only coverage, with the person selecting the coverage paying the balance of the partially contributory premium not paid by the Plan. The amount of State funds contributed shall not exceed the Plan's cost for Employee Only coverage. The Executive Administrator and Board of Trustees shall not impose a partially contributory premium until after it has consulted on the premium and the optional coverage design with the ~~Committee on Employee Hospital and Medical Benefits.~~State Treasurer. ";

and on page 3, by deleting line 32 and substituting the following:

"SECTION 10. G.S. 135-45.7 reads as rewritten:

"§ 135-45.7. Prior approval procedures.

The Executive Administrator and Board of Trustees may establish procedures to require prior medical approval and may implement the procedures after consultation with the ~~Committee on Employee Hospital and Medical Benefits.~~State Treasurer. "

SECTION 11. G.S. 135-45.10(d) reads as rewritten:

"§ 135-45.10. Persons eligible for Medicare; optional participation in other Medicare products.

. . .

(d) Notwithstanding the foregoing provisions of this section or any other provisions of the Plan, the Executive Administrator and Board of Trustees may enter into negotiations with the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, in order to secure a more favorable coordination of the Plan's benefits with those provided by Medicare, including but not limited to, measures by which the Plan would provide Medicare benefits for all of its Medicare-eligible members in return for adequate payments from the federal government in providing such benefits. Should such negotiations result in an agreement favorable to the Plan and its Medicare-eligible members, the Executive Administrator and Board of Trustees may, after consultation with the ~~Committee on Employee Hospital and Medical Benefits,~~State Treasurer, implement such an agreement which shall supersede all other provisions of the Plan to the contrary related to its payment of claims for Medicare-eligible members."

SECTION 12. 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~~ State Treasurer for ~~its~~ 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~~ State Treasurer for review."

SECTION 13. G.S. 135-45.13(b) reads as rewritten:

"§ 135-45.13. Conversion.

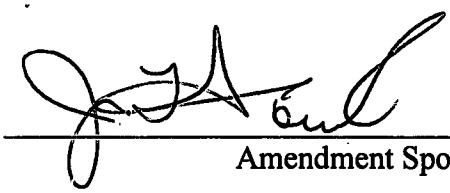
. . .

(b) The Executive Administrator and Board of Trustees shall provide for the continuation of conversion privilege exercised under the predecessor plan, on a fully contributory basis. The Executive Administrator and Board of Trustees shall consult with the ~~Committee on Employee Hospital and Medical Benefits~~ State Treasurer before taking action under this subsection."

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

H161-ARC-6 [v.4]

SECTION 14. This act becomes effective September 1, 2011.".

SIGNED 
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

MINUTES

HOUSE COMMITTEE ON INSURANCE

March, 29, 2011

The House Committee on Insurance met in Room 1228 of the Legislative Building on March 29, 2011, at 1:00 pm. The following Committee members were present: Representatives Dockham, Chair, Blust, Brown, Brubaker, Bryant, Burr, Collins, Crawford, Current, Faison, Floyd, Folwell, Glazier, Graham, Hamilton, Howard, Hurley, Insko, Jackson, Johnson, McElraft, McGuirt, Mills, Murry, Pierce, Shepard, Steen, Stevens, Wainwright, Warren, Wilkins, and Wray. Tim Hovis, Bill Patterson, and Kory Goldsmith (Research Staff Counsels), Mark Trogdon (Fiscal Staff Counsel), and Ryan Blackledge (Bill Drafting Staff Counsel), were in attendance. A Visitor Registration list is attached and made part of these minutes. (Attachment I)

Representative Dockham, Chair, called the meeting to order at 1:25 pm. He introduced the pages and the Sergeant of Arms staff. (Attachment II) The following bill was considered:

SB 265, entitled, A BILL TO BE ENTITLED AN ACT TO MAKE APPROPRIATIONS AND ADJUSTMENTS FOR THE 2011-2013 FISCAL BIENNIUM TO THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES; AND TO TRANSFER THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES TO THE OFFICE OF STATE TREASURER.

Representative Dockham recognized Senator Apodaca, bill sponsor, to explain the Senate Committee Substitute for SB 265. Senator Apodaca presented an overview of the current condition of the State Health Plan, benefits the Plan presently provides, and the proposed changes. The State Health Plan offers medical insurance for 667,000 state workers, public school teachers and retirees. In 2008, the Plan experienced a financial meltdown going from a projected $50 million surplus to a $65 million and then to a projected $250 million shortfall. After the plan was audited, State Auditor Les Merritt called for oversight of the plan to be moved from the Legislature to an executive branch agency to avoid separation of powers issues and the potential for undue political influence. The same recommendation was also made in a 1994 audit. In both cases, neither recommendation was acted upon.

Currently, the Plan is facing over a half billion dollar shortfall. Taxpayers, State employees and retirees need to have their confidence restored, that the State Health Plan is being properly managed and that it is fiscally sound. This Senate Committee Substitute bill does both in a manner that tries to balance the needs of Plan members and the checkbook of taxpayers.

The Senate Committee Substitute for SB 256 moves governance of the State Health Plan from the Legislature to the State Treasurer's Office. In doing so the Senate Committee Substitute follows through on changes that have been recommended for over a decade and brings North Carolina in line with the majority of other states, most of which operate their state health plans under an executive branch agency.

This move would be effective January 1, 2012, giving the Treasurer time to prepare for managing the Plan. The Treasurer will have mediate authority to appoint an executive administrator since the current administrator is retiring. The Senate Committee Substitute puts the Plan on sound financial footing. The Committee Substitute calls for roughly $8 million in

general fund appropriations for FY 2011-12 and roughly $100 million in general fund appropriations for FY 2012-13. Similar to the Governor's proposal, the Legislature is asking Plan participants to help in this effort to stabilize the Plan by paying monthly premiums.

- Retirees would have premium-free coverage in the 70/30 plan. If retirees opt for an 80/20 plan they would pay a roughly $21 monthly premium. Medicare eligible retirees opting for an 80/20 plan would pay roughly $16.

- We were able to keep Co-pays for generic prescriptions at $10 – an improvement from the $15 necessitated by the Governor's proposal.

- The Committee Substitute removes the special exemption from the public records law for State Health Plan contracts and cleans up the statutes.

Representative Dockham recognized Ryan Blackledge, Bill Drafting Counsel, to explain the Senate Committee Substitute for SB 265 (Attachment III & IV) and Mark Trogdon, Fiscal Research Counsel, to explain the Actuary Note for SB 265 (Attachment V).

The Chair recognized Dr. Jack W. Walker, Ph.D., Executive Administrator of the NC State Health Plan for Teachers and State Employees. Dr. Walker stated that SB 265 was well-written and that he is looking forward to his retirement in June.

Ardis Watkins, Director, Legislative Affairs, State Employees Association of NC (SEANC) specified that even though this legislation gets SEANC members that much closer to accomplishing their number one legislative priority for this session, moving oversight of the State Health Plan (SHP) away from the General Assembly and into a government agency, the bill's inclusion of health care premiums is giving a lot of people mixed feelings. SEANC has always opposed unfair cost-shifting to state employees, but in its totality, this bill is a huge step forward. The positive reform in this bill is overwhelming and will, for the first time, give state employees, retirees and taxpayers more control over the future of the SHP.

Wanda Caldwell, Ed.S., Pam Deardorff, NC Retired School Personnel, Ed Regan, NC Retired Governmental Employees Association, Brian Lewis, NC Association of Educators, Evelyn Hawthorne, Professional Educators of NC, spoke very strongly in opposition of the initiation of premiums to be paid by active and retired State employees.

After a lengthy discussion Representative Brubaker moved for a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations. The motion passed.

There being no further business, the Chair adjourned the meeting at 2:45 pm.

Respectfully submitted,

Representative Jerry C. Dockham, Chair

Regina Irwin, Committee Assistant

Attachments

AGENDA

HOUSE COMMITTEE ON INSURANCE

March 29, 2011

Room 1228

1:00 pm

OPENING REMARKS

Representative Jerry Dockham, Chairman
Insurance Committee

AGENDA ITEMS

SB 265 STATE HEALTH PLAN/APPROPRIATIONS AND TRANSFER.
Senator Tom Apodaca, Sponsor
Senator Peter S. Brunstetter, Sponsor
Senator Fletcher L. Hartsell, Jr., Sponsor

ADJOURNMENT

ATTACHMENT I

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

MARCH 29, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Starling	DST
Carl Havell	DST
Josiane Laumann	Retired
Faye Powell	Retired
Forrest Gilliam	Governor's Office
[illegible]	NMRS
Jennifer Cohen	IFNC
John Bowdish	AstraZeneca
Barbara Canales	BCCA
Christine Cray	WakeMed
Martha McConnell	Carolinas HealthCare Sys
Mimi Wilding	Novant

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

MARCH 29, 2011
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amy Whited	NCMS
Linda Dunlap	NCAE
Brian Lewis	NCAE
Marge Forcman	NCAE
Carol Durrell	State Health Plan
Jack Walker	State Health Plan
Lacey Barnes	"
Mona Moon	SHP
Solari	DST
Andrea Holton	DST
Jason Sheffield	DST

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

MARCH 29, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ed [illegible]	[illegible]
Matt Harrell	NCSBA
Barry Braswell Jr	NC Retired School Personnel
Ed Regan	NC Retired Govt'l Employees Assoc.
Katherine Joyce	NC ASA
Jaime King	NCEL
[illegible]	Smith Anderson
J Peacock	WFU
Matt [illegible]	NCRMSE
[illegible]	NMC
[illegible]	NCMA

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

MARCH 29, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Michael Houser	NC DOR
T. Stephenson	SHP
Anne Rogers	SHP
Vicky Rogers	NCRSP
Vera Taylor	NCRSP
Pam Deardorff	NCRSP
Wanda Caldwell	retired teacher
[illegible]	Duke
Kathryn W Miller	BCBSNC
Sara Fender	IFNC
Sherman McCoy	Nationwide
Ardis Watkins	SEANC
Suzanne Bogley	SEANC
Chuck Stone	SEANC
Mitch Leonard	SEANC

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

MARCH 29, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jane Hill	Harnett County Democratic Women
Loretta Martin	" "
Kay Emanuel	Legislative Reporting Services
Leanne Winner	NCSBA
Cheryl Posner-Cahill	NC School Bych Assoc
[illegible]	BCBSNC
Heather Barrett	Williams Mullen
Keri Bunce	NWC
BJ Miller	Moses Cone
Andy Ellen	NCHA
Chris Valauri	Valauri Group LLC

VISITOR REGISTRATION SHEET

" INSURANCE — MARCH 29, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

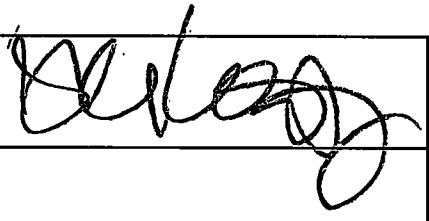
NAME	FIRM OR AGENCY AND ADDRESS
Adam Linker	NC Justice Center
Carl Dean	DSP
Joanne Stevens	Stevens Lobby & Consulting
Evelyn Hawthorne	DOR
Mark Fleming	BCBSNC
DAVID BARNES	PSG
Scott Coster	NCRHC

VISITOR REGISTRATION SHEET

INSURANCE — MARCH 29, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	NRS

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

MARCH 29, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
MIKE ADAMS	VCTIA

PLEASE PRINT

ATTACHMENT II

HOUSE PAGES

NAME OF COMMITTEE: INSURANCE **DATE:** MARCH 29, 2011

1. NAME: Mae Shelley
   County: Cabarrus
   Sponsor: Ken Goodman
2. NAME: Kimberly Bryan
   County: Wake
   Sponsor: Howard
3. NAME: Oriana McConnell
   County: Forsyth
   Sponsor: Larry Womble
4. NAME:
   County:
   Sponsor:
5. NAME:
   County:
   Sponsor:

SERGEANTS-AT-ARMS

1. Name: Marth Gadison
2. Name: Reggie Sills
3. Name: Garland Shephead
4. Name:
5: Name:

2011 COMMITTEE REPORT

HOUSE OF REPRESENTATIVES

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

By Representative Dockham (Chair) for the Committee on INSURANCE.

☒Committee Substitute #2 for

SB 265 A BILL TO BE ENTITLED AN ACT TO MAKE APPROPRIATIONS AND ADJUSTMENTS FOR THE 2011-2013 FISCAL BIENNIUM TO THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES; AND TO TRANSFER THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES TO THE OFFICE OF STATE TREASURER.

☒ 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 III

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S 3

SENATE BILL 265
Insurance Committee Substitute Adopted 3/22/11
Appropriations/Base Budget Committee Substitute Adopted 3/23/11

Short Title: State Health Plan/Appropriations and Transfer. (Public)

Sponsors:

Referred to:

March 9, 2011

A BILL TO BE ENTITLED

AN ACT TO MAKE APPROPRIATIONS AND ADJUSTMENTS FOR THE 2011-2013 FISCAL BIENNIUM TO THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES; AND TO TRANSFER THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES TO THE OFFICE OF STATE TREASURER.

The General Assembly of North Carolina enacts:

PART I. APPROPRIATIONS AND CONTRIBUTIONS FOR 2011-2013 FISCAL BIENNIUM

APPROPRIATIONS FROM GENERAL FUND AND HIGHWAY FUND

SECTION 1.1.(a) General Fund Appropriation. – 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 eight million sixty-one thousand seven hundred ninety-eight dollars ($8,061,798) for the 2011-2012 fiscal year and the sum of one hundred one million seven hundred eighty-two thousand six hundred seventy dollars ($101,782,670) for the 2012-2013 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2011-2013 fiscal biennium.

SECTION 1.1.(b) Highway Fund Appropriation. – 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 three hundred seventy-six thousand two hundred seventeen dollars ($376,217) for the 2011-2012 fiscal year and the sum of four million seven hundred forty-nine thousand eight hundred fifty-eight dollars ($4,749,858) for the 2012-2013 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2011-2013 fiscal biennium.

SECTION 1.1.(c) All other agency funds required to fund the premium increase enacted in this act, other than funds appropriated in subsections (a) and (b) of this section, are appropriated for the 2011-2013 fiscal biennium.

PREMIUM ADJUSTMENTS

SECTION 1.2.(a) Partially Contributory Coverage. – Employee and retiree monthly premium rates for partially contributory coverage under G.S. 135-45.2(a1), as enacted by Section 1.6 of this act, and established in accordance with G.S. 135-44.6, as enacted by this act, shall be as follows for the 2011-2012 and 2012-2013 fiscal years:

	FY 2011-2012	FY 2012-2013

	Basic	Standard	Basic	Standard
Employee Contribution	$10.86	$21.72	$11.43	$22.85
Retiree Contribution				
Non-Medicare Eligible	$0.00	$21.72	$0.00	$22.85
Medicare Eligible	$0.00	$16.72	$0.00	$17.59

SECTION 1.2.(b) Contributory Coverage. – Premium rates for contributory coverage established in accordance with G.S. 135-44.6 shall be increased by five and two-tenths percent (5.2%) for contributory coverage for the 2011-2012 fiscal year and shall be increased by an additional five and two-tenths percent (5.2%) over the premium rate for contributory coverage for the 2012-2013 fiscal year.

DEDUCTIBLE, COINSURANCE, AND CO-PAYMENT ADJUSTMENTS

SECTION 1.3.(a) Effective July 1, 2011, 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 nine hundred thirty-three dollars ($933.00) for member-only coverage and to one thousand eight hundred sixty-six dollars ($1,866) 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 seven hundred ninety-three dollars ($3,793) for member-only coverage and to seven thousand five hundred eighty-six dollars ($7,586) 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 eighty-seven dollars ($87.00) per covered individual.

d. Increase the in-network primary care co-payment to thirty-five dollars ($35.00) per covered individual.

e. Increase the in-network specialist co-payment to eighty-one dollars ($81.00) per covered individual, except that for mental health and substance abuse services, chiropractic services, and physical therapy, occupational therapy, and speech therapy services, the in-network specialist co-payment shall be sixty-four dollars ($64.00) per covered individual.

f. Increase the in-network and out-of-network inpatient co-payment to two hundred ninety-one dollars ($291.00) per covered individual.

g. Increase the in-network and out-of-network emergency room co-payment to two hundred ninety-one dollars ($291.00) per covered individual.

h. Increase prescription drug co-payments as required under G.S. 135-45.6(b)(1) as amended by this section.

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 2010-2011 benefit year.

(2) Standard Plan (80/20):

a. Increase the in-network annual deductible to seven hundred dollars ($700.00) for member-only coverage and to one thousand four hundred dollars ($1,400) 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 three thousand two hundred ten dollars ($3,210) for member-only coverage and to six thousand four hundred twenty dollars ($6,420) 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 eighty-seven dollars ($87.00) per covered individual.

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

e. Increase the in-network specialist co-payment to seventy dollars ($70.00) per covered individual, except that for mental health and substance abuse services, chiropractic services, and physical therapy, occupational therapy, and speech therapy services, the in-network specialist co-payment shall be fifty-two dollars ($52.00) per covered individual.

f. Increase the in-network and out-of-network inpatient co-payment to two hundred thirty-three dollars ($233.00) per covered individual.

g. Increase the in-network and out-of-network emergency room co-payment to two hundred thirty-three dollars ($233.00) per covered individual.

h. Increase prescription drug co-pays as required under G.S. 135-45.6(b)(1) as amended by this act.

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 2010-2011 benefit year.

SECTION 1.3.(b) G.S. 135-45.6(b)(1) reads as rewritten:

"(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 five dollars ($35.00)~~ forty dollars ($40.00) for each preferred branded prescription without a generic equivalent, and ~~fifty five dollars ($55.00)~~ sixty-four dollars ($64.00) for each nonpreferred branded 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."

LIMITATION ON AUTHORITY TO CHANGE BENEFITS

SECTION 1.4. 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, 2009,~~ July 1, 2011, that would result in a net increased cost to the Plan or in a reduction in benefits to Plan members unless and until the proposed changes are directed to be made in an act of the General Assembly."

REPEAL COMPREHENSIVE WELLNESS INITIATIVE

SECTION 1.5. Section 2(b) of S.L. 2009-16, as amended by S.L. 2009-571, is repealed.

IMPLEMENT MONTHLY CONTRIBUTION BY EMPLOYEES AND CERTAIN RETIREES

SECTION 1.6.(a) G.S. 135-45(b) reads as rewritten:

"(b) Individuals eligible for coverage under G.S. 135-45.2 on a ~~fully or partially~~ partially, one-half, or fully contributory basis are eligible to participate in any plan authorized under this section."

SECTION 1.6.(b) G.S. 135-45.2 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:

~~(1) All permanent full-time employees of an employing unit who meet the following conditions:~~

~~a. Paid from general or special State funds, or~~

~~b. Paid from non-State funds and in a group for which his or her employing unit has agreed to provide coverage.~~

~~Employees of State agencies, departments, institutions, boards, and commissions not otherwise covered by the Plan who are employed in permanent job positions on a recurring basis and who work 30 or more hours per week for nine or more months per calendar year are covered by the provisions of this subdivision.~~

~~(2) Permanent hourly employees as defined in G.S. 126-5(c4) who work at least one-half of the workdays of each pay period.~~

(3) Retired teachers, State employees, members of the General Assembly, and retired State law enforcement officers who retired under the Law Enforcement Officers' Retirement System prior to January 1, 1985. Except as otherwise provided in this subdivision, on and after January 1, 1988, a retiring employee or retiree must have completed at least five years of contributory retirement service with an employing unit prior to retirement from any State-supported retirement system in order to be eligible for group benefits under this Part as a retired employee or retiree. For employees first hired on and after October 1, 2006, and members of the General Assembly first taking office on and after February 1, 2007, future coverage as retired employees and retired members of the General Assembly is subject to a requirement that the future retiree have 20 or more years of retirement service credit in order to be covered by the provisions of this subdivision.

(4) Surviving spouses of:

a. Deceased retired employees, provided the death of the former plan member occurred prior to October 1, 1986; and

b. Deceased teachers, State employees, and members of the General Assembly who are receiving a survivor's alternate benefit under any

of the State-supported retirement programs, provided the death of the former plan member occurred prior to October 1, 1986.

~~(5) Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except for legislative interns and pages.~~

~~(6) Members of the General Assembly.~~

~~(7) Notwithstanding the provisions of subsection (c) of this section, employees on official leave of absence while completing a full-time program in school administration in an approved program as a Principal Fellow in accordance with Article 5C of Chapter 116 of the General Statutes.~~

~~(8) Notwithstanding the provisions of 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, 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. An employee formerly covered by the provisions of this section shall not be eligible for coverage under this subdivision if the employee is provided health benefit coverage on a non-contributory basis by a subsequent employer.~~

~~(9) Any member enrolled pursuant to subdivision (1) or (2) of this subsection who is on approved leave of absence with pay or receiving workers' compensation.~~

~~(10) Employees on approved Family and Medical Leave.~~

(a1) Partially Contributory Coverage. – The following persons are eligible for coverage under the Plan, on a partially contributory basis, subject to the provisions of G.S. 135-45.4:

(1) All permanent full-time employees of an employing unit who meet either of the following conditions:

a. Paid from general or special State funds.

b. Paid from non-State funds and in a group for which his or her employing unit has agreed to provide coverage.

Employees of State agencies, departments, institutions, boards, and commissions not otherwise covered by the Plan who are employed in permanent job positions on a recurring basis and who work 30 or more hours per week for nine or more months per calendar year are covered by the provisions of this subdivision.

(2) Permanent hourly employees who work at least one-half of the workdays of each pay period.

(3) Retired teachers, State employees, members of the General Assembly, and retired State law enforcement officers who retired under the Law Enforcement Officers' Retirement System prior to January 1, 1985. Except as otherwise provided in this subdivision, on and after January 1, 1988, a retiring employee or retiree must have completed at least five years of contributory retirement service with an employing unit prior to retirement from any State-supported retirement system in order to be eligible for group benefits under this Part as a retired employee or retiree. For employees first hired on and after October 1, 2006, and members of the General Assembly

first taking office on and after February 1, 2007, future coverage as retired employees and retired members of the General Assembly is subject to a requirement that the future retiree have 20 or more years of retirement service credit in order to be covered by the provisions of this subdivision.

(4) Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except for legislative interns and pages.

(5) Members of the General Assembly.

(6) Notwithstanding the provisions of subsection (e) of this section, employees on official leave of absence while completing a full-time program in school administration in an approved program as a Principal Fellow in accordance with Article 5C of Chapter 116 of the General Statutes.

(7) Notwithstanding the provisions of G.S. 135-45.12, employees formerly covered by the provisions of this subsection, other than retired employees, who have been employed for 12 or more months by an employing 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. An employee formerly covered by the provisions of this subsection shall not be eligible for coverage under this subdivision if the employee is provided health benefit coverage on a noncontributory basis by a subsequent employer.

(8) Any member enrolled pursuant to subdivision (1) or (2) of this subsection who is on approved leave of absence with pay or receiving workers' compensation.

(9) Employees on approved Family and Medical Leave.

(b) ~~Partially Contributory.~~ One-Half Contributory Coverage. – The following persons are eligible for coverage under the ~~Plan~~ Plan, on a ~~partially~~ one-half contributory ~~basis~~ basis, subject to the provisions of G.S. 135-45.4:

(1) A school employee in a job-sharing position as ~~defined in G.S. 135-45.4.~~ described in G.S. 115C-326.5. If these employees elect to participate in the Plan, the employing unit shall pay fifty percent (50%) of the Plan's total ~~noncontributory~~ employer premiums. Individual employees shall pay the balance of the total ~~noncontributory~~ premiums not paid by the employing unit.

(2) ~~Subject to the provisions of G.S. 135-45.4, employees~~ Employees and members of the General Assembly with 10 but less than 20 years of retirement service credit provided the employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007. For such future retirees, the State shall pay fifty percent (50%) of the Plan's total ~~noncontributory~~ employer premiums. Individual retirees shall pay the balance of the total ~~noncontributory~~ premiums not paid by the State.

(c) Fully ~~Contributory.~~ Contributory Coverage. – The following ~~person~~ persons shall be eligible for coverage under the Plan, on a fully contributory basis, subject to the provisions of G.S. 135-45.4:

(1) Former members of the General Assembly who enroll before October 1, 1986.

(2) For enrollments after September 30, 1986, former members of the General Assembly if covered under the Plan at termination of membership in the General Assembly. To be eligible for coverage as a former member of the General Assembly, application must be made within 30 days of the end of the term of office. Only members of the General Assembly covered by the Plan at the end of the term of office are eligible. If application is not made within the specified time period, the member forfeits eligibility.

(3) Surviving spouses of deceased former members of the General Assembly who enroll before October 1, 1986.

(4) Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except for legislative interns and pages.

(5) For enrollments after September 30, 1986, surviving spouses of deceased former members of the General Assembly, if covered under the Plan at the time of death of the former member of the General Assembly.

(6) All permanent part-time employees (designated as half-time or more) of an employing unit who ~~meets~~ meet the conditions outlined in ~~subdivision (a)(1)a. above,~~ sub-subdivision (a1)(1)a. of this section and who are not covered by the provisions of ~~G.S. 135-45.2(a)(1).~~ subdivision (a1)(1) of this section.

(7) The spouses and eligible dependent children of enrolled teachers, State employees, retirees, former members of the General Assembly, former employees covered by the provisions of ~~G.S. 135-45.2(a)(8),~~ former subdivision (a)(8) or subdivision (a1)(7) of this section, Disability Income Plan beneficiaries, enrolled continuation members, and members of the General Assembly. Spouses of surviving dependents are not eligible, nor are dependent children if they were not covered at the time of the member's death. Surviving spouses may cover their dependent children provided the children were enrolled at the time of the member's death or enroll within 90 days of the member's death.

(8) Blind persons licensed by the State to operate vending facilities under contract with the Department of Health and Human Services, Division of Services for the Blind and its successors, who are:

a. Operating such a vending facility;

b. Former operators of such a vending facility whose service as an operator would have made these operators eligible for an early or service retirement allowance under Article 1 of this Chapter had they been members of the Retirement System; and

c. Former operators of such a vending facility who attain five or more years of service as operators and who become eligible for and receive a disability benefit under the Social Security Act upon cessation of service as an operator.

Spouses, dependent children, surviving spouses, and surviving dependent children of such members are not eligible for coverage.

(9) Surviving spouses of deceased retirees and surviving spouses of deceased teachers, State employees, and members of the General Assembly provided the death of the former Plan member occurred after September 30, 1986, and the surviving spouse was covered under the Plan at the time of death.

(10) Any eligible dependent child of the deceased retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary, provided the child was

covered at the time of death of the retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary, (or was in posse at the time and is covered at birth under this Part), or was covered under the Plan on September 30, 1986. An eligible surviving dependent child can remain covered until ~~age 19, or~~ age 26 ~~if a full-time student,~~ or indefinitely if certified as incapacitated under ~~G.S. 135-45.1(5)b.~~ G.S. 135-45.2(d).

(11) Retired teachers, State employees, and members of the General Assembly with less than 10 years of retirement service credit, provided the teachers and State employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007.

(12) Notwithstanding the provisions of G.S. 135-45.12 former employees covered by the provisions of ~~G.S. 135-45.2~~ this section and their spouses and eligible dependent children who were covered by the Plan at the time of the former employees' separation from service pursuant to ~~G.S. 135-45.2,~~ this section, following expiration of the former employees' coverage provided by ~~G.S. 135-45.2.~~ this section. Election of coverage under this subdivision shall be made within 90 days after the termination of coverage provided under ~~G.S. 135-45.2.~~ this section.

(13) Firefighters, rescue squad workers, and members of the National Guard, their eligible spouses, and eligible dependent children.

...."

ALLOW COVERAGE FOR CHILDREN UP TO 26 YEARS OLD, IN COMPLIANCE WITH FEDERAL AFFORDABLE CARE ACT

SECTION 1.7.(a) G.S. 135-45.1(10) reads as rewritten:

"(10) Dependent child. – Subject to the eligibility requirements of G.S. 135-45.2(d), any of the following:

a. A ~~natural,~~ natural or legally ~~adopted, or foster~~ adopted child or children of the employee ~~and or spouse, unmarried,~~ up to the first of the month following ~~his or her 19th~~ the child's 26th 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.~~ employee.

b. A foster child or children of the employee up to the first month following the child's 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for the child's maintenance and support.

c. ~~Dependent child also includes a~~ 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.

d. ~~Dependent child also includes a~~ A stepchild ~~of the member~~ who primarily resides with a 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.~~

e. ~~Dependent child shall also include any~~ Any child under age 19 who has reached his or her 18th birthday, provided the employee was legally responsible for ~~such~~ the child's maintenance and support on his or her 18th birthday. ~~Dependent~~

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 1.7.(b) 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~~ 26th birthday ~~under the following conditions:~~

~~(1) If the dependent is a full-time student, through the end of the month following the student's 26th 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 or injury 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 or injury.~~

~~(2)~~ ~~The~~ if 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.~~ G.S. 135-45.2(c)(7)."

SALARY-RELATED CONTRIBUTIONS

SECTION 1.8.(a) Effective for the 2011-2013 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, as defined in G.S. 135-45.1 or in G.S. 135-48.1 as enacted by this act, 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 1.8.(b) Effective July 1, 2011, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2011-2012 fiscal year are: (i) ten and sixty-one hundredths percent (10.61%) – Teachers and State Employees; (ii) fifteen and sixty-one hundredths percent (15.61%) – State Law Enforcement Officers; (iii) twelve and thirty-six hundredths percent (12.36%) – University Employees' Optional Retirement System; (iv) twelve and thirty-six hundredths percent (12.36%) – Community College Optional Retirement Program; (v) twenty and eleven hundredths percent (20.11%) – Consolidated Judicial Retirement System; and (vi) five and zero hundredths percent (5.00%) – Legislative Retirement System. Each of the foregoing contribution rates includes five and zero hundredths percent (5.00%) 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 1.8.(c) Effective July 1, 2012, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2012-2013 fiscal year are: (i) ten and ninety-one hundredths percent (10.91%) – Teachers and State Employees; (ii) fifteen and ninety-one hundredths percent (15.91%) – State Law Enforcement Officers; (iii) twelve and sixty-six hundredths percent (12.66%) – University Employees' Optional Retirement System; (iv) twelve and sixty-six hundredths percent (12.66%) – Community College Optional Retirement Program; (v) twenty and forty-one hundredths percent (20.41%) – Consolidated Judicial Retirement System; and (vi) five and thirty hundredths percent (5.30%) – Legislative Retirement System. Each of the foregoing contribution rates includes five and thirty hundredths percent (5.30%) 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 1.8.(d) Effective July 1, 2011, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2011-2012 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand seven hundred sixty-eight dollars ($3,768) and (ii) non-Medicare-eligible employees and retirees – four thousand nine hundred fifty-two dollars ($4,952).

SECTION 1.8.(e) Effective July 1, 2012, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2012-2013 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand nine hundred sixty-five dollars ($3,965) and (ii) non-Medicare-eligible employees and retirees – five thousand two hundred eleven dollars ($5,211).

REMOVE SPECIAL EXEMPTION FROM PUBLIC RECORDS LAW FOR STATE HEALTH PLAN CONTRACTS

SECTION 1.9.(a) 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 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~~ Statutes. No provision of law, however, shall ~~not~~ be construed to prevent or restrict the release of any information ~~made not a public record under this subsection~~ in a Plan contract to the State Auditor, the Attorney General, the Director of the State Budget, the Plan's Executive Administrator, and 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 Article 3 of Chapter 143 of the General Statutes. However, the Executive Administrator and Board of Trustees shall: (i) submit all proposed statewide and agency term contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subsection to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all proposed contracts to be awarded by the Executive Administrator and Board of Trustees under this section a standard clause which provides that the State Auditor and internal auditors of the Plan may audit the records of the contractor during the term of the contract to verify accounts and data affecting fees and performance. The Executive Administrator and Board of Trustees shall not award a cost plus percentage of cost agreement or contract for any purpose. 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 1.9.(b) Contracts with the State Health Plan retain the trade secret protections provided under G.S. 132-1.2.

SECTION 1.9.(c) This section is effective when it becomes law.

EFFECTIVE DATE FOR PART I

SECTION 1.10. Except as otherwise provided, Part I of this act becomes effective July 1, 2011.

PART II. TRANSFER STATE HEALTH PLAN TO DEPARTMENT OF STATE TREASURER

GRANT STATE TREASURER IMMEDIATE AUTHORITY TO APPOINT EXECUTIVE ADMINISTRATOR

SECTION 2.1.(a) G.S. 135-44.2(b) reads as rewritten:

"(b) The Executive Administrator shall be appointed by the ~~State Health Plan Administrative Commission.~~ State Treasurer. 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.~~ State Treasurer after consultation with the Board of Trustees.

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,~~ State Treasurer after consultation with the Board of Trustees, 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.~~ State Treasurer."

SECTION 2.1.(b) The State Treasurer shall have the power to designate an interim Executive Administrator prior to appointing an Executive Administrator under this section.

SECTION 2.1.(c) This section is effective when it becomes law.

TRANSFER OF STATE HEALTH PLAN WITHIN STATE GOVERNMENT

SECTION 2.2. The North Carolina State Health Plan for Teachers and State Employees is transferred to the Department of State Treasurer. This transfer shall have all the elements of a Type II transfer, as defined by G.S. 143A-6.

STATUTORY FRAMEWORK FOR AMENDED STATE HEALTH PLAN STATUTE

SECTION 2.3.(a) The title of Chapter 135 of the General Statutes reads as rewritten:

"**Chapter 135.**

Retirement System for Teachers and State Employees; Social Security; ~~Health Insurance Program for Children.~~ State Health Plan for Teachers and State Employees."

SECTION 2.3.(b) Chapter 135 of the General Statutes is amended by adding a new Article 3B to be entitled "State Health Plan for Teachers and State Employees; Long-Term Care Benefits." That new Article shall be divided into six parts, as follows:

(1) "Part 1. General Provisions."
(2) "Part 2. Administrative Structure."
(3) "Part 3. Plan Operation."
(4) "Part 4. Eligibility and Enrollment."
(5) "Part 5. Coverage Mandates and Exclusions; Other Mandates."
(6) "Part 6. Long-Term Care Benefits."

RECODIFY PORTIONS OF PART 1 OF EXISTING STATE HEALTH PLAN ARTICLE

SECTION 2.4.(a) Subsections (a) and (b) of G.S. 135-43, as amended by Section 1.9 of this act, [confidentiality] are recodified as G.S. 135-48.10 under Part 1 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act. Subsection (c) of G.S. 135-43 is recodified as G.S. 135-48.57, to be entitled "Payments for county or city ambulance service.", under Part 5 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.4.(b) G.S. 135-43.4 [Committee on Actuarial Valuation] is recodified as G.S. 135-48.12 under Part 1 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.4.(c) G.S. 135-43.5 [auditing the Plan] is recodified as G.S. 135-48.28 under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.4.(d) G.S. 135-43.6 [reports to General Assembly] is recodified as G.S. 135-48.27 under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.4.(e) G.S. 135-43.7 [contract disputes] is recodified as G.S. 135-48.35 under Part 3 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

RECODIFY PORTIONS OF PART 2 OF EXISTING STATE HEALTH PLAN ARTICLE

SECTION 2.5.(a) G.S. 135-44 [Board of Trustees] is recodified as G.S. 135-48.20 under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.5.(b) G.S. 135-44.1 [officers, quorum, meetings] is recodified as G.S. 135-48.21 under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.5.(c) G.S. 135-44.2, as amended by Section 2.1 of this act, [Executive Administrator] is recodified as G.S. 135-48.23 under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.5.(d) Subdivision (26) of G.S. 135-44.4 [member education] is recodified as G.S. 135-48.56, to be entitled "Education of covered active and retired employees.", under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.5.(e) G.S. 135-44.5 [trust funds] is recodified as G.S. 135-48.5 under Part 1 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.5.(f) G.S. 135-44.6(d) [firefighter premiums] is recodified as G.S. 135-48.58, to be entitled "Premiums for firefighters, rescue squad workers, and members of National Guard.", under Part 5 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act. G.S. 135-44.6(e) [interest on late payments] is recodified as G.S. 135-48.55, to be entitled "Interest charged to charter schools on late premiums.", under Part 5 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.5.(g) G.S. 135-44.7 [administrative review] is recodified as G.S. 135-48.24 under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.5.(h) G.S. 135-44.8 [rules] is recodified as G.S. 135-48.25 under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

RECODIFY PORTIONS OF PART 3 OF EXISTING STATE HEALTH PLAN ARTICLE

SECTION 2.6.(a) Subsections (a) and (e) of G.S. 135-45 [undertaking] are recodified as subsections (a) and (b) of G.S. 135-48.2 under Part 1 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act. G.S. 135-45(c) [firefighter coverage in public interest] is recodified as G.S. 135-48.8, to be entitled "Statements of public interest.", under Part 1 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act. Subsection (d) of G.S. 135-45 [contracts with claim processors] is recodified as G.S. 135-48.32, to be entitled "Contracts to provide benefits.", under Part 3 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act. Subsection (d1) of G.S. 135-45 [contracting provisions] is recodified as G.S. 135-48.33, to be entitled "Contracting provisions; large contract review by Attorney General, auditing, no cost plus contracts.", under Part 3 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.6.(b) G.S. 135-45.1 [definitions] is recodified as G.S. 135-48.1 under Part 1 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.6.(c) Subsections (a), (a1), (b), and (c) of G.S. 135-45.2 [eligibility categories] are recodified as subsections (a), (b), (c), and (d) in G.S. 135-48.40, to be entitled "Categories of eligibility.", under Part 4 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act. Subsections (d), (e), (f), (g), (h), (i), (j), and (k) of G.S. 135-45.2 [other eligibility rules] are recodified as subsections (a), (c), (d), (e), (f), (g), (h), and (i) of G.S. 135-48.41, to be entitled "Additional eligibility provisions.", under Part 4 of Article 3B of Chapter 135 of the General Statues, as created by Section 2.3 of this act.

SECTION 2.6.(d) G.S. 135-45.3 [enrollment] is recodified as G.S. 135-48.42 under Part 4 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.6.(e) G.S. 135-45.4 [effective dates of coverage] is recodified as G.S. 135-48.43 under Part 4 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.6.(f) G.S. 135-45.5 [charter schools' participation] is recodified as G.S. 135-48.54 under Part 5 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.6.(g) G.S. 135-45.10 [Medicare] is recodified as G.S. 135-48.38 under Part 3 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.6.(h) G.S. 135-45.12 [cessation of coverage] is recodified as G.S. 135-48.44 under Part 4 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.6.(i) G.S. 135-45.13 [conversion] is recodified as G.S. 135-48.45 under Part 4 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.6.(j) G.S. 135-45.15 [subrogation] is recodified as G.S. 135-48.37 under Part 3 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.6.(k) G.S. 135-45.16 [right to amend] is recodified as G.S. 135-48.3 under Part 1 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

RECODIFY PART 4 OF EXISTING STATE HEALTH PLAN ARTICLE

SECTION 2.7. G.S. 135-46 through G.S. 135-46.2 [long-term care] are recodified as G.S. 135-48.60 through G.S. 135-48.62 under Part 5 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

PLACE CHILD HEALTH INSURANCE FUND ESTABLISHMENT IN CHILD HEALTH INSURANCE PROGRAM STATUTES

SECTION 2.8. G.S. 135-47.2 [child health insurance fund] is recodified as G.S. 108A-70.20A.

REPEAL STATE HEALTH PLAN SECTIONS NOT RECODIFIED BY THIS PART

SECTION 2.9. Article 3A of Chapter 135 of the General Statutes is repealed.

REWRITE STATE HEALTH PLAN STATUTE

SECTION 2.10. Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act and as amended by Sections 1.6, 1.7, 2.1, 2.4, 2.5, 2.6, and 2.7 of this act, reads as rewritten:

"Article 3B.

"State Health Plan for Teachers and State Employees; Long-term Care Benefits.

"Part 1. General Provisions.

"§ 135-48.1. General definitions.

As used in this Article unless the context clearly requires otherwise, the following definitions apply:

~~(1) Allowed amount. – The charge that the Plan or its claims processors determines is reasonable for covered services provided to a Plan member. This amount may be established in accordance with an agreement between the provider and the Plan or its claims processor. In the case of providers that have not entered into an agreement with the Plan or its claims processor, the allowed amount will be the lesser of the provider's actual charge or a reasonable charge established by the Plan or its claims processor using a methodology that is applied to comparable providers for similar services under a similar health benefit plan.~~

~~(2)~~(1) Benefit period. – The period of time during which charges for covered services provided to a Plan member must be incurred in order to be eligible for payment by the Plan.

~~(3)~~(2) Chemical dependency. – The pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

~~(4)~~(3) Claims Processor. – One or more administrators, third-party administrators, or other parties contracting with the Plan to administer Plan benefits.

~~(5) Clinical trials. – Patient research studies designed to evaluate new treatments, including prescription drugs. Coverage for clinical trials shall be as provided in G.S. 135-45.8.~~

~~(6)~~(4) Comprehensive health benefit plan. – Health care coverage that consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies, and equipment that are generally available in the health insurance market.

(5) Comprehensive group health benefit plan. – A comprehensive health benefit plan offered to an individual because of an employment, organizational, or other group affiliation.

~~(7)~~(6) Covered service; benefit; allowable expense. – Any medically necessary, reasonable, and customary items of service, including prescription drugs, and medical supplies included in the Plan.

~~(8)~~(7) Deductible. – The dollar amount that must be incurred for certain covered services in a benefit period before benefits are payable by the Plan.

~~The deductible applies separately to each covered individual in each fiscal year, subject to an aggregate maximum per employee and child, employee and spouse, or employee and family coverage contract in any fiscal year.~~

~~If two or more family members are injured in the same accident, only one deductible is required for charges related to that accident during the benefit period.~~

~~(9)~~(8) Dependent. – An eligible Plan member other than the subscriber.

~~(10)~~(9) Dependent child. – Subject to the eligibility requirements of ~~G.S. 135-45.2(d),~~ subsections (a) and (b) of G.S. 135-48.41, any of the following:

a. A natural or legally adopted child or children of the employee up to the first of the month following the child's 26th birthday, whether or not the child is living with the employee.

b. A foster child or children of the employee up to the first month following the child's 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for the child's maintenance and support.

c. 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.

d. A stepchild who primarily resides with a member who is married to the stepchild's natural parent.

e. Any child under age 19 who has reached his or her 18th birthday, provided the subscriber was legally responsible for the 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.~~

~~(11)~~(10) Employee or State employee. – Any permanent full-time or permanent part-time regular employee (designated as half-time or more) of an employing unit.

~~(12)~~(11) Employing Unit. – A North Carolina School System; Community College; State Department, Agency, or Institution; Administrative Office of the Courts; or Association or Examining Board whose employees are eligible for membership in a State-Supported Retirement System. An employing unit also shall mean a charter school in accordance with Part 6A of Chapter 115C of the General Statutes whose board of directors elects to become a participating employer in the Plan under ~~G.S. 135-45.5.~~ G.S. 135-48.54. Bona fide fire departments, rescue or emergency medical service squads, and National Guard units are deemed to be employing units for the purpose of providing benefits under this Article.

~~(13) Experimental/Investigational. – Experimental/Investigational Medical Procedures. The use of a service, supply, drug, or device not recognized as standard medical care for the condition, disease, illness, or injury being treated as determined by the Executive Administrator and Board of Trustees upon the advice of the Claims Processor.~~

~~(14)~~(12) Firefighter. – ~~Eligible firefighters as defined by G.S. 58-86-25 who belong to a bona fide fire department as defined by G.S. 58-86-25 and who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Firefighter shall also include members of the North Carolina Firemen and Rescue Squad Workers' Pension Fund who are in receipt of a monthly pension, who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage, and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Comprehensive group health~~

~~insurance and other benefit coverage consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies, and equipment that are generally available in the health insurance market. For purposes of this subdivision, comprehensive group health insurance and other benefit coverage includes Medicare benefits, CHAMPUS benefits, and other Uniformed Services benefits. North Carolina fire departments or their respective governing bodies shall certify the eligibility of their firefighters to the Plan for their participation in its benefits prior to enrollment.~~ A member of the group "eligible firemen" as defined in G.S. 58-86-25.

~~(15)~~(13) Health Benefits ~~Representative.~~ Representative or HBR. – The employee designated by the employing unit to administer the Plan for the unit and its employees. The HBR is responsible for enrolling new employees, reporting changes, explaining benefits, reconciling group statements, and remitting group fees. The State Retirement System is the Health Benefits Representative for retired State employees.

~~(16) Medical necessity or medically necessary. Covered services or supplies that are:~~

~~a. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials covered under the Plan, not for experimental, investigational, or cosmetic purposes.~~

~~b. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.~~

~~c. Within generally accepted standards of medical care in the community.~~

~~d. Not solely for the convenience of the Plan member, the Plan member's family, or the provider.~~

~~For medically necessary services, the Plan or its representative may compare the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered and in what setting medically necessary services are eligible for coverage.~~

~~(17) National Guard members. Members of the North Carolina Army and Air National Guard who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Members of the North Carolina Army and Air National Guard include those who are actively serving in the National Guard as well as former members of the National Guard who have completed 20 or more years of service in the National Guard but have not attained the minimum age to begin receipt of a uniformed service military retirement benefit. Comprehensive group health insurance and other benefit coverage consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies, and equipment that are generally available in the health insurance market. Comprehensive group health insurance and other benefit coverage includes Medicare benefits, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) benefits, and other Uniformed Services benefits. North Carolina National Guard units shall certify the eligibility of their members to the Plan for their participation in its benefits prior to enrollment.~~

~~(18) Optional alternative comprehensive benefit plans. – Comprehensive benefit plans administered by the Plan that differ in coverage, deductibles, coinsurance from the Standard Plan providing for 80/20 coinsurance, and that are alternative choices for coverage at the option of the Plan member.~~

~~(19)~~(14) Plan or State Health Plan. – The North Carolina State Health Plan for Teachers and State Employees. ~~Unless otherwise expressly provided,~~ Depending on the context, the term may refer to the entity created in G.S. 153-48.2 or to the health benefit plans offered by the entity, in which case "Plan" includes all comprehensive health benefit plans offered under the Plan.

~~(20)~~(15) Plan member. – A subscriber or dependent who is eligible and currently enrolled in the Plan and for whom a premium is paid.

~~(21) Plan year. – The period beginning July 1 and ending on June 30 of the succeeding calendar year.~~

~~(22)~~(16) Predecessor plan. – The Hospital and Medical Benefits for the Teachers' and State Employees' Retirement System of the State of North Carolina and the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan.

~~(23)~~(17) Rescue squad ~~workers.~~ worker. – ~~Eligible rescue squad workers as defined by the provisions of G.S. 58-86-30 who belong to a rescue or emergency medical services squad as defined by the same statute and who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Rescue squad workers shall also include members of the North Carolina Firemen and Rescue Squad Workers' Pension Fund who are in receipt of a monthly pension, who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage, and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Comprehensive group health insurance and other benefit coverage consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies, and equipment that are generally available in the health insurance market. For purposes of this subdivision, comprehensive group health insurance and other benefit coverage includes Medicare benefits, CHAMPUS benefits, and other Uniformed Services benefits. North Carolina rescue or emergency medical services squads or their respective governing bodies shall certify the eligibility of their rescue squad workers to the Plan for their participation in its benefits prior to enrollment.~~ An "eligible rescue squad worker" as defined in G.S. 58-86-30.

~~(24)~~(18) Retired employee (retiree). – Retired teachers, State employees, and members of the General Assembly who are receiving monthly retirement benefits from any retirement system supported in whole or in part by contributions of the State of North Carolina, so long as the retiree is enrolled.

~~(25)~~(19) Subscriber. – ~~A Plan member who is not a dependent.~~ A person who qualifies for coverage under the Plan under G.S. 135-48.40 as the primary insured.

~~(26)~~(20) Surviving spouse. – The spouse of a deceased ~~Plan member~~ subscriber who is eligible for Plan enrollment.

"**§ 135-48.2. Undertaking.**

(a) The State of North Carolina undertakes to make available a State Health Plan (hereinafter called the "Plan") exclusively for the benefit of eligible employees, eligible retired employees, and certain of their eligible dependents, which will pay benefits in accordance with the terms of this Article. The Plan shall have all the powers and privileges of a corporation and shall be known as the State Health Plan for Teachers and State Employees. The State Treasurer, Executive ~~Administrator~~ Administrator, and Board of Trustees shall carry out their duties and responsibilities as fiduciaries for the Plan. The Plan shall administer one or more group health plans that are comprehensive in ~~coverage and shall provide eligible employees and retired employees coverage on a noncontributory basis under at least one of the group plans with benefits equal to that specified in subsection (g) of this section.~~ coverage. The ~~Executive Administrator and Board of Trustees~~ State Treasurer may operate group plans as a preferred provider option, or health maintenance, point-of-service, or other organizational ~~arrangement and may offer the plans to employees and retirees on a noncontributory or partially contributory basis. Plans offered on a partially contributory basis must provide benefits that are additional to that specified in subsection (g) of this section and may not be offered unless approved in an act of the General Assembly.~~ arrangement.

(b) Payroll deduction shall be available for coverage under ~~this Part~~ the Plan for subscribers able to meet the Plan's requirements for payroll deduction.

"**§ 135-48.3. Right to amend.**

The General Assembly reserves the right to alter, amend, or repeal this Article.

"**§ 135-48.4: Reserved for future codification purposes.**

"**§ 135-48.5. Health benefit trust funds created.**

(a) There are hereby established two health benefit trust funds, to be known as the Public Employee Health Benefit Fund and the Health Benefit Reserve Fund for the payment of hospital and medical benefits. As used in this section, the term "health benefit trust funds" refers to the fund type described under G.S. 143C-1-3(a)(10).

All premiums, fees, charges, rebates, refunds or any other receipts including, but not limited to, earnings on investments, occurring or arising in connection with health benefits programs established by this Article, shall be deposited into the Public Employee Health Benefit Fund. Disbursements from the Fund shall include any and all amounts required to pay the benefits and administrative costs of such programs as may be determined by the Executive Administrator and Board of Trustees.

Any unencumbered balance in excess of prepaid premiums or charges in the Public Employee Health Benefit Fund at the end of each fiscal year shall be used first, to provide an actuarially determined Health Benefit Reserve Fund for incurred but unpresented claims, second, to reduce the premiums required in providing the benefits of the health benefits programs, and third to improve the plan, as may be provided by the General Assembly. The balance in the Health Benefits Reserve Fund may be transferred from time to time to the Public Employee Health Benefit Fund to provide for any deficiency occurring therein.

The Public Employee Health Benefit Fund and the Health Benefit Reserve Fund shall be deposited with the State Treasurer and invested as provided in G.S. 147-69.2 and 147-69.3.

(b) Disbursement from the Public Employee Health Benefit Fund may be made by warrant drawn on the State Treasurer by the Executive Administrator, or the Executive Administrator and Board of Trustees may by contract authorize the Claims Processors to draw the warrant.

(c) Separate and apart from the health benefit trust funds authorized by subsections (a) and (b) of this section, there shall be a Public Employee Long-Term Care Benefit Fund if the long-term care benefits provided by ~~Part 4~~ Part 5 of this Article are administered on a self-insured basis.

"**§§ 135-48.6 through 135-48.7: Reserved for future codification purposes.**

"**§ 135-48.8. Statements of public interest.**

The State of North Carolina deems it to be in the public interest for North Carolina firefighters, rescue squad workers, and members of the National Guard, and certain of their dependents, who are not eligible for any other type of comprehensive group health insurance or other comprehensive group health benefits, and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six consecutive months, to be given the opportunity to participate in the benefits provided by the State Health Plan for Teachers and State Employees. Coverage under the Plan shall be voluntary for eligible firefighters, rescue squad workers, and members of the National Guard who elect participation in the Plan for themselves and their eligible dependents.

"**§ 135-48.9: Reserved for future codification purposes.**

"**§ 135-48.10. Confidentiality of information and medical records; provider contracts.**

(a) Any information ~~as herein~~ described in this section ~~which~~ that 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~~ This information ~~may~~ may, however, be released to 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~~ State Treasurer. 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.

(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~~ 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 under Chapter 132 of the General Statutes. No provision of law, however, shall be construed to prevent or restrict the release of any information in a Plan contract to the State Treasurer, 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. However, the Executive Administrator and Board of Trustees shall: (i) submit all proposed statewide and agency term contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subsection to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all proposed contracts to be awarded by the Executive Administrator and Board of Trustees under this section a standard clause which provides that~~

~~the State Auditor and internal auditors of the Plan may audit the records of the contractor during the term of the contract to verify accounts and data affecting fees and performance. The Executive Administrator and Board of Trustees shall not award a cost-plus-percentage-of-cost agreement or contract for any purpose. 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.~~ responsibilities.

"**§ 135-48.11: Reserved for future codification purposes.**

"**§ 135-48.12. Committee on Actuarial Valuation of Retired Employees' Health Benefits.**

(a) There is established the Committee on Actuarial Valuation of Retired Employees' Health Benefits. The Committee shall be responsible for collecting data and reviewing assumptions for the sole purpose of conducting required actuarial valuations of State supported retired employees' health benefits under other post-employment benefit accounting standards set forth by the Governmental Accounting Standards Board of the Financial Accounting Foundation.

(b) The Committee on Actuarial Valuation of Retired Employees' Health Benefits shall consist of five members serving ex officio, as follows:

(1) The State Budget Officer, who shall serve as the Chair;

(2) The State Auditor;

(3) The State Controller;

(4) The State Treasurer; and

(5) The Executive Administrator for the ~~Teachers' and the State Employees' Comprehensive Major Medical Plan [State Health Plan for Teachers and State Employees].~~ State Health Plan for Teachers and State Employees.

(c) A majority of the members of the Committee then serving shall constitute a quorum.

(d) Each member shall be entitled to one vote on the Committee. Three affirmative votes shall be necessary for a decision by the members at any meeting of the Committee.

(e) The Committee shall keep in convenient form such data as is necessary for actuarial valuation of retired employees' health benefits under accounting standards set forth by the Governmental Accounting Standards Board of the Financial Accounting Foundation. The Department of State Treasurer, Retirement Systems Division, the State Health Plan for Teachers and State Employees, and any other State agency, department, or university institution, local public school agency, or local community college institution shall provide any necessary data upon request of the Committee for the purpose of conducting its responsibilities.

(f) The Committee shall designate either the actuary under contract with the Department of State Treasurer, Retirement Systems Division, or the actuary under contract with the State Health Plan for Teachers and State Employees as the technical adviser to the Committee on matters regarding the actuarial valuation of retired employees' health benefits created by the provisions of this Chapter. The technical advisor shall perform such actuarial valuation and other duties as are required under this Chapter.

(g) The Committee shall secure an annual calendar-year actuarial valuation of retired employees' health benefits under accounting standards set forth by the Governmental Accounting Standards Board of the Financial Accounting Foundation.

(h) The Committee shall keep a record of all of its proceedings which shall be open to public inspection.

"Part 2. Administrative Structure.

"**§ 135-48.20. Board of Trustees established.**

(a) There is established the Board of Trustees of the State Health Plan for Teachers and State Employees.

(b) The Board of Trustees of the State Health Plan for Teachers and State Employees shall consist of ~~nine~~ 10 members.

(c) The State Treasurer shall be an ex officio member of the Board and shall serve as its Chair, but shall only vote in order to break a tie vote.

(d) The Director of the Office of State Budget and Management shall be an ex officio nonvoting member of the Board.

~~(c)~~(e) ~~Three~~ Two members shall be appointed by the Governor. Terms shall be for two years. Vacancies shall be filled by the Governor. ~~Of the members appointed by the Governor, one shall be either:~~

~~(1) An employee of a State department, agency, or institution;~~

~~(2) A teacher employed by a North Carolina public school system;~~

~~(3) A retired employee of a State department, agency, or institution; or~~

~~(4) A retired teacher from a North Carolina public school system.~~

(f) Two members shall be appointed by the State Treasurer. Terms shall be for two years. Vacancies shall be filled by the State Treasurer.

~~(d)~~(g) ~~Three~~ Two members shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives in accordance with G.S. 120-121. Terms shall be for two years. Vacancies shall be filled in accordance with G.S. 120-122.

~~(e)~~(h) ~~Three~~ Two members shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate in accordance with G.S. 120-121. Terms shall be for two years. Vacancies shall be filled in accordance with G.S. 120-122.

(i) In making appointments, the appointing authorities shall ensure that one of the appointees under subsection (e) of this section, one of the appointees under subsection (f) of this section, and one of the appointees under subsection (g) of this section, and one of the appointees under subsection (h) of this section are one of the following:

(1) An employee of a State department, agency, or institution;

(2) A teacher employed by a North Carolina public school system;

(3) A retired employee of a State department, agency, or institution; or

(4) A retired teacher from a North Carolina public school system.

Each appointing authority shall consult with all other appointing authorities to ensure that the Board's composition reflects a diversity of employees, teachers, retired employees, and retired teachers.

(j) In making appointments, except for the appointees under subsection (i) of this section, the appointing authorities shall appoint individuals from the following areas of expertise:

(1) Actuarial science.

(2) Health economics.

(3) Health benefits and administration.

(4) Health law and policy.

In making appointments to the Board under this section, each appointing authority shall consult with all other appointing authorities to ensure that each of the areas of expertise required by this subsection is represented by at least one member of the Board. Each appointing authority shall consider the expertise of the other members of the Board and make appointments so that the Board's composition reflects a diversity of expertise.

~~(f)~~(k) Each appointing authority may remove any member appointed by that appointing authority.

~~(g)~~(l) The members of the Board of Trustees shall receive one hundred dollars ($100.00) per day, except employees eligible to enroll in the Plan, whenever the full Board of Trustees holds a public session, and travel allowances under G.S. 138-6 when traveling to and from meetings of the Board of Trustees or hearings under ~~G.S. 135-44.7,~~ G.S. 135-48.24, but shall not receive any subsistence allowance or per diem under G.S. 138-5, except when holding a

meeting or hearing where this section does not provide for payment of one hundred dollars ($100.00) per day.

~~(h)~~(m) No member of the Board of Trustees may serve more than three consecutive two-year terms.

~~(i) Meetings of the Board of Trustees may be called by the Executive Administrator, the Chair, or by any three members.~~

"§ 135-48.21. ~~Officers,~~ Board officers, quorum, meetings.

(a) ~~The~~ Besides the Chair, the Board of Trustees shall elect from its own membership such officers as it sees fit.

(b) A majority of the voting 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.~~ Article.

(c) The Board shall meet at least quarterly. Meetings may also be called by the Chair, or at the written request of three members.

"§ 135-48.22. Board powers and duties.

The Board of Trustees shall have the following powers and duties:

(1) Approve benefit programs, as provided in G.S. 135-48.30(2).

(2) Approve premium rates, co-pays, deductibles, and coinsurance maximums for the Plan, as provided in G.S. 135-48.30(2).

(3) Oversee administrative reviews and appeals, as provided in G.S. 135-48.24.

(4) Approve large contracts, as provided in G.S. 135-48.33(a).

(5) Consult with and advise the State Treasurer as required by this Article and as requested by the State Treasurer.

(6) Develop and maintain a strategic plan for the Plan.

"§ 135-48.23. 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 Treasurer. The term of employment and salary of the Executive Administrator shall be set by the State Treasurer after consultation with the Board of Trustees.

The Executive Administrator may be removed from office by the State Treasurer after consultation with the Board of Trustees, and any vacancy in the office of Executive Administrator may be filled by the State Treasurer.

(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~~ Administrator, the Board of ~~Trustees~~ Trustees, and the State Treasurer 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,~~ G.S. 135-48.2, 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.~~ State Treasurer.

~~(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)~~(d) The Executive Administrator shall quarterly make reports and recommendations on the Plan to the President Pro Tempore of the ~~Senate,~~ Senate and the Speaker of the House of ~~Representatives and the Committee on Employee Hospital and Medical Benefits.~~ Representatives.

"§ 135-48.24. 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 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.

(b) The ~~Executive Administrator and Board of Trustees~~ State Treasurer, in consultation with the Board of Trustees, shall adopt and implement utilization review and internal grievance procedures that are substantially equivalent to those required under G.S. 58-50-61 and G.S. 58-50-62. External review of determinations shall be conducted in accordance with Part 4 of Article 50 of Chapter 58 of the General Statutes. As used in this section, "determination" is a decision by the ~~Executive Administrator and Board of Trustees,~~ State Treasurer, or the Plan's designated utilization review organization administrated by or under contract with the Plan that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness, and the requested service is therefore denied, reduced, or terminated.

(c) The Board of Trustees shall make the final agency decision in all cases contested pursuant to Chapter 150B of the General Statutes. The Executive Administrator shall execute the Board's final agency decisions. For purposes of G.S. 150B-44, the Board of Trustees is an agency that is a board or commission.

"§ 135-48.25. Rules.

The ~~Executive Administrator and Board of Trustees~~ State Treasurer, in consultation with the Board of Trustees, may adopt rules to implement ~~Parts 2, 3, 4, and 5 of~~ this Article. The ~~Executive Administrator and Board of Trustees~~ State Treasurer shall provide to all employing units, all health benefit representatives, ~~the oversight team 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~~ State Treasurer 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.~~ State Treasurer. The ~~Executive Administrator and Board of Trustees~~ State Treasurer shall provide a written description of the rules adopted under this section to all employing units, all health benefit representatives, ~~the oversight team 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~~ State Treasurer on a timely basis. Rules adopted by the ~~Executive Administrator and Board of Trustees~~ State Treasurer to implement this Article are not subject to Article 2A of Chapter 150B of the General Statutes.

"**§ 135-48.26: Reserved for future codification purposes.**

"**§ 135-48.27. Reports to the General Assembly.**

~~The~~ In addition to the reports required by G.S. 135-48.22(d), the State Treasurer, the Executive ~~Administrator~~ 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 Pro Tempore of the Senate and the Speaker of the House of Representatives.

"**§ 135-48.28. Auditing of the Plan.**

The ~~Board of Trustees and the Executive Administrator of the~~ State Health Plan for Teachers and State Employees and the Claims Processor shall be subject to the oversight of the State Auditor pursuant to Article 5A of Chapter 147 of the General Statutes.

"Part 3. Plan Operation.

"**§ 135-48.30. Powers and duties of the State Treasurer.**

The State Treasurer shall have the following powers and duties:

(1) Administer and operate the State Health Plan for Teachers and State Employees in accordance with G.S. 135-48.2 and the provisions of this Article.

(2) Set benefits, premium rates, co-pays, deductibles, and coinsurance maximums, subject to approval by the Board of Trustees.

(3) Set the allowable charges for medical and prescription drug benefits, as necessary.

(4) Design and implement coordination of benefits policies.

(5) May offer wellness incentives.

(6) Set administrative and medical policies that are not in direct conflict with this Article.

(7) Adopt and implement, in consultation with the Board of Trustees, utilization review and internal grievance procedures that are substantially equivalent to those required under G.S. 58-50-61 and G.S. 58-50-62. External review of determinations shall be conducted in accordance with Part 4 of Article 50 of Chapter 58 of the General Statutes.

(8) Implement and administer pharmacy and medical utilization management programs and programs to detect and address utilization abuse of benefits.

(9) Establish and operate fraud detection and audit programs.

(10) Expend funds for any independent audit.
(11) Establish procedures to require prior medical approval and implement the procedures after consultation with the Board of Trustees.
(12) Prepare and submit to the Governor and the General Assembly cost estimates for the Plan, including those required by Article 15 of Chapter 120 of the General Statutes.
(13) Disclose to the Governor 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.
(14) Secure and maintain tax qualification of the Plan under any applicable provisions of the Internal Revenue Code.
(15) Implement and administer a program of long-term care benefits pursuant to Part 6 of this Article.
(16) Establish separate premium rates for the long-term care benefits provided by Part 6 of this Article if the benefits are administered on a self-insured basis.
(17) Optionally offer Medicare-related options under G.S. 135-48.38.

(b) The State Treasurer may delegate his or her powers and duties under this section to the Executive Administrator, the Board of Trustees, and employees of the Plan. In delegating powers or duties, however, the State Treasurer maintains the responsibility for the performance of those powers or duties.

"**§ 135-48.31: Reserved for future codification purposes.**

"**§ 135-48.32. Contracts to provide benefits.**

The Plan benefits shall be provided under contracts between the Plan and the claims processors selected by the Plan. The ~~Executive Administrator~~ State Treasurer 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~~ this Article 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~~ this Article and the request for proposals must be modified for inclusion in the contract because of State law, such modification shall be made. The ~~Executive Administrator~~ State Treasurer shall ensure that the terms of the contract between the Plan and the Plan's Claims Processing Contractor, the Pharmacy Benefit Manager, and the Disease Management Contractor require the contractor to provide the following:

(1) Detailed billing by each entity showing itemized cost information, including individual administrative services provided;
(2) Transactional data; and
(3) The cost to the Plan for each administrative function performed by the contractor.

"**§ 135-48.33. Contracting provisions; large contract review by Board of Trustees and Attorney General, auditing, no cost plus contracts.**

(a) The Board of Trustees must approve all Plan contracts in excess of five hundred thousand dollars ($500,000), including contracts with an initial cost of less than five hundred thousand dollars ($500,000), but that may exceed five hundred thousand dollars ($500,000) during the term of the contract.

(b) The ~~Executive Administrator and Board of Trustees~~ Plan shall: (i) submit all proposed statewide and agency term contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by ~~subsection (d) of this section~~ this Article to the Attorney General or the Attorney General's designee for

review as provided in G.S. 114-8.3; and (ii) include in all proposed contracts to be awarded by the ~~Executive Administrator and Board of Trustees~~ Plan under this section a standard clause which provides that the State Auditor and internal auditors of the Plan may audit the records of the contractor during the term of the contract to verify accounts and data affecting fees and performance. The ~~Executive Administrator and Board of Trustees~~ Plan shall not award a cost plus percentage of cost agreement or contract for any purpose.

"**§ 135-48.34. Contracts not subject to Article 3 of Chapter 143 of the General Statutes.**

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. 135-48.2, are not subject to the requirements of Article 3 of Chapter 143 of the General Statutes, but are subject to the requirements of G.S. 135-48.33.

"**§ 135-48.35. Contract disputes not contested case under the Administrative Procedure Act, Chapter 150B of the General Statutes.**

A dispute involving the performance, terms, or conditions of a contract between the Plan and an entity under contract with the Plan is not a contested case under Article 3 of Chapter 150B of the General Statutes.

"**§ 135.48.36: Reserved for future codification purposes.**

"**§ 135-48.37. Liability of third person; right of subrogation; right of first recovery.**

(a) The Plan shall have the right of subrogation upon all of the Plan member's right to recover from a liable third party for payment made under the Plan, for all medical expenses, including provider, hospital, surgical, or prescription drug expenses, to the extent those payments are related to an injury caused by a liable third party. The Plan member shall do nothing to prejudice these rights. The Plan has the right to first recovery on any amounts so recovered, whether by the Plan or the Plan member, and whether recovered by litigation, arbitration, mediation, settlement, or otherwise. Notwithstanding any other provision of law to the contrary, the recovery limitation set forth in G.S. 28A-18-2 shall not apply to the Plan's right of subrogation of Plan members.

(b) If the Plan is precluded from exercising its right of subrogation, it may exercise its rights of recovery ~~pursuant to G.S. 135-40.13(g).~~ against any third party who was overpaid. If the Plan recovers damages from a liable third party in excess of the claims paid, any excess will be paid to the member, less a proportionate share of the costs of collection.

(c) In the event a Plan member recovers any amounts from a liable third party to which the Plan is entitled under this section, the Plan may recover the amounts directly from the Plan member. The Plan has a lien, for not more than the value of claims paid related to the liability of the third party, on any damages subsequently recovered against the liable third party. If the Plan member fails to pursue the remedy against a liable third party, the Plan is subrogated to the rights of the Plan member and is entitled to enforce liability in the Plan's own name or in the name of the Plan member for the amount paid by the Plan.

(d) In no event shall the Plan's lien exceed fifty percent (50%) of the total damages recovered by the Plan member, exclusive of the Plan member's reasonable costs of collection as determined by the Plan in the Plan's sole discretion. The decision by the Plan as to the reasonable cost of collection is conclusive and is not a "final agency decision" for purposes of a contested case under Chapter 150B of the General Statutes. Notice of the Plan's lien or right to recovery shall be presumed when a Plan member is represented by an attorney, and the attorney shall disburse proceeds pursuant to this section.

"**§ 135-48.38. Persons eligible for Medicare; optional participation in other Medicare products.**

(a) Benefits payable for covered expenses under this Plan ~~in G.S. 135-45.6 through G.S. 135-45.10~~ will be reduced by any benefits payable for the same covered expenses under

Medicare, so that Medicare will be the primary carrier except where compliance with federal law specifies otherwise.

(b) For those participants eligible for Medicare, the Plan will be administered on a "carve out" basis. The provisions of the Plan are applied to the charges not paid by Medicare (Parts A & B). In other words, those charges not paid by Medicare would be subject to the deductible and coinsurance of the Plan just as if the charges not paid by Medicare were the total bill.

(c) For those individuals eligible for Part A (at no cost to them), benefits under this program will be reduced by the amounts to which the covered individuals would be entitled to under Parts A and B of Medicare, even if they choose not to enroll for Part B.

(d) Notwithstanding the foregoing provisions of this section or any other provisions of the Plan, the ~~Executive Administrator and Board of Trustees~~ State Treasurer may enter into negotiations with the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, in order to secure a more favorable coordination of the Plan's benefits with those provided by Medicare, including but not limited to, measures by which the Plan would provide Medicare benefits for all of its Medicare-eligible members in return for adequate payments from the federal government in providing such benefits. Should such negotiations result in an agreement favorable to the Plan and its Medicare-eligible members, the ~~Executive Administrator and Board of Trustees~~ State Treasurer may, after consultation with the ~~Committee on Employee Hospital and Medical Benefits,~~ Board of Trustees, implement such an agreement which shall supersede all other provisions of the Plan to the contrary related to its payment of claims for Medicare-eligible members.

(e) Notwithstanding subsections (a), (b), and (c) of this section, ~~the Plan may offer an optional Medicare Advantage plan to a Medicare eligible Plan member. A Medicare Advantage plan offered by the Plan shall be an insured product offered through a private insurance carrier authorized by the Centers for Medicare and Medicaid Services to offer Medicare Advantage plans. A Medicare Advantage plan offered by the Plan shall not be a self funded benefit plan underwritten by the State of North Carolina. Prescription drug benefits shall not be included in the benefits offered under a Medicare Advantage insurance product but shall continue to be provided by the Plan as authorized under G.S. 135 45.6. An eligible Plan member may choose to enroll in a Medicare Advantage plan in lieu of any other benefit coverage plan offered under the Plan to Medicare eligible Plan members. A Medicare eligible Plan member must be enrolled in Medicare Part B to participate in an optional Medicare Advantage plan. A non Medicare eligible dependent of a Medicare Advantage eligible Plan member may enroll on a fully contributory basis in benefit plans offered under the Plan to non Medicare eligible Plan members. If an enrolled Plan member decides not to re enroll in an optional Medicare Advantage plan during the Plan's annual enrollment period, the Plan member may at that time re enroll in other benefit coverage offered by the Plan in accordance with the provisions of subsections (a), (b), and (c) of this section.~~ the State Treasurer may contract for coverage in lieu of or to supplement Medicare benefits and may, after consultation with the Board of Trustees, implement such an agreement, which shall supersede all other provisions of the Plan to the contrary related to its payment of claims for Medicare-eligible members.

"Part 4. Eligibility and Enrollment.

"§ 135-48.40. Categories of 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:~~ G.S. 135-48.43:

~~(3)~~(1) Retired teachers, State employees, members of the General Assembly, and retired State law enforcement officers who retired under the Law Enforcement Officers' Retirement System prior to January 1, 1985. Except as otherwise provided in this subdivision, on and after January 1, 1988, a

retiring employee or retiree must have completed at least five years of contributory retirement service with an employing unit prior to retirement from any State-supported retirement system in order to be eligible for group benefits under this Part as a retired employee or retiree. For employees first hired on and after October 1, 2006, and members of the General Assembly first taking office on and after February 1, 2007, future coverage as retired employees and retired members of the General Assembly is subject to a requirement that the future retiree have 20 or more years of retirement service credit in order to be covered by the provisions of this subdivision.

~~(4)~~(2) Surviving spouses of:

a. Deceased retired employees, provided the death of the former plan member occurred prior to October 1, 1986; and

b. Deceased teachers, State employees, and members of the General Assembly who are receiving a survivor's alternate benefit under any of the State-supported retirement programs, provided the death of the former plan member occurred prior to October 1, 1986.

(b) Partially Contributory Coverage. – The following persons are eligible for coverage under the Plan, on a partially contributory basis, subject to the provisions of ~~G.S. 135-45.4:~~ G.S. 135-48.43:

(1) All permanent full-time employees of an employing unit who meet either of the following conditions:

a. Paid from general or special State funds.

b. Paid from non-State funds and in a group for which his or her employing unit has agreed to provide coverage.

Employees of State agencies, departments, institutions, boards, and commissions not otherwise covered by the Plan who are employed in permanent job positions on a recurring basis and who work 30 or more hours per week for nine or more months per calendar year are covered by the provisions of this subdivision.

(2) Permanent hourly employees who work at least one-half of the workdays of each pay period.

(3) Retired teachers, State employees, members of the General Assembly, and retired State law enforcement officers who retired under the Law Enforcement Officers' Retirement System prior to January 1, 1985. Except as otherwise provided in this subdivision, on and after January 1, 1988, a retiring employee or retiree must have completed at least five years of contributory retirement service with an employing unit prior to retirement from any State-supported retirement system in order to be eligible for group benefits under this Part as a retired employee or retiree. For employees first hired on and after October 1, 2006, and members of the General Assembly first taking office on and after February 1, 2007, future coverage as retired employees and retired members of the General Assembly is subject to a requirement that the future retiree have 20 or more years of retirement service credit in order to be covered by the provisions of this subdivision.

(4) Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except for legislative interns and pages.

(5) Members of the General Assembly.

(6) Notwithstanding the provisions of subsection (e) of this section, employees on official leave of absence while completing a full-time program in school

administration in an approved program as a Principal Fellow in accordance with Article 5C of Chapter 116 of the General Statutes.

(7) Notwithstanding the provisions of ~~G.S. 135-45.12,~~ G.S. 135-48.44, 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, 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. An employee formerly covered by the provisions of this section shall not be eligible for coverage under this subdivision if the employee is provided health benefit coverage on a non-contributory basis by a subsequent employer.

(8) Any member enrolled pursuant to subdivision (1) or (2) of this subsection who is on approved leave of absence with pay or receiving workers' compensation.

(9) Employees on approved Family and Medical Leave.

(c) One-Half Contributory Coverage. – The following persons are eligible for coverage under the Plan, on a one-half contributory basis, subject to the provisions of ~~G.S. 135-45.4;~~ G.S. 135-48.43:

(1) A school employee in a job-sharing position as described in G.S. 115C-326.5. If these employees elect to participate in the Plan, the employing unit shall pay fifty percent (50%) of the Plan's total employer premiums. Individual employees shall pay the balance of the total premiums not paid by the employing unit.

(2) Employees and members of the General Assembly with 10 but less than 20 years of retirement service credit provided the employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007. For such future retirees, the State shall pay fifty percent (50%) of the Plan's total employer premiums. Individual retirees shall pay the balance of the total premiums not paid by the State.

(d) Fully Contributory Coverage. – The following persons shall be eligible for coverage under the Plan, on a fully contributory basis, subject to the provisions of ~~G.S. 135-45.4;~~ G.S. 135-48.43:

(1) Former members of the General Assembly who enroll before October 1, 1986.

(2) For enrollments after September 30, 1986, former members of the General Assembly if covered under the Plan at termination of membership in the General Assembly. To be eligible for coverage as a former member of the General Assembly, application must be made within 30 days of the end of the term of office. Only members of the General Assembly covered by the Plan at the end of the term of office are eligible. If application is not made within the specified time period, the member forfeits eligibility.

(3) Surviving spouses of deceased former members of the General Assembly who enroll before October 1, 1986.

(4) Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except for legislative interns and pages.

(5) For enrollments after September 30, 1986, surviving spouses of deceased former members of the General Assembly, if covered under the Plan at the time of death of the former member of the General Assembly.

(6) All permanent part-time employees (designated as half-time or more) of an employing unit who meet the conditions outlined in sub-subdivision ~~(a1)(1)a.~~ (b)(1)a. of this section and who are not covered by the provisions of subdivision ~~(a1)(1)~~ (b)(1) of this section.

(7) The spouses and eligible dependent children of enrolled teachers, State employees, retirees, former members of the General Assembly, former employees covered by the provisions of ~~former subdivision (a)(8) or~~ subdivision ~~(a1)(7)~~ (b)(7) of this section, Disability Income Plan beneficiaries, enrolled continuation members, and members of the General Assembly. Spouses of surviving dependents are not eligible, nor are dependent children if they were not covered at the time of the member's death. Surviving spouses may cover their dependent children provided the children were enrolled at the time of the member's death or enroll within 90 days of the member's death.

(8) Blind persons licensed by the State to operate vending facilities under contract with the Department of Health and Human Services, Division of Services for the Blind and its successors, who are:

a. Operating such a vending facility;

b. Former operators of such a vending facility whose service as an operator would have made these operators eligible for an early or service retirement allowance under Article 1 of this Chapter had they been members of the Retirement System; and

c. Former operators of such a vending facility who attain five or more years of service as operators and who become eligible for and receive a disability benefit under the Social Security Act upon cessation of service as an operator.

Spouses, dependent children, surviving spouses, and surviving dependent children of such members are not eligible for coverage.

(9) Surviving spouses of deceased retirees and surviving spouses of deceased teachers, State employees, and members of the General Assembly provided the death of the former Plan member occurred after September 30, 1986, and the surviving spouse was covered under the Plan at the time of death.

(10) Any eligible dependent child of the deceased retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary, provided the child was covered at the time of death of the retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary, (or was in posse at the time and is covered at birth under this Part), or was covered under the Plan on September 30, 1986. An eligible surviving dependent child can remain covered until age 26 or indefinitely if certified as incapacitated under ~~G.S. 135-45.2(d).~~ G.S. 135-44.41(b).

(11) Retired teachers, State employees, and members of the General Assembly with less than 10 years of retirement service credit, provided the teachers and State employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007.

(12) Notwithstanding the provisions of ~~G.S. 135-45.12~~ G.S. 135-48.44, former employees covered by the provisions of this section and their spouses and

eligible dependent children who were covered by the Plan at the time of the former employees' separation from service pursuant to this section, following expiration of the former employees' coverage provided by this section. Election of coverage under this subdivision shall be made within 90 days after the termination of coverage provided under this section.

(13) ~~Firefighters, rescue squad workers, and members of the National Guard,~~ The following persons, their eligible spouses, and eligible dependent ~~children.~~ children, provided that the person seeking coverage as a subscriber (i) is not eligible for another comprehensive group health benefit plan and (ii) has been without coverage under a comprehensive group health benefit plan for at least six consecutive months:

a. Firefighters.
b. Rescue squad workers.
c. Persons receiving a pension from the North Carolina Firemen and Rescue Squad Workers' Pension Fund.
d. Members of the North Carolina National Guard.
e. Retirees of the North Carolina National Guard with 20 years of service.

For the purposes of this subdivision, Medicare benefits, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) benefits, and other Uniformed Services benefits shall be considered comprehensive group health benefit plans. The Plan may require certification of persons seeking coverage under this subdivision.

"§ 135-48.41. Additional eligibility provisions.

(a) 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.

(b) Coverage of a dependent child may be extended beyond the 26th birthday if 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(c)(7).~~ G.S. 135-48.40(d)(7).

(c) No person shall be eligible for coverage as a dependent if eligible as an employee or retired employee, except when a spouse is eligible on a fully contributory basis. In addition, no person shall be eligible for coverage as a dependent of more than one employee or retired employee at the same time.

(d) Former employees who are receiving disability retirement benefits or disability income benefits pursuant to Article 6 of Chapter 135 of the General Statutes or who are approved for those benefits but not in receipt of the benefits due to lump-sum payouts of vacation and bonus leave, provided the former employee has at least five years of contributory retirement service with an employing unit of a State-supported retirement system, shall be eligible for the benefit provisions of this Plan, as set forth in this Part, on a noncontributory

basis. Such coverage shall terminate as of the end of the month in which such former employee is no longer eligible for disability retirement benefits or disability income benefits pursuant to Article 6 of this Chapter.

(e) Employees on official leave of absence without pay may elect to continue this group coverage at group cost provided that they pay the full employee and employer contribution through the employing unit during the leave period.

(f) For the support of the benefits made available to any member vested at the time of retirement, their spouses or surviving spouses, and the surviving spouses of employees who are receiving a survivor's alternate benefit under G.S. 135-5(m) of those associations listed in G.S. 135-27(a), licensing and examining boards under G.S. 135-1.1, the North Carolina State Art Society, Inc., and the North Carolina Symphony Society, Inc., each association, organization or board shall pay to the Plan the full cost of providing these benefits under this section as determined by ~~the Board of Trustees of~~ the State Health Plan for Teachers and State Employees. In addition, each association, organization or board shall pay to the Plan an amount equal to the cost of the benefits provided under this section to presently retired members of each association, organization or board since such benefits became available at no cost to the retired member. This subsection applies only to those individuals employed prior to July 1, 1983, as provided in G.S. 135-27(d).

(g) An eligible surviving spouse and any eligible surviving dependent child of a deceased retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary shall be eligible for group benefits under this section without waiting periods for preexisting conditions provided coverage is elected within 90 days after the death of the former plan member. Coverage may be elected at a later time, but will be subject to the 12-month waiting period for preexisting conditions and will be effective the first day of the month following receipt of the application.

(h) No person shall be eligible for coverage as an employee or retired employee or as a dependent of an employee or retired employee upon a finding by the ~~Executive Administrator or Board of Trustees~~ State Treasurer or by a court of competent jurisdiction that the employee or dependent knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan or in any representation or attestation to the Plan.

The ~~Executive Administrator and Board of Trustees~~ State Treasurer may make an exception to the provisions of this subsection when persons subject to this subsection have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subsection shall be construed to obligate the ~~Executive Administrator and Board of Trustees~~ State Treasurer to make an exception as allowed for under this subsection.

(i) Any employee receiving benefits pursuant to Article 6 of this Chapter when the employee has less than five years of retirement membership service, or an employee on leave without pay due to illness or injury for up to 12 months, is entitled to continued coverage under the Plan for the employee and any eligible dependents by paying one hundred percent (100%) of the cost.

"§ 135-48.42. Enrollment.

(a) Except as otherwise required by applicable federal law, new employees must be given the opportunity to enroll or decline enrollment for themselves and their dependents within 30 days from the date of employment or from first becoming eligible on a noncontributory basis. Coverage may become effective on the first day of the month following date of entry on payroll or on the first day of the following month. New employees not enrolling themselves and their dependents within 30 days, or not adding dependents when first eligible as provided herein may enroll on the first day of any month but will be subject to a 12-month waiting period for preexisting health conditions, except for employees who elect to

change their coverage in accordance with rules established by the ~~Executive Administrator and Board of Trustees~~ State Treasurer for optional or alternative plans available under the Plan. Children born to covered employees having coverage type (2) or (3), as outlined in ~~G.S. 135-45.4(d)~~ G.S. 135-48.43(d) shall be automatically covered at the time of birth without any waiting period for preexisting health conditions. Children born to covered employees having coverage type (1) shall be automatically covered at birth without any waiting period for preexisting health conditions so long as the claims processor receives notification within 30 days of the date of birth that the employee desires to change from coverage (1) to coverage type (2) or (3), provided that the employee pays any additional premium required by the coverage type selected retroactive to the first day of the month in which the child was born.

(b) 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.

(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.

"**§ 135-48.43. Effective dates of coverage.**

(a) Employees and Retired Employees. –

(1) Employees and retired employees covered under the Predecessor Plan will continue to be covered, subject to the terms hereof.

(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.

(3) Employees not enrolling or adding dependents when first eligible in accordance with ~~G.S. 135-45.3~~ G.S. 135-48.42 may enroll later on the first of any following month but will be subject to a 12-month waiting period for a preexisting health condition, except employees who elect to change their coverage in accordance with rules adopted by the ~~Executive Administrator and Board of Trustees~~ State Treasurer for optional alternative plans offered under the Plan.

(4) Members of the General Assembly, beginning with the 1985 Session, shall become first eligible with the convening of each Session of the General Assembly, regardless of a Member's service during previous Sessions. Members and their dependents enrolled when first eligible after the convening of each Session of the General Assembly will not be subject to any waiting periods for preexisting health conditions. Members of the 1983 Session of the General Assembly, not already enrolled, shall be eligible to enroll themselves and their dependents on or before October 1, 1983,

without being subject to any waiting periods for preexisting health conditions.

(b) Waiting Periods and Preexisting Conditions. –

(1) New employees and dependents enrolling when first eligible are subject to no waiting period for preexisting conditions under the Plan.

(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.

(3) Retiring employees and dependents enrolled when first eligible after an employee's retirement are subject to no waiting period for preexisting conditions under the Plan. Retiring employees not enrolled or not adding dependents when first eligible after an employee's retirement may enroll later on the first of any following month, but will be subject to a 12-month waiting period for preexisting conditions except as provided in subdivision (a)(3) of this section.

(4) Employees and dependents enrolling or reenrolling within 12 months after a termination of enrollment or employment that were not enrolled at the time of this previous termination, regardless of the employing units involved, shall not be considered as newly-eligible employees or dependents for the purposes of waiting periods and preexisting conditions. Employees and dependents transferring from optional prepaid alternative plans available under the Plan; employees and dependents immediately returning to service from an employing unit's approved periods of leave without pay for illness, injury, educational improvement, workers' compensation, parental duties, or for military reasons; employees and dependents immediately returning to service from a reduction in an employing unit's work force; retiring employees and dependents reenrolled in accordance with ~~G.S. 135-45.4(b)(3);~~ subdivision (3) of this subsection; formerly-enrolled dependents reenrolling as eligible employees; formerly-enrolled employees reenrolling as eligible dependents; and employees and dependents reenrolled without waiting periods and preexisting conditions under specific rules adopted by the ~~Executive Administrator and Board of Trustees~~ State Treasurer in the best interests of the Plan shall not be considered reenrollments for the purpose of this subdivision. Furthermore, employees accepting permanent, full-time appointments who had previously worked in a part-time or temporary position and their qualified dependents shall not be covered by waiting periods and preexisting conditions under this division provided enrollment as a permanent, full-time employee is made when the employee and his dependents are first eligible to enroll.

(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.

(c) Dependents of Employees and Retired Employees. –

(1) Dependents of employees and retired employees who have family coverage under the Predecessor Plan will continue to be covered subject to the terms hereof.

(2) Employees who have dependents may apply for family coverage at the time they enroll as provided in subdivisions (a)(2) and (a)(3) of this section and such dependents will be covered under the Plan beginning the same date as such employees.

(3) Employees and retired employees may change from one category of coverage to a different category of coverage without a waiting period for preexisting conditions, and, as applicable, dependents will be covered under the Plan the first of the month or the first of the second month following the dependent's eligibility for coverage, provided written application is submitted to the Health Benefits Representative within 30 days of becoming eligible.

(4) Employees or retired employees who wish to change to employee only coverage shall give written notice to their Health Benefits Representative within 30 days after any change in the status of dependents, (resulting from death, divorce, etc.) that requires a change in contract category. The effective date will be the first of the month following the dependent's ineligibility event. If notification was not made within the 30 days following the dependent's ineligibility event, the dependent will be retroactively removed the first of the month following the dependent's ineligibility event, and the coverage category change will be the first of the month following written notification, except in cases of death, in which case the coverage category change will be made retroactive to the first of the month following the death.

(5) Employees not adding dependents when first eligible may enroll later on the first of any following month, but dependents will be subject to a 12-month waiting period for preexisting health conditions except as provided in subdivision (a)(3) of this section.

(6) Employees or retired employees who wish to change to employee only coverage even though their dependents continue to be eligible, shall give written notification to their Health Benefits Representative. Except as otherwise required by applicable federal law, the date of this category change will be the first of the month following written notification or any first of the month thereafter as desired by the employee.

(7) The effective date for newborns or adopted children will be date of birth, date of adoption, or placement with adoptive parent provided member is currently covered under employee and family or employee and child coverage. If the member wishes to add a newborn or adopted child and is currently enrolled in employee only coverage, the member must submit application for coverage and a coverage type change within 30 days of the child's birth or date of adoption or placement. Effective date for the coverage category change is the first of the month in which the child is born, adopted, or placed. Adopted children may also be covered the first of the month following placement or adoption.

(d) Categories of Coverage Available. – There are four categories of coverage which an employee or retiree may elect.

(1) Employee Only. – Covers enrolled employees only. Maternity benefits are provided to employee only.

(2) Employee and Child. – Covers enrolled employee and all eligible dependent children. Maternity benefits are provided to the employee only.

(3) Employee and Family. – Covers employee and spouse, and all eligible dependent children. Maternity benefits are provided to employee or enrolled spouse.

(4) Employee and ~~spouse.~~ Spouse. – Covers employee and spouse only. Maternity benefits are provided to the employee or the employee's enrolled spouse.

~~(e) Notwithstanding any other provision of this section, no coverage under the Plan shall become effective prior to the payment of premiums required by the Plan.~~

~~(f)~~(d) Firefighters, rescue squad workers, and members of the National Guard are subject to the same terms and conditions of this section as are employees. Eligible dependents of firefighters, rescue squad workers, and members of the National Guard are subject to the same terms and conditions of this section as are dependents of employees.

~~(g) Different categories of coverage may be offered for optional alternative plans or programs.~~

~~(h)~~(e) If any provision of this section is in conflict with applicable federal law, federal law shall control to the extent of the conflict.

"§ 135-48.44. Cessation of coverage.

(a) Coverage under this Plan of an employee and his or her surviving spouse or eligible dependent children or of a retired employee and his or her surviving spouse or eligible dependent children shall cease on the earliest of the following dates:

(1) The last day of the month in which an employee or retired employee dies. Provided such surviving spouse or eligible dependent children were covered under the Plan at the time of death of the former employee or retired employee, or were covered on September 30, 1986, any such surviving spouse or eligible dependent children may then elect to continue coverage under the Plan by submitting written application to the Claims Processor and by paying the cost for such coverage when due at the applicable fees. Such coverage shall cease on the last day of the month in which such surviving spouse or eligible dependent children die, except as provided by this Article.

(2) The last day of the month in which an employee's employment with the State is terminated as provided in subsection (c) of this section.

(3) The last day of the month in which a divorce becomes final.

(4) The last day of the month in which an employee or retired employee requests cancellation of coverage.

(5) The last day of the month in which a covered individual enters active military service.

(6) The last day of the month in which a covered individual is found to have knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan. The ~~Executive Administrator and Board of Trustees~~ State Treasurer may make an exception to the provisions of this subdivision when persons subject to this subdivision have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subdivision shall be construed to obligate the ~~Executive Administrator and~~

~~Board of Trustees~~ State Treasurer to make an exception as allowed for under this subdivision.

(7) The last day of the month in which an employee who is Medicare-eligible selects Medicare to be the primary payer of medical benefits. Coverage for a Medicare-eligible spouse of an employee shall also cease the last day of the month in which Medicare is selected to be the primary payer of medical benefits for the Medicare-eligible spouse. Such members are eligible to apply for conversion coverage.

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

(b) Coverage under this Plan as a dependent child ceases when the child ceases to be a dependent child as defined by ~~G.S. 135-45.1~~ G.S. 135-48.1 except, coverage may continue under this Plan for a period of not more than 36 months after loss of dependent status on a fully contributory basis provided the dependent child was covered under the Plan at the time of loss of dependent status.

(c) Coverage under the Plan as a surviving dependent child whether covered as a dependent of a surviving spouse, or as an individual member (no living parent), ceases when the child ceases to be a dependent child as defined by ~~G.S. 135-45.1,~~ G.S. 135-48.1, except coverage may continue under the Plan on a fully contributory basis for a period of not more than 36 months after loss of dependent status.

(d) Termination of employment shall mean termination for any reason, including layoff and leave of absence, except as provided in subdivisions (a)(1) and (2) of this section, but shall not, for purposes of this Plan, include retirement upon which the employee is granted an immediate service or disability pension under and pursuant to a State-supported Retirement System.

(1) In the event of termination for any reason other than death, coverage under the Plan for an employee and his or her eligible spouse or dependent children, provided the eligible spouse or dependent children were covered under the Plan at termination of employment may be continued for a period of not more than 18 months following termination of employment on a fully contributory basis. Employees who were covered under the Plan at termination of employment may be continued for a period of not more than 18 months or 29 months if determined to be disabled under the Social Security Act, Title II, OASDI or Title XVI, SSI.

(2) In the event of approved leave of absence without pay, other than for active duty in the armed forces of the United States, coverage under this Plan for an employee and his or her dependents may be continued during the period of such leave of absence by the employee's paying one hundred percent (100%) of the cost.

(3) If employment is terminated in the second half of a calendar month and the covered individual has made the required contribution for any coverage in the following month, that coverage will be continued to the end of the calendar month following the month in which employment was terminated.

(4) Employees paid for less than 12 months in a year, who are terminated at the end of the work year and who have made contributions for the non-work months, will continue to be covered to the end of the period for which they have made contributions, with the understanding that if they are not employed by another State-covered employer under this Plan at the beginning of the next work year, the employee will refund to the ex-employer the amount of the employer's cost paid for them during the non-paycheck months.

(5) Any employee receiving benefits pursuant to Article 6 of this Chapter when the employee has less than five years of retirement membership service, or an employee on leave of absence without pay due to illness or injury for up to 12 months, is entitled to continued coverage under the Plan for the employee and any eligible dependents by the employee's paying one hundred percent (100%) of the cost.

(e) A legally divorced spouse and any eligible dependent children of a covered employee or retired employee may continue coverage under this Plan for a period of not more than 36 months following the first of the month after a divorce becomes final on a fully contributory basis, provided the former spouse and any eligible dependent children were covered under the Plan at the time a divorce became final.

(f) A legally separated spouse of a covered employee or retired employee may continue coverage under this Plan for a period not to exceed 36 months from the separation date on a fully contributory basis, provided the separated spouse was covered under the Plan at the time of separation and provided the covered employee's or retired employee's actions result in the loss of coverage for the separated spouse. Eligible dependent children may also continue coverage if covered under the Plan at time of separation, provided the employee's or retired employee's actions result in the loss of coverage for the dependent children.

(g) Whenever this section gives a right to continuation coverage, such coverage must be elected within the time allowed by applicable federal law.

(h) Continuation coverage under this Plan shall not be continued past the occurrence of any one of the following events:

(1) The termination of the Plan.

(2) Failure of a Plan member to pay monthly in advance any required premiums.

(3) A person becomes a covered employee or a dependent of a covered employee under any group health plan and that group health plan has no restrictions or limitations on benefits.

(4) A person becomes eligible for Medicare benefits on or after the effective date of the continuation coverage.

(5) The person was determined to be no longer disabled, provided the 18-month coverage was extended to 29 months due to having been determined to be disabled under the Social Security Act, Title II, OASDI or Title XVI, SSI.

(6) The person reaches the maximum applicable continuation period of 18, 29, or 36 months.

(i) Notice requirements concerning continuation coverage shall be developed by the ~~Executive Administrator and Board of Trustees.~~ Plan.

(j) The spouse and any eligible dependent children of a covered employee may continue coverage under the Plan on a fully contributory basis for a period not to exceed 36 months from the date the employee becomes eligible for Medicare benefits which results in a loss of coverage under the Plan, provided that the spouse and eligible dependent children were covered under the Plan at the time the employee became eligible for Medicare benefits which results in a loss of coverage under the Plan.

"§ 135-48.45. Conversion.

(a) Upon a cessation of group coverage under the Plan and/or eligibility for group coverage under the Plan, an employee or dependent shall be entitled to a conversion to nongroup coverage without the necessity of a physical examination. Such conversion coverage shall include hospitalization, surgical, and medical benefits as contained in the major medical and alternative plan conversion provisions of Article 53 of Chapter 58 of the General Statutes. The ~~Executive Administrator and Board of Trustees~~ State Treasurer in ~~their~~ his or her sole discretion shall approve the conversion coverage, which shall be administered by the Claims Processor through an insurance contract arranged by the Claims Processor, or administered as

otherwise directed by the ~~Executive Administrator and Board of Trustees.~~ State Treasurer. An eligible employee or dependent must apply for conversion coverage within 30 days after termination of group eligibility.

(b) The ~~Executive Administrator and Board of Trustees~~ State Treasurer shall provide for the continuation of conversion privilege exercised under the predecessor plan, on a fully contributory basis. The ~~Executive Administrator and Board of Trustees~~ State Treasurer shall consult with the ~~Committee on Employee Hospital and Medical Benefits~~ Board of Trustees before taking action under this subsection.

"Part 5. Coverage Mandates and Exclusions; Other Mandates

"**§ 135-48.50. Coverage mandates.**

The Plan shall provide coverage subject to the following coverage mandates:

(1) Reserved.

(2) Immunizations. – The Plan shall pay one hundred percent (100%) of allowable medical charges for immunizations for the prevention of contagious diseases as generally accepted medical practices would dictate when directed by a credentialed provider as determined by the claims processor.

(3) Insulin. – Prescription benefits shall be provided for insulin even though a prescription is not required.

(4) Mental health parity. – Benefits for the treatment of mental illness and chemical dependency are covered by the Plan and shall be subject to the same deductibles, durational limits, and coinsurance factors as are benefits for physical illness generally. Nothing in this subdivision, however, shall prohibit the Plan from requiring the most cost-effective treatment setting to be utilized by a person undergoing necessary care and treatment for chemical dependency.

(5) Reserved.

(6) Permissive coverage extension. – If a covered service becomes excluded from coverage under the Plan, the Executive Administrator and Claims Processor may, in the event of exceptional situations creating undue hardships or adverse medical conditions, allow persons enrolled in the Plan to remain covered by the Plan's previous coverage for up to three months after the effective date of the change in coverage, provided the persons so enrolled had been undergoing a continuous plan of specific treatment initiated within three months prior to the effective date of the change in coverage.

(7) Reconstructive surgery. – Charges for cosmetic surgery or treatment required for correction of damage caused by accidental injury sustained by the covered individual while coverage under this plan is in force on his or her account or to correct congenital deformities or anomalies shall not be excluded if they otherwise qualify as covered medical expenses. Reconstructive breast surgery following mastectomy, as those terms are defined in G.S. 58-51-62, shall be covered.

"**§ 135-48.51. Coverage and operational mandates related to Chapter 58 of the General Statutes.**

The following provisions of Chapter 58 of the General Statutes apply to the State Health Plan:

(1) G.S. 58-3-191, Managed care reporting and disclosure requirements.

(2) G.S. 58-3-221, Access to nonformulary and restricted access prescription drugs.

(3) G.S. 58-3-223, Managed care access to specialist care.

(4) G.S. 58-3-225, Prompt claim payments under health benefit plans.
(5) G.S. 58-3-235, Selection of specialist as primary care provider.
(6) G.S. 58-3-240, Direct access to pediatrician for minors.
(7) G.S. 58-3-245, Provider directories.
(8) G.S. 58-3-250, Payment obligations for covered services.
(9) G.S. 58-3-265, Payment obligations for covered services.
(10) G.S. 58-3-280, Coverage for the diagnosis and treatment of lymphedema.
(11) G.S. 58-3-285, Coverage for hearing aids.
(12) G.S. 58-50-30, Right to choose services of optometrist, podiatrist, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, licensed marriage and family therapist, or physician assistant
(13) G.S. 58-67-88, Continuity of care.

"**§ 135-48.52. General limitations and exclusions.**

The Plan shall not provide coverage for or pay any benefits for any of the following:

(1) Charges to the extent paid, or which the individual is entitled to have paid, or to obtain without cost, in accordance with any government laws or regulations except Medicare. If a charge is made to any such person which he or she is legally required to pay, any benefits under this Plan will be computed in accordance with its provisions, taking into account only such charge. "Any government" includes the federal, State, provincial, or local government, or any political subdivision thereof, of the United States, Canada, or any other country.
(2) Charges for services rendered in connection with any occupational injury or disease arising out of and in the course of employment with any employer, if (i) the employer furnishes, pays for or provides reimbursement for such charges, or (ii) the employer makes a settlement payment for such charges, or (iii) the person incurring such charges waives or fails to assert his or her rights respecting such charges.
(3) Charges for any services rendered as a result of injury or sickness due to an act of war, declared or undeclared, which act shall have occurred after the effective date of a person's coverage under the Plan.
(4) Charges for any services with respect to which there is no legal obligation to pay. For the purposes of this item, any charge which exceeds the charge that would have been made if a person were not covered under this Plan shall, to the extent of such excess, be treated as a charge for which there is no legal obligation to pay; and any charge made by any person for anything which is normally or customarily furnished by such person without payment from the recipient or user thereof shall also be treated as a charge for which there is no legal obligation to pay.
(5) Charges during a continuous hospital confinement which commenced prior to the effective date of the person's coverage under this Plan.
(6) Charges for services unless a claim is filed within 18 months from the date of service.
(7) Charges for sexual dysfunction or hair growth drugs or for nonmedically necessary drugs used for cosmetic purposes.

"**§ 135-48.53. Reserved for future codification purposes.**

"**§ 135-48.54. Optional participation for charter schools operated by private nonprofit corporations.**

(a) The board of directors of each charter school operated by a private nonprofit corporation shall elect whether to become a participating employer in the Plan in accordance with this Article. This election shall be in writing, shall be made no later than 30 days after ~~this section becomes law,~~ October 28, 1998, and shall be filed with the ~~Executive Administrator and Board of Trustees~~ Plan and with the State Board of Education. For each charter school employee who is employed on or before the date the board makes the election, membership in the Plan is effective as of the date the board makes the election. For each charter school employee who is employed after the date the board makes the election, membership in the Plan is effective as of the date of that employee's entry into eligible service. This subsection applies only to charter schools that received State Board of Education approval under G.S. 115C-238.29D in 1997 or 1998.

(b) No later than 30 days after both parties have signed the written charter under G.S. 115C-238.29E, the board of directors of a charter school operated by a private nonprofit corporation shall elect whether to become a participating employer in the Plan in accordance with this Article. This election shall be in writing and filed with the ~~Executive Administrator, the Board of Trustees,~~ Plan and the State Board of Education. This election is effective for each charter school employee as of the date of that employee's entry into eligible service. This subsection applies to charter schools that receive State Board of Education approval under G.S. 115C-238.29D after 1998.

(c) A board's election to become a participating employer in the Plan under this section is irrevocable and shall require all eligible employees of the charter school to participate.

(d) If a charter school's board of directors does not elect to become a participating employer in the Plan under this section, that school's employees and the dependents of those employees are not eligible for any benefits under the Plan on account of employment with a charter school.

(e) The board of directors of each charter school shall notify each of its employees as to whether the board elected to become a participating employer in the Plan under this section. This notification shall be in writing and shall be provided within 30 days of the board's election or at the time an initial offer for employment is made, whichever occurs last. If the board did not elect to become a participating employer in the Plan, the notice shall include a statement that the employee shall have no legal recourse against the board or the State for any possible benefit under the Plan. The employee shall provide written acknowledgment of the employee's receipt of the notification under this subsection.

"§ 135-48.55. Interest charged to charter schools on late premiums.

The total amount of premiums due the Plan from charter schools as employing units, including amounts withheld from the compensation of Plan members, that is not remitted to the Plan by the fifteenth day of the month following the due date of remittance shall be assessed interest of one and one-half percent (1 1/2%) of the amount due the Plan, per month or fraction thereof, beginning with the sixteenth day of the month following the due date of the remittance. The interest authorized by this section shall be assessed until the premium payment plus the accrued interest amount is remitted to the Plan. The remittance of premium payments under this section shall be presumed to have been made if the remittance is postmarked in the United States mail on a date not later than the fifteenth day of the month following the due date of the remittance.

"§ 135-48.56. Education of covered active and retired employees.

It is the intent of the General Assembly that active employees and retired employees covered under the Plan and its successor Plan shall have several opportunities in each fiscal year to attend presentations conducted by Plan management staff providing detailed information about benefits, limitations, premiums, co-payments, and other pertinent Plan matters. To this end, the Plan's management staff shall conduct multiple presentations each year to Plan members and association groups representing active and retired employees across all

geographic regions of the State. Regional meetings shall be held in locations that afford reasonably convenient access to Plan members. The presentations shall be designed not only to present information about the Plan but also to hear and respond to Plan members' questions and concerns.

"§ 135-48.57. Payments for county or city ambulance service.

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.

"§ 135-48.58. Premiums for firefighters, rescue squad workers, and members of National Guard.

In setting premiums for firefighters, rescue squad workers, and members of the National Guard, and their eligible dependents, the ~~Executive Administrator and Board of Trustees~~ Plan shall establish rates separate from those affecting other members of the Plan. These separate premium rates shall include rate factors for incurred but unreported claim costs, for the effects of adverse selection from voluntary participation in the Plan, and for any other actuarially determined measures needed to protect the financial integrity of the Plan for the benefit of its served employees, retired employees, and their eligible dependents.

"Part 6. Long-term Care Benefits.

"§ 135-48.60. Undertaking.

(a) The State of North Carolina undertakes to make available an optional program of long-term care benefits for the benefit of its qualified employees, retired employees and their dependents which will pay benefits in accordance with the terms hereof. Retired employees of the Local Governmental Employees' Retirement System pursuant to Article 3 of Chapter 128 of the General Statutes and their dependents are also eligible to be qualified for the benefits provided by this Part.

(b) The long-term care benefits provided by this Part shall be made available through the State Health Plan for Teachers and State Employees pursuant to ~~Article~~ Articles 2 and ~~3A~~ 3B of this Chapter (hereinafter called the "Plan") and administered by the ~~Plan's Executive Administrator and Board of Trustees.~~ State Treasurer. In administering the benefits provided by this Part, the ~~Executive Administrator and Board of Trustees~~ State Treasurer shall have the same type of powers and duties that are provided under ~~Part 3~~ the other Parts of this Article for hospital and medical benefits. The benefits provided by this Part may be offered by the Plan on a self-insured basis, in which case a third-party claims processor shall be chosen through competitive bids, or through a contract of insurance, in which case a carrier licensed to do business in North Carolina shall be selected on a competitive bid basis in accordance with State law.

(c) The benefits authorized by this Part are available only to qualified employees and retired employees who voluntarily elect to provide such benefits for themselves and their qualified dependents. Payroll deductions shall be available from employee salary and disability benefit payments and from retired employee retirement benefit payments for fully contributory premium amounts.

(d) The ~~Executive Administrator and Board of Trustees of the Plan~~ State Treasurer shall insure insofar as possible that the long-term care benefits provided by this Part shall be tax-qualified under federal law.

"§ 135-48.61. Long-term care benefits.

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

(1) Adult care facility. – A facility which (i) is operated under State law to provide group care for the aged and disabled in a setting away from their

residence on a less than 24-hour basis when such aged or disabled would otherwise be in need of full-time personal care away from their residence; or (ii) meets the requirements for certification under Chapter 131D of the General Statutes.

(2) Assisted living facility. – A facility which (i) is operated under State law to provide residential care for the aged or disabled whose principal need is a home which provides personal care appropriate to their age or disability; or (ii) meets the requirements for licensure under Chapter 131D of the General Statutes.

(3) Home care agency. – A residential care agency which is (i) operated under State law and which is qualified as a home health care agency under Medicare; or (ii) an agency meeting the requirements for licensure as a home care agency under Chapter 131E of the General Statutes.

(4) Nursing home. – A facility or a part of a facility which is (i) operated under State law and which is qualified as a skilled nursing or intermediate nursing facility under Medicare; or is (ii) a facility meeting the requirements for licensure under Chapter 131E of the General Statutes.

(b) Long-term care benefits provided by this Part are subject to elimination periods, coinsurance provisions, and other limitations separate and apart from those provided for in ~~Part 3~~ the other Parts of this Article. No limitation on out-of-pocket expenses are provided for the benefits covered by this section. Long-term care benefits are as follows:

(1) Nursing Home Benefits. – The Plan will pay a fixed amount of the reasonable and customary daily charges allowed for nursing facilities providing skilled nursing care and intermediate nursing care up to a maximum amount per day for each day after a fixed number of consecutive days for each nursing home stay. Such daily charges shall be inclusive of semiprivate room and board; skilled and semiskilled nursing services; routine laboratory tests and examinations; physical, occupational, and speech therapy; respiratory and other gas therapy; and drugs, injections, biologicals, fluids, solutions, dietary aids and supplements, and other routine medical supplies and equipment. Readmission to a nursing home within 180 days, exclusive of hospital stays, for the same or related cause or causes shall be considered a single nursing home stay for the purposes of this section. Benefits payable under this subdivision are contingent upon compliance with the following conditions and will, in no instance, be paid under this section without compliance with each of the following conditions:

a. Confinement to a nursing home is medically appropriate due to an illness, disease, or injury upon recommendation of an admitting physician other than a proprietor, employee, or agent of the nursing home;

b. Confinement to a nursing home is for any overnight stay for which a charge for a day's stay is due and payable; and

c. Prior to confinement, the admitting physician secures approval certification from the Plan for confinement.

~~As used in this section, a nursing home is a facility or a part of a facility which is (i) operated under State law and which is qualified as a skilled nursing or intermediate nursing facility under Medicare; or is (ii) a facility meeting the requirements for licensure under Chapter 131E of the General Statutes.~~

(2) Custodial Benefits. – The Plan will pay a fixed percentage of the fixed amount of reasonable and customary daily charges allowed by the Plan in subdivision (1) of this section for assisted living facilities, for adult day care

facilities, and for home care agencies up to a maximum amount per day for each day after a fixed number of consecutive days that such custodial care is provided. Benefits payable under this subdivision are contingent upon compliance with the following conditions and will, in no instance, be paid under this subdivision without compliance with each of the following conditions:

a. Use of such custodial benefits is medically appropriate in a treatment plan established and certified initially and at least once every six months by an attending physician or other allied health professionals other than a proprietor, employee, or agent of one or more of the aforementioned facilities and agencies;

b. Confinement to a nursing home would be medically appropriate without custodial care proposed to be rendered by one or more of the aforementioned facilities or agencies; and

c. Prior to use of such custodial benefits, an attending physician or other allied health professional secures approval from the Plan for the use of the benefits.

~~As used in this section, an assisted living facility is a facility which (i) is operated under State law to provide residential care for the aged or disabled whose principal need is a home which provides personal care appropriate to their age or disability; or (ii) meets the requirements for licensure under Chapter 131D of the General Statutes. As used in this section, an adult care facility is a facility which (i) is operated under State law to provide group care for the aged and disabled in a setting away from their residence on a less than 24-hour basis when such aged or disabled would otherwise be in need of full-time personal care away from their residence; or (ii) meets the requirements for certification under Chapter 131D of the General Statutes. As used in this section, a home care agency is a residential care agency which is (i) operated under State law and which is qualified as a home health care agency under Medicare; or (ii) an agency meeting the requirements for licensure as a home care agency under Chapter 131E of the General Statutes.~~

(3) Other Benefits. – Upon prior approval of the Plan, other care, services, supplies, and equipment may be used as more cost-effective alternatives to the benefits provided by this section when directed by an attending physician.

(4) The Executive Administrator and Board of Trustees of the Plan shall establish the payment percentages, maximum daily payment rates, benefit periods, elimination periods, and maximum lifetime benefits payable for each covered individual for the nursing home and custodial benefits provided by this section. The Executive Administrator and Board of Trustees shall provide for inflationary increases in the maximum daily payment rates and the maximum lifetime benefits payable for each covered individual.

(5) The ~~Executive Administrator and Board of Trustees of the~~ Plan shall provide a bed reservation benefit whenever Plan members are hospitalized during a stay in a nursing home or an assisted living facility.

(6) The ~~Executive Administrator and Board of Trustees of the~~ Plan shall provide for a waiver of premiums involving minimum lengths of stay in a nursing home or an assisted living facility. In addition, the Executive Administrator and Board of Trustees shall allow coverage to be reinstated upon failure to pay premiums, provided certain grace periods are not exceeded and retroactive premium payments are made.

(7) Limitations and Exclusions to Long-Term Care Benefits. – The benefits provided by this section are for the purpose of meeting the requirements for

assistance from the loss of functional capacity associated with a chronic illness, disease, or disabling injury for extended periods of time; and are, in no way, intended to duplicate the benefits provided for acute and other medical care provided by Medicare or Part 3 of this Article. A loss of functional capacity can occur from: (i) an illness, disease, or disabling injury resulting in a physical incapacity to perform the activities of daily living; or (ii) an irreversible organic mental impairment resulting in a mental incapacity. Activities of daily living consist of routine functions involving personal care and mobility.

"**§ 135-48.62. Conversion.**

Upon cessation of group coverage under this Part, an employee, retired employee, or dependent shall be entitled to a conversion to a nongroup plan of long-term care benefits. The Executive Administrator and Board of Trustees of the Plan shall determine how the conversion rights authorized by this Part shall be administered."

STATEMENT OF LEGISLATIVE INTENT REGARDING REPEAL OF LANGUAGE

SECTION 2.11. In repealing a specific, detailed provision of Article 3A of Chapter 135 of the General Statutes and not placing that detailed provision into Article 3B of Chapter 135 of the General Statutes, it is not necessarily the intent of the General Assembly to prohibit the State Treasurer or the State Health Plan from having that authority.

CARRYOVER OF RULES AND POLICIES

SECTION 2.12. Rules and policies adopted by the Executive Administrator and the Board of Trustees prior to the effective date of this section shall continue to be in effect unless the rule or policy directly conflicts with a provision of Article 3B of Chapter 135 of the General Statutes or until the State Treasurer changes the rule or policy.

EFFECTIVE DATE FOR PART II

SECTION 2.13. Except as otherwise provided, Part II of this act becomes effective January 1, 2012.

PART III. MISCELLANEOUS PROVISIONS

EFFECT OF HEADINGS

SECTION 3.1. The headings to the parts and sections of this act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of this act, except for effective dates referring to a part.

EFFECTIVE DATE

SECTION 3.2. Except as otherwise provided, the remainder of this act is effective when it becomes law.

SENATE BILL 265:
State Health Plan/Appropriations and Transfer

2011-2012 General Assembly

Committee:	House Insurance, if favorable, Appropriations	**Date:**	March 29, 2011
Introduced by:	Sens. Apodaca, Brunstetter, Hartsell	**Prepared by:**	Kory Goldsmith
Analysis of:	PCS to Third Edition S265-PCS95043-ME-7		Committee Counsel

SUMMARY: Senate Bill 265 provides funding for the State Health Plan for Teachers and State Employees for the 2011-2013 fiscal biennium; adjusts contributory coverage, deductibles, coinsurance, and co-payments; and transfers control and operation of the State Health Plan to the State Treasurer effective January 1, 2012.

BACKGROUND: The State Health Plan for Teachers and State Employees (State Health 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.

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 $2.90 billion for FY 2011-12 and $3.08 billion for FY 2012-13. Enrollment in the State Health Plan as of December 31, 2010 was 663,238.

EFFECTIVE DATES: The PCS for SB 265 contains three Parts and the following effective dates: Section 1.10(a) is effective retroactively July 1, 2010, the remaining sections of Sections 1-8 of Part I become effective July 1, 2011, Section 9 of Part I becomes effective when it becomes law; Section 2.1 of Part II becomes effective when it becomes law, the remainder of Part II becomes effective January 1, 2012; Part III provides that the remainder of the act is effective when it becomes law.

BILL ANALYSIS:

Part I. Appropriations and Contributions for 2011-2013 Fiscal Biennium

Section 1.1 appropriates funds for health benefit coverage for eligible employees and retirees notwithstanding the appropriations bill order process outlined by law (G.S. 143C-5-2). The appropriations are made to the Reserve for the State Health Plan in the Office of State Budget and Management for the 2011-2013 biennium and are allocated to employing units to pay the increase cost of coverage for the employer's share of the premium contribution charged by the State Health Plan for employee or retiree coverage:

Fund	FY 2011-12	FY 2012-13
General Fund Appropriation	$8,061,798	$101,782,670
Highway Fund Appropriation	$376,217	$4,749,858

Other agency funds to provide health benefit coverage, but not specifically listed, are also appropriated for the 2011-13 fiscal biennium.

Section 1.2 specifies monthly premium contribution rates. Section 1.2(a) provides the maximum rates for the partially contributory coverage established in Section 1.6. The rates are provided in the chart below. Current rates have also been provided in the shaded portion.

	Current Basic (70/30) Plan	*FY 2011-12 Proposed* Basic (70/30) Plan	*FY 2012-13 Proposed* Basic (70/30) Plan	Current Standard (80/20) Plan	*FY 2011-12 Proposed* Standard (80/20) Plan	*FY 2012-13 Proposed* Standard (80/20) Plan
Employee Contribution (Non-Medicare, Medicare secondary)	$0	$10.86	$11.43	$0	$21.72	$22.85
Employee Contribution (Medicare Primary)	$0	$8.27	$8.70	$0	$16.54	$17.40
Retiree (Non-Medicare) Contribution	$0	$0	$0	$0	$21.72	$22.85
Retiree (Medicare) Contribution	$0	$0	$0	$0	$16.72	$17.59

Section 1.2(b) establishes an increase in the premium rates for contributory coverage. G.S. 135-44.6 requires the Executive Administrator and Board of Trustees to recommend premium rate adjustments to the General Assembly. This section of the bill establishes a maximum 5.2% premium rate increase for contributory coverage for FY 2011-12, and an additional, maximum 5.2% premium rate increase for contributory coverage for FY 2012-13.

Estimates of Select Rate Increases: The following information provides estimates of premium rate increases for an employee or retiree to provide family coverage or coverage for children under the Basic and Standard Plans. *The chart does not represent estimated rate increases in all categories of coverage, it only provides for illustration purposes the current rates and estimated increased rates of two categories of coverage.*

Basic 70/30 Plan Illustration of Select Rates	Current 2010-11	Estimate of 2011-12 w/ 5.2% Increase	Estimate of 2012-13 w/ 5.2% Increase
Cost for Employee/Retiree to Cover Children*	$178.68	$187.97	$197.75
Cost for Employee/Retiree to Cover Family*	$490.34	$515.84	$542.66

Standard 80/20 Plan Illustration of Select Rates	Current 2010-11	Estimate of 2011-12 w/ 5.2% Increase	Estimate of 2012-13 w/ 5.2% Increase
Cost for Employee/Retiree to Cover Children*	$237.62	$249.98	$262.98
Cost for Employee/Retiree to Cover Family*	$580.44	$610.62	$642.38

*The chart does not include the cost of employee/retiree premium contribution increases if applicable.

Section 1.3 requires the Executive Administrator to make changes to deductibles, coinsurance, and co-payments effective July 1, 2011 for the Basic and Standard PPO Plans. The charts below provide those deductible, coinsurance and co-payment amounts. (For information purposes, current rates (effective on July 1, 2009) have been provided in the shaded portion of the chart.)

Basic 70/30	Current In-Network	2011-12 In-Network	Current Out-of-Network	2011-12 Out-of-Network
Annual Deductible	$800 Member Only $2,400 Family	$933 Member Only $2,799 Family	$1,600 Member Only $4,800 Family	$1,866 Member Only $5,598 Family
Coinsurance	$3,250 Member Only $9,750 Family	$3,793 Member Only $11,379 Family	$6,500 Member Only $19,500 Family	$7,586 Member Only $22,758 Family
Urgent Care Co-Payment	$75/Individual	$87/Individual	Same as in-network	Same as in-network
Primary Care Co-Payment	$30/Individual	$35/Individual	50% coinsurance after deductible	50% coinsurance after deductible
Specialist Co-Payment	$70/Individual	$81/Individual	50% coinsurance	50% coinsurance

			after deductible	after deductible
Other Specialist Co-Payment [1]	**$55/Individual**	$64/Individual	**50% Coinsurance after deductible**	50% Coinsurance after deductible
Inpatient Co-Payment	**$250/Individual**	$291/Individual	**$250/Individual**	$291/Individual
Emergency Room Co-Payment	**$250/Individual**	$291/Individual	**$250/Individual**	$291/ Individual

Standard 80/20	**Current In-Network**	**2011-12 In-Network**	**Current Out-of-Network**	**2011-12 Out-of-Network**
Annual Deductible	**$600 Member Only $1,800 Family**	$700 Member Only $2,100 Family	**$1,200 Member Only $3,600 Family**	$1,400 Member Only $4,200 Family
Coinsurance	**$2,750 Member Only $8,250 Family**	$3,210 Member Only $9,630 Family	**$5,500 Member Only $16,500 Family**	$6,420 Member Only $19260 Family
Urgent Care Co-Payment	**$75/Individual**	$87/Individual	**Same as in-network**	Same as in-network
Primary Care Co-Payment	**$25/Individual**	$30/Individual	**40% coinsurance after deductible**	40% coinsurance after deductible
Specialist Co-Payment	**$60/Individual**	$70/Individual	**40% coinsurance after deductible**	40% coinsurance after deductible
Other Specialist Co-Payment [2]	**$45/Individual**	$52/Individual	**40% Coinsurance after deductible**	40% Coinsurance after deductible
Inpatient Co-Payment	**$200/Individual**	$233/Individual	**$200/Individual**	$233/Individual
Emergency Room Co-Payment	**$200/Individual**	$233/Individual	**$200/Individual**	$233/Individual

Section 1.3(b) amends G.S. 135-45.6(b)(1) to provide that the Plan will pay the allowable charges for each outpatient prescription drug minus the following copayments:

- $40 (currently $35) for each preferred branded prescription without a generic equivalent
- $64 (currently $55) for each nonpreferred branded prescription.

The $10 charge for generic prescriptions remains unchanged. Also unchanged is the requirement that for a branded prescription with a generic equivalent drug, the member 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.

Section 1.4 amends G.S. 135-45(g) to limit the authority of the Executive Administrator and Board of Trustees to change benefits in effect on July 1, 2011 unless directed by the General Assembly.

Section 1.5 repeals the Comprehensive Wellness Initiative for individuals covered by the State Health Plan which focused on smoking cessation (effective July 1, 2010) and weight management (July 1, 2011 effective date).

Section 1.6(a) authorizes individuals eligible for coverage to participate on a contributory (partially, one-half, or fully) basis in authorized plans. **Section 1.6(b)** amends G.S. 135-45.2 to eliminate noncontributory and authorize partially contributory coverage for permanent employees, employees of the General Assembly as determined by the Legislative Services Commission and not otherwise covered, Members of the General Assembly, employees on a leave of absence, and employees whose positions were eliminated. (The new contribution rates are outlined in Section 1.2 of the bill.) For a school employee in a job-sharing position that elects to participate in the Plan, the bill provides that an employing unit will pay 50% of the Plan's total employer premiums and the employee will pay the

[1] Other Specialist Co-Payment Services Include: Mental Health, Substance Abuse, Chiropractic, Physical Therapy, Occupational Therapy, and Speech Therapy.
[2] Other Specialist Co-Payment Services Include: Mental Health, Substance Abuse, Chiropractic, Physical Therapy, Occupational Therapy, and Speech Therapy.

balance of the total premiums not paid by the State. Upon retirement, the State will pay 50% of the total employer premiums for employees and members of the General Assembly with 10 but less than 20 years of retirement service credit if the employees were first hired on or after October 1, 2006 and members took office on or after February 1, 2007, these future retirees will be responsible for the balance of the premium. The section also makes technical and conforming changes.

Section 1.7 pertains to eligibility requirements for coverage of a dependent child and complies with provisions of the federal Affordable Care Act. (Coverage for children up to age 26 under the Act was effective for plan or policy years beginning on September 23, 2010.) Section 1.7(a) conforms the definition of "dependent child" contained in G.S. 135-45.1(10) with the federal law to allow coverage for a natural or legally adopted child up to the first of the month following the child's 26th (currently 19th) birthday and makes additional technical and organizational changes to the statute . Eligibility requirements for coverage of a dependent child are currently provided in G.S. 135-45.2(d). Section 1.7(b) amends G.S. 135-45.2(d) to conform with the federal law to allow coverage of a dependent child beyond the 26th (currently 19th) birthday if 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 the provisions for contributory coverage of dependents and surviving dependents (contained in G.S. 135-45.2(c)(7)). Section 1.7(c) and (d) add preexisting condition waiting periods to coverage for dependents age 19 and older. Section 1.7(c) provides that eligible dependents younger than age 19 are not subject to any waiting period for preexisting conditions.

Section 1.8(a-e) contains standard language that is typically found in the Appropriations bill outlining employer salary-related contribution rates.

Section 1.9 amends G.S. 135-45(b) to make the protection of trade secrets in State Health Plan contracts consistent with the general trade secret protection for all public agency contracts.

Section 1.10(a-c) allows the Executive Administrator to authorize coverage that has been denied because of administrative or system errors and authorizes the Health Benefits Representative (HBR) to enroll dependents.

Part II. Transfer State Health Plan to Department of State Treasurer

Section 2.1 amends G.S. 135-2(b) to grant the State Treasurer the authority, after consultation with the Board of Trustees, to hire, fire and set the terms of employment for the State Health Plan's Executive Administrator. It also allows the Treasurer to appoint an interim Executive Administrator.

Section 2.2 transfers the State Health Plan to the Department of State Treasurer as a Type II transfer. A Type II transfer means the transferring intact of an existing agency to a principal department established by Chapter 143A.

Section 2.3 amends the title of Chapter 135 to reference the State Health Plan and to add a new Article 3B to the Chapter. Article 3B will be organized into 6 Parts: General Provisions, Administrative Structure, Plan Operation, Eligibility and Enrollment, Coverage Mandates and Exclusions/Other Mandates, and Long-Term Care Benefits.

Sections 2.4 through 2.7 recodify portions of Article 3A to create the new Article 3B of Chapter 135. A very brief description of the recodified provision appears in brackets after each specific citation. The Child Health Insurance Fund is recodified as G.S. 108A-70.20A. Although recodified, the provisions related to eligibility, enrollment, effective date of coverage and cessation of coverage are retained.

Section 2.8 repeals any portion of Article 3A of Chapter 135 that was not recodified. Some of the provisions that are repealed include: G.S. 135-43.1 (Committee on Employee Hospital and Medical Benefits), G.S. 135-43.2 (State Health Plan Administrative Commission), G.S. 135-43.3 (Oversight team), G.S. 135-44.4 (Powers and duties of the Executive Administrator and Board of Trustees) and G.S. 135-46.1 (Long-term care benefits). Other provisions that essentially set the terms and conditions of the Plan [G.S. 135-45.6 (Benefits not subject to deductible or coinsurance), G.S. 135-45.7 (Prior approval procedures), G.S. 135-45.8 (General limitations and exclusions), G.S. 135-45.9 (Special provisions for chemical dependency and mental health benefits)] are repealed, but are re-enacted as duties of the Treasurer [G.S. 135-48.30(a)]. The Coverage Mandates (Part 5 of Article 3B) are consolidated, but include the same coverage mandates as under current law.

Section 2.9 amends the newly created Article 3B to provide the State Treasurer the necessary authority to operate the State Health Plan, to further reorganize the remaining provisions, and to conform internal and external citations. Some of the changes include:

- Repealing the definition of "plan year".
- Adding the Treasurer to the State Health Plan Board of Trustee as an ex officio member as well as the Director of the Office of State Budget and Management. The Treasurer could vote in the event of a tie, but the Director would be a nonvoting member. The remaining 8 members of the Board would be appointed 2 each by the Treasurer, the Governor, and the General Assembly (2 upon the recommendation of the President Pro Tempore of the Senate and 2 upon the recommendation of the Speaker of the House). A current and a retired teacher and a current and a retired State employee must be included among the members of the Board.
- Specifying the Treasurer's Powers and Duties (G.S. 135-48.30). These include: setting benefits, premium rates, and out-of-pocket expenses; setting allowable charges for medical and prescription drug benefits; adopting and implementing utilization review and internal grievance procedures; establishing fraud detection and audit programs; preparing and submitting cost estimates to the Governor and General Assembly; establishing, administering and setting premium rates for long-term care benefits.
- Requiring quarterly reports by the Executive Administrator to the President Pro Tempore of the Senate and the Speaker of the House. The Treasurer must also submit reports upon the request of either office.

Section 2.10 makes technical changes.

Section 2.11 provides that by repealing a specific provision in Article 3A, the General Assembly did not necessarily intend to prevent the Treasurer or the State Health Plan from having that authority.

Section 2.12 provides that existing rules and policies continue to be effective unless they directly conflict with new Article 3B or until changed by the Treasurer.

Section 2.13 provides that, except as otherwise provided, Part II of this act becomes effective January 1, 2012.

Part III. Miscellaneous Provisions

Section 3.1 provides that headings are for the convenience of the reader and are for reference only.

Section 3.2 provides that, except as otherwise provided, this act is effective when it becomes law.

ATTACHMENT V

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: Senate Bill 265 (Third Edition)

SHORT TITLE: State Health Plan/Appropriations and Transfer.

SPONSOR(S): Senators Hartsell, Apodaca, and Brunstetter

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: Senate Bill 265 (Third Edition) 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 proposed bill also moves the Plan under the Department of State Treasurer via a Type II transfer, provides the State Treasurer with the power to appoint or remove the Plan's Executive Administrator, and generally gives the State Treasurer broad authority over the operation of the Plan.

EFFECTIVE DATE: Section 1.9 becomes effective when it becomes law. All other sections of Part I become effective July 1, 2011. Section 2.1 becomes effective when it becomes law. All other sections of Part II become effective January 1, 2012.

ESTIMATED IMPACT ON STATE:

2011-13 Biennium

Increased Premium Contributions

Appropriated Funds

Sections 1.1(a), (b), and (c) appropriate the estimated required funds to support increased employer contributions to the Plan for the 2011-13 biennium. These appropriations are based on increased employer contribution rates derived from an annual 5.2 % premium increase in total premium rates for the fiscal year beginning July 1, 2011, and an additional annual premium increase of 5.2% for the fiscal year beginning July 1, 2012. The table below reflects the allocation of appropriated funds by fund source:

Additional Employer Contributions Appropriated Funds			
Fund Source	**FY 2011-12**	**FY 2012-13**	**Biennium**
General Fund	$8,061,798	$101,782,670	$109,844,468
Highway Fund	$376,217	$4,749,858	$5,126,075
Other Funds	$1,663,159	$20,997,887	$22,661,046
Total	$10,101,174	$127,530,415	$137,631,589

Employee Funds

Section 1.2(a) of the bill establishes new monthly contribution rates for active employees in the Basic 70/30 plan and the Standard 80/20 plan options, and for retired employees enrolled in the Standard 80/20 plan. There is no monthly contribution required for retired employees enrolled in the Basic 70/30 plan option. A summary of the most common estimated monthly contribution rates are reflected below:

Employee & Retired Employee Contribution Rates for Own Coverage				
	FY 2011-12		FY 2012-13	
	Basic 70/30	Standard 80/20	Basic 70/30	Standard 80/20
Employeee Contribution	$10.86	$21.72	$11.43	$22.85
Retiree Contribution				
Non-Medicare Eligible	$0.00	$21.72	$0.00	$22.85
Medicare Eligible	$0.00	$16.72	$0.00	$17.59

Section 1.2(b) of the bill authorizes an annual 5.2% premium increase in contributory premium rates for dependent coverage for the fiscal year beginning July 1, 2011, and an additional annual premium increase of 5.2% for the fiscal year beginning July 1, 2012.

The estimated additional premium contributions from these collective changes in Section 1.2 are listed below:

Additional Member Contributions			
Coverage Category	**FY 2011-12**	**FY 2012-13**	**Biennium**
Contributions for Employee Coverage	$79,744,912	$83,086,125	$162,831,036
Contributions for Retiree Coverage	$27,598,650	$29,324,999	$56,923,650
Contributions for Dependent Coverage	$22,035,960	$44,933,201	$66,969,161
Total	$129,379,522	$157,344,325	$286,723,847

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 2011-13 biennium as a result of the authorized premium rate increase:

Total Additonal Premium Contributions
From Appropriated and Employee/Retiree Paid Funds

Fund Source	FY 2011-12	FY 2012-13	Biennium
Appropriated			
General Fund	$8,061,798	$101,782,670	$109,844,468
Highway Fund	$376,217	$4,749,858	$5,126,075
Other Funds	$1,663,159	$20,997,887	$22,661,046
Sub-total	$10,101,174	$127,530,415	$137,631,589
Member Contributions			
Contributions for Employee Coverage	$79,744,912	$83,086,125	$162,831,036
Contributions for Retiree Coverage	$27,598,650	$29,324,999	$56,923,650
Contributions for Dependent Coverage	$22,035,960	$44,933,201	$66,969,161
Sub-total	$129,379,522	$157,344,325	$286,723,847
Total	$139,480,696	$284,874,740	$424,355,436

Financial Savings for the 2011-13 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 authorized increases in plan member out-of-pocket requirements and other changes that are estimated to affect the financial condition of the Plan. A summary of the authorized changes are described below including the estimated actuarial impact of these changes.

Sections 1.3(a)(1), (a)(2) and (b) of the bill authorize various increases in plan member out-of-pocket requirements to include increased annual deductibles and annual co-insurance maximums, increased office visit co-pays and increased outpatient prescription drug co-pays.

The in-network out-of-pocket changes for medical and pharmacy benefit related services are summarized in the table below:

	Basic 70/30		Standard 80/20	
	Current	New	Current	New
Medical Benefits				
Plan Member Co-pays (per visit)				
Primary Care	$30	$35	$25	$30
Mid-Tier	$55	$64	$45	$52
Specialty Care	$70	$81	$60	$70
Urgent Care	$75	$87	$75	$87
Inpatient Hospital	$250	$291	$200	$233
Emergency Room	$250	$291	$200	$233
Annual Deductible (Individual)				
In-network	$800	$933	$600	$700
Out-of-network	$1,600	$1,866	$1,200	$1,400
Coinsurance Maximum (Individual)				
In-network	$3,250	$3,793	$2,750	$3,210
Out-of-network	$6,500	$7,586	$5,500	$6,420
Pharmacy Benefits				
Generic (copay)	$10	No change	$10	No change
Preferred Brand (copay)	$35	$40	$35	$40
Non-preferred Brand (copay)	$55	$64	$55	$64

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

Aon Consulting
Projected Financial Savings
Increasing Out-of-Pocket Limits

Category	FY 2011-12	FY 2012-13	Biennium
Medical Benefits	$43,657,837	$48,670,256	$92,328,093
Pharmacy Benefits	$17,302,875	$19,998,817	$37,301,692
Total	$60,960,712	$68,669,073	$129,629,785

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

Hartman & Associates
Projected Financial Savings
Increasing Out-of-Pocket Limits

Category	FY 2011-12	FY 2012-13	Biennium
Medical Benefits	$44,506,165	$53,115,895	$97,622,060
Pharmacy Benefits	$14,829,123	$14,651,174	$29,480,297
Total	$59,335,288	$67,767,069	$127,102,357

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

Total Projected Financial Savings From Increasing Out-of-Pocket Limits (By Type)

	Aon Consulting (Plan)			Hartman & Assoc. (General Assembly)		
Category	FY 2011-12	FY 2012-13	Biennium	FY 2011-12	FY 2012-13	Biennium
Medical Benefits						
Primary Care Co-pay (Increase)	$6,650,120	$7,454,181	$14,104,301	$7,036,512	$8,026,021	$15,062,533
Mid-tier Specialty Co-pay (Increase)	$2,869,525	$3,216,476	$6,086,001	$2,989,322	$3,409,696	$6,399,018
Specialist Co-pay (Increase)	$7,903,492	$8,859,097	$16,762,589	$8,099,385	$9,440,846	$17,540,231
Urgent Care Co-pay (Increase)	$452,746	$507,488	$960,234	$496,656	$571,464	$1,068,120
Inpatient Co-pay (Increase)	$1,321,982	$1,481,822	$2,803,804	$1,391,786	$1,587,505	$2,979,291
Emergency Room Co-pay (Increase)	$2,203,033	$2,469,400	$4,672,433	$2,326,070	$2,653,172	$4,979,242
Deductible and Coinsurance Max (Increase)	$22,256,937	$24,681,793	$46,938,730	$22,166,434	$27,427,191	$49,593,625
Sub-total	$43,657,835	$48,670,257	$92,328,092	$44,506,165	$53,115,895	$97,622,060
Outpatient Prescription Drugs (acute drugs)						
Brand Drug Co-pay (Increase)	$10,921,107	$12,523,397	$23,444,504	$8,358,944	$8,258,637	$16,617,581
Non-Preferred Brand Drug Co-pay (Increase)	$6,381,768	$7,475,419	$13,857,187	$6,470,179	$6,392,537	$12,862,716
Sub-total	$17,302,875	$19,998,816	$37,301,691	$14,829,123	$14,651,174	$29,480,297
Grand Total	$60,960,710	$68,669,073	$129,629,783	$59,335,288	$67,767,069	$127,102,357

Other Changes Affecting the Plan

Section 1.5 repeals the "Comprehensive Wellness Initiative" authorized originally under Session Law 2009-16. The Plan's consulting actuary has incorporated the increased financial cost of the program's repeal into the overall actuarial cost projection for the changes proposed in the bill, by assuming approximately 95% of employee or retiree contracts, that involve a plan member who is a tobacco-user and currently enrolled in the Basic 70/30 plan per the requirement of the Comprehensive Wellness Initiative, will migrate back to the Standard 80/20 plan in the absence of the requirement. The Plan's consulting actuary estimates by fiscal year the increased financial impact to the Plan for the 2011-13 biennium:

	FY 2011-12	FY 2012-13	Biennium
Repeal Comprehensive Wellness Initiative	$17.4M	$26.0M	$43.4M

Since the weight management component of the Comprehensive Wellness Initiative would not be implemented prior to the repeal date of the program, no actuarial cost impact was expected.

Section 1.6 amends current statutory language under G.S. 135-45 to allow implementation of monthly premium contribution rates to be paid by employees and certain retired employees for their own coverage under the Plan.

Section 1.7 amends G.S. 135-45.1 to conform to requirements under the federal Affordable Care Act requiring coverage to be offered to dependent children to age 26 without requiring the dependent to be a full-time student.

Section 1.8 is a boilerplate provision used to set specific employer contribution amounts paid by State agencies and departments, universities, local public schools, and local community colleges to fund health benefit coverage for employees, and percentage-based payroll contributions paid to the Retiree Health Benefit Fund to finance premiums paid by the Retirement Systems Division of the Department of State Treasurer on behalf of retired employees.

Annual Employer Contributions

	Basic 70/30		Standard 80/20	
I. Employees & Retirees	FY 2011-12	FY 2012-13	FY 2011-12	FY 2012-13
Employees	$4,952	$5,211	$4,952	$5,211
Non-Medicare Retiree	$4,952	$5,211	$4,952	$5,211
Medicare Retiree	$3,768	$3,965	$3,768	$3,965
II. Retiree Health Benefit Fund	FY 2011-12	FY 2012-13		
Payroll Contribution Rate	5.0%	5.3%		

Section 2 of the bill (Part II), which transfers the Plan to the Department of State Treasurer, and provides the State Treasurer with broad authority over the Plan, is not estimated to have any financial impact on the Plan.

Reconciliation of Plan's Projected Financial Requirements for the 2011-13 Biennium

For the new biennium beginning July 1, 2011 the Plan is estimated to require over $515.5 million in additional financial support to remain solvent and maintain current benefit levels and minimum claim stabilization reserves. This estimate assumes the Plan will experience a 9.5% per capita claims trend, continued implementation of the Comprehensive Wellness Initiative, extending coverage to dependent children to age 26 per the requirements of the federal Affordable Care Act, receiving $25.6 million in Early Retiree Reinsurance Program as authorized by the federal Affordable Care Act, maintaining "grandfather" status per the federal Affordable Care Act, achieving an additional $151 million in pharmacy cost savings over the biennium through a new pharmacy benefit management contract effective October 1, 2011, and implementing an estimated 6.3% premium increase on July 1, 2011 and again on July 1, 2012.

The bill addresses the projected shortfall described above by authorizing the following changes:

1. Authorizing a 5.2% annual premium increase on July 1 of each fiscal year of the biennium for total premium rates;

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

3. Establishing new monthly contribution rates for active employees in the Basic 70/30 plan and the Standard 80/20 plan options and for retired employees enrolled in the Standard 80/20 plan. There is no monthly contribution required for retired employees enrolled in the Basic 70/30 plan option.

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 2011-13 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[1,2]

Senate Bill 265 (Third Edition)

($ Million)

	FY 2011-12	FY 2012-13	Biennium
1) Projected Financial Support Required	$168.8	$346.7	$515.5
2) Benefit Reductions (Changes in Out-of-Pocket Amounts) Effective July 1, 2011			
Medical			
Primary Care Co-pay (Increase)	($6.7)	($7.5)	($14.1)
Mid-tier Specialist Co-pay (Increase)	($2.9)	($3.2)	($6.1)
Specialist Co-pay (Increase)	($7.9)	($8.9)	($16.8)
Urgent Care Co-pay (Increase)	($0.5)	($0.5)	($1.0)
Inpatient Co-pay (Increase)	($1.3)	($1.5)	($2.8)
Emergency Room Co-pay (Increase)	($2.2)	($2.5)	($4.7)
Deductible and Coinsurance Maximum (Increase)	($22.3)	($24.7)	($46.9)
Sub-total	($43.7)	($48.7)	($92.3)
Outpatient Acute and Specialty Prescription Drugs			
Brand Drug Co-pay (Increase)	($10.9)	($12.5)	($23.4)
Non-Preferred Brand Drug Co-pay (Increase)	($6.4)	($7.5)	($13.9)
Sub-total	($17.3)	($20.0)	($37.3)
Total -- Benefit Reductions	($61.0)	($68.7)	($129.6)
3) Appropriations by the General Assembly			
Premium increase for Employing Agencies			
General Fund	($8.1)	($101.8)	($109.8)
Highway Fund	($0.4)	($4.7)	($5.1)
Other Employer Funds	($1.7)	($21.0)	($22.7)
Total Additional Employer Funds	($10.1)	($127.5)	($137.6)
4) Premium increases paid by Employees and Retirees			
Paid for Employee's Own Coverage	($79.7)	($83.1)	($162.8)
Paid for Retiree's Own Coverage	($27.6)	($29.3)	($56.9)
Paid for Spouses and Dependent Children	($22.0)	($44.9)	($67.0)
Total Employee Additional Funds	($129.4)	($157.3)	($286.7)
5) Net Financial Effect of Member Migration Between Plan Options	$17.0	$25.2	$42.2
6) Balance	($14.6)	$18.4	$3.7

Notes:

[1] The $3.7 million balance remaining at the end of the biennium (see Item 6) is a product of rounding error and a difference in projected ending cash balances between baseline financial projections and final projections after the authorized premium increases, benefit changes, and other program changes. This difference is not expected to have an adverse effect on the Plan's finances.

[2]The $42.2 million in financial costs to the Plan (see Item 5) reflects mostly the predicted effect of certain plan members currently enrolled in the Basic 70/30 plan migrating back to the Standard 80/20 plan to receive lower out-of-pocket requirements. This assumption is due to the repeal of the requirement under the current Comprehensive

Wellness Initiative for a plan member to enroll in the Basic 70/30 plan if that plan member is a tobacco-user who declines to participate in tobacco use cessation programs to maintain eligibility for the Standard 80/20 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.

Premium contributions rates and estimates of aggregate collections, projected claims expenditures, estimated administrative expenditures, projections of enrollment migration between the Basic 70/30 plan and the Standard 80/20 plan, effects due to the repeal of the Comprehensive Wellness initiative, and other financial impacts on the Plan were estimated by the Plan's consulting actuary for the purposes of this Legislative Actuarial Note.

General Assumption Highlights

The following items represent key assumptions used with respect to predicting the Plan's financial requirements for the 2011-13 biennium:

1. The Plan will maintain "grandfather' status under the federal Affordable Care Act. To maintain grandfather status under the federal guidelines, premium contributions for an employee or retired employee's own coverage cannot exceed 5% of the premium cost. In addition, the out-of-pocket limits cannot increase by more than 15% plus the rate of medical inflation in FY 2011-12, and by the rate of medical inflation in FY 2012-13. For the purposes increasing out-of-pocket limits in the bill, FY 2011-12, the rate of increase was 16.7% which is calculated by using a medical inflation rate of 1.7% plus the aforementioned 15% one-time adjustment. There was no adjustment made for the FY 2012-13.
2. The Plan will achieve $151 million in additional savings over the 2011-13 biennium on pharmacy related claims and administrative costs over current costs. These savings are estimated due to the implementation of a new pharmacy benefit management contract effective October 1, 2011.
3. The Plan will incur projected additional costs of $15.6 million in FY 2011-12 and $17.0 million in FY 2012-13 to provide dependent coverage to age 26 per the requirements of the federal Affordable Care Act.
4. The Plan will collect $45.1 million in FY 2010-11, and $25.6 million in FY 2011-12 in Early Retiree Reinsurance Program funds authorized under the federal Affordable Care Act.
5. Approximately 95% of employee or retiree contracts, that involve a plan member who is a tobacco-user and currently enrolled in the Basic 70/30 plan per the requirement of the Comprehensive Wellness Initiative, will migrate back to the Standard 80/20 plan in the absence of the requirement. An estimated 25% of retiree only contracts in the Standard 80/20 plan are expected to migrate to the Basic 70/30 plan to avoid paying a monthly premium contribution charged to retired employees in the Standard 80/20 plan. It is estimated that 5% of employee only contracts and contracts covering dependents in the Standard 80/20 plan will migrate to the Basic 70/30 plan to reduce their amount of monthly premium contribution paid. It is generally assumed that plan members will migrate to the plan option that will most benefit them economically based on their relative need for medical services.

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.

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 $2.90 billion for FY 2011-12 and $3.08 billion for FY 2012-13. 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.

The following table provides a summary of most monthly premium rates for the Plan in FY 2010-11:

	Basic 70/30		Standard 80/20	
Coverage Type	Employee/ Retiree	Employer	Employee/ Retiree	Employer
Non-Medicare Active Employee/Retiree				
Employee	$0.00	$410.80	$0.00	$410.80
Employee + Child(ren)	$178.68	$410.80	$237.62	$410.80
Employee + Spouse	$460.36	$410.80	$547.48	$410.80
Employee + Family	$490.34	$410.80	$580.44	$410.80
Medicare Primary for Only Employee/Retiree				
Employee	$0.00	$312.76	$0.00	$312.76
Employee + Child(ren)	$187.60	$312.76	$237.62	$312.76
Employee + Spouse	$469.28	$312.76	$547.48	$312.76
Employee + Family	$499.26	$312.76	$580.44	$312.76

The employer share of premiums for retirees is paid from the Retiree Health Benefit Fund. During FY 2010-11, employers contribute 4.9% of active employee payroll into the Fund. Total contributions for the year are projected to be approximately $721 million.

Financial Condition

Current and Projected Results for 2009-11 Biennium – The following summarizes actual financial results for FY 2009-10 and projected financial results for FY 2010-11, based on financial experience through December, 2010.

	($ millions) Actual FY 2009-10	Projected FY 2010-11
Beginning Cash Balance	$189.9	$121.5
Receipts:		
Net Premium Collections	$2,412.6	$2,677.4
Early Retirement Reinsurance Program	$0.0	$45.0
Medicare Part D Subsidies	$74.4	$60.5
Investment Earnings	$3.5	$2.4
Total	$2,490.5	$2,785.3
Disbursements:		
Net Medical Claim Payment Expenses	$1,797.5	$1,860.5
Net Pharmacy Claim Payment Expenses	$596.7	$647.7
Administration and Claims-Processing Expenses	$164.6	$171.7
Total	$2,558.9	$2,679.9
Net Operating Income (Loss)	($68.4)	$105.4

Financial Projection 2011-13 Biennium – The following summarizes a financial projection conducted by the Plan's consulting actuary, Aon Consulting, for the 2011-13 biennium. The information is provided by fiscal year based on year-to-date financial experience (through December 2010) and other updated factors. The projection assumes a 9.5% annual claims growth trend, that benefit provisions remain the same, and that both employer and member-paid premiums are increased by 6.3% effective July 1, 2011 and July 1, 2012.

	($ millions) Projected FY 2011-12	Projected FY 2012-13
Beginning Cash Balance	$226.8	$239.0
Receipts:		
Net Premium Collections	$2,829.0	$2,995.2
Early Retirement Reinsurance Program	$25.6	$0.0
Medicare Part D Subsidies	$60.1	$62.6
Investment Earnings	$2.3	$2.5
Total	$2,917.0	$3,060.3
Disbursements:		
Net Medical Claim Payment Expenses	$2,065.1	$2,199.0
Net Pharmacy Claim Payment Expenses	$659.2	$699.4
Administration and Claims-Processing Expenses	$180.5	$183.6
Total	$2,904.8	$3,082.0
Net Operating Income (Loss)	$12.2	($21.7)

This projection incorporates $151 million in projected savings over the biennium from a new Pharmacy Benefit Manager (PBM) contract to be effective October 1, 2011. It assumes that the Plan maintains "grandfathered" status under the federal Affordable Care Act (ACA). It assumes the Plan experiences an increase of $33 million in claims over the biennium due to requirements in the ACA to cover additional dependents.

Other Information

In the 2009-11 biennium, the annual premium increases were applied at the beginning of each fiscal year of the biennium. Historically, the Plan had applied a premium increase in October of the first fiscal year of a 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 9.5% annually according to the Plan's consulting actuary. Investment earnings are based upon a 1.0% return on available cash balances. The active population is projected to decline by 1% per year, the COBRA population is projected to remain constant, and the retired population is projected to increase by 1% per year.

Enrollment by Category Type

State Health Plan Enrollment as of December 31, 2010

I. No. of Participants	Basic	Standard	Total	Percent of Total
Actives				
Employees	65,849	256,468	322,317	48.6%
Dependents	50,588	105,759	156,347	23.6%
Sub-total	116,437	362,227	478,664	72.2%
Retired				
Employees	16,429	143,764	160,193	24.2%
Dependents	4,352	14,173	18,525	2.8%
Sub-total	20,781	157,937	178,718	26.9%
Former Employees with Continuation Coverage				
Employees	1,014	1,237	2,251	0.3%
Dependents	403	347	750	0.1%
Sub-total	1,417	1,584	3,001	0.5%
Firefighters, Rescue Squad & National Guard				
Employees	2	3	5	0.0%
Dependents	1	2	3	0.0%
Sub-total	3	5	8	0.0%
Local Governments				
Employees	486	1,429	1,915	0.3%
Dependents	303	629	932	0.1%
Sub-total	789	2,058	2,847	0.4%
Total				
Employees	83,780	402,901	486,681	73.4%
Dependents	55,647	120,910	176,557	26.6%
Grand Total	**139,427**	**523,811**	**663,238**	**100%**
Percent of Total	**21.0%**	**79.0%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Total
Employee Only	55,472	335,154	390,626
Employee Child(ren)	13,817	36,176	49,993
Employee Spouse	5,719	17,462	23,181
Employee Family	8,772	14,109	22,881
Total	**83,780**	**402,901**	**486,681**

Percent Enrollment by Contract	Basic	Standard	Total
Employee Only	66.2%	83.2%	80.3%
Employee Child(ren)	16.5%	9.0%	10.3%
Employee Spouse	6.8%	4.3%	4.8%
Employee Family	10.5%	3.5%	4.7%
Total	**100.0%**	**100.0%**	**100.0%**

III. Enrollment by Sex	Basic	Standard	Total
Female	75,627	338,703	414,330
Male	63,800	185,108	248,908
Total	**139,427**	**523,811**	**663,238**

Percent Enrollment by Sex	Basic	Standard	Total
Female	54.2%	64.7%	62.5%
Male	45.8%	35.3%	37.5%
Total	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Total
19 & Under	35,455	74,859	110,314
20 to 29	12,915	46,222	59,137
30 to 44	31,582	98,133	129,715
45 to 54	27,089	85,600	112,689
55 to 64	29,854	106,470	136,324
65 & Over	2,532	112,527	115,059
Total	**139,427**	**523,811**	**663,238**

Percent Enrollment by Age	Basic	Standard	Total
19 & Under	25.4%	14.3%	16.6%
20 to 29	9.3%	8.8%	8.9%
30 to 44	22.7%	18.7%	19.6%
45 to 54	19.4%	16.3%	17.0%
55 to 64	21.4%	20.3%	20.6%
65 & Over	1.8%	21.5%	17.3%
Total	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	53,034	11,292	64,326
Medicare Eligible	107,159	7,233	114,392
Total	**160,193**	**18,525**	178,718

Percent Enrollment by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.1%	61.0%	36.0%
Medicare Eligible	66.9%	39.0%	64.0%
Total	**100.0%**	**100.0%**	100.0%

VI. Enrollment By Major Employer Groups	Employees	Dependents	Total
State Agencies	75,779	33,151	108,930
UNC System	50,357	29,457	79,814
Local Public Schools	180,864	86,046	266,910
Local Community Colleges	15,317	7,693	23,010
Other			
Local Governments	1,915	932	2,847
COBRA	2,251	750	3,001
Nat. Guard, Fire & Rescue	5	3	8
Sub-total	326,488	158,032	484,520
Retirement System	160,193	18,525	178,718
Total	**486,681**	**176,557**	**663,238**

Percent Enrollment by Major Employer Groups	Employees	Dependents	Total
State Agencies	15.6%	18.8%	16.4%
UNC System	10.3%	16.7%	12.0%
Local Public Schools	37.2%	48.7%	40.2%
Local Community Colleges	3.1%	4.4%	3.5%
Other			
Local Governments	0.4%	0.5%	0.4%
COBRA	0.5%	0.4%	0.5%
Nat. Guard, Fire & Rescue	0.0%	0.0%	0.0%
Sub-total	67.1%	89.5%	73.1%
Retirement System	32.9%	10.5%	26.9%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

Aon Consulting, North Carolina State Health Plan, Financial Projections – January 2011, Total for All Plans – 9.5% Trend with Risk Adjustment, with PBM Contract Savings, February 4, 2011.

Aon Consulting, North Carolina State Health Plan, Financial Projections – January 2011 – 14b ($10 Generic), Total for All Plans – 9.5% Trend with Risk Adjustment, with Max GF Benefits except $10 Generic, with PBM Contract Savings, Additional Premium Charged to All Tiers – Active 5% Standard, 2.5% Basic; Retiree 5% Standard, 0% Basic ($5 less for Medicare) Non-Smoker Movement: Active 5% single, 5% dependents; Retiree: 25%, 5% dependents, March 14, 2011.

Medco Health Solutions, various outpatient acute, specialty, and maintenance drug data and discount assumptions, December 2010.

State Health Plan, various summarized claims reports for medical claims by category and purpose and time period, December 2010.

-Actuarial Note, Hartman & Associates, Senate Bill 265 PCS, "Senate Bill 265 Proposed Committee Substitute S265-PCS35127-ME-4: An Act to Make Appropriations and Adjustments for the 2011-13 Biennium to the state Health Plan and to Transfer the Plan to the Office of State Treasurer", March 17, 2011, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, Senate Bill 265 PCS, "Senate Bill 265 Proposed Committee Substitute S265-PCS35127-ME-4 State Health Plan/Appropriations and Transfer", March 17, 2011, 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: March 29, 2011



Signed Copy Located in the NCGA Principal Clerk's Offices

MINUTES

HOUSE COMMITTEE ON INSURANCE

April 5, 2011

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 5, 2011, at 1:00 pm. The following members were present: Representatives Dockham, Chair, Blust, Brown, Bryant, Burr, Collins, Crawford, Current, Faison, Floyd, Folwell, Glazier, Hamilton, Howard, Hurley, Jackson, Johnson, McElraft, McGuirt, Mills, Murry, Pierce, Shepard, Steen, Stevens, Wainwright, Warren, and Wilkins. Tim Hovis and Bill Patterson, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes. (Attachment I)

Representative Dockham, Chair, called the meeting to order at 1:00 pm. He introduced the pages and the Sergeant of Arms staff. (Attachment II)

Chairman Dockham recognized Representative Folwell to introduce Dr. Richard A. Victor, Executive Director Workers Compensation Research Institute. (Attachment III)

Dr. Victor introduced himself and gave a PowerPoint presentation regarding the Workers Compensation Research Institute's major findings from its series of studies on the North Carolina workers' compensation system – focused on workers' outcomes and employers' costs. (Attachment IV)

Representative Dockham welcomed questions from the committee and discussion followed.

There being no further business, the Chair adjourned the meeting at 1:45 pm.

Respectfully submitted,

Jerry C. Dockham

Representative Jerry C. Dockham, Chair

Regina Irwin

Regina Irwin, Committee Assistant

Attachments

AGENDA

HOUSE COMMITTEE ON INSURANCE

April 5, 2011

1:00 pm

Room 1228/1327

WELCOME AND OPENING REMARKS

Representative Jerry Dockham, Chairman

INTRODUCTIONS

Pages & Sargent at Arms

Dr. Richard A. Victor, Executive Director Workers Compensation Research Institute

Carol Telles, Senior Analyst

Andrew Kenneally, Manager, Marketing & Communications

PRESENTATION

Dr. Victor, will present major findings from its series of studies on the North Carolina workers' compensation system – focused on workers' outcomes and employers' costs.

ADJOURNMENT

ATTACHMENT I

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

APRIL 5, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Paul Pulley	NCAJ
John McAlister	NC Chamber
Kimberly Robinson	NCRMA
Linda Wike	
Megan Shaver	
Ed Pauley	Workers in NC
Mark Dorby	AGAINST REFORM, NJ WORK. COMP
Lane Wallace	502 Polk St, Raleigh, NC
Whitney Wallace	opposed to WC reform
Krystal Draughn	against WC reform Bill
Matt Jacobs	Murphy-Brown LLC

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

APRIL 5, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
George Povets	CAT
David D Rogers	874 Montgomery Rd Lumberton, NC 28358
Willie R. Nixon	4690 US Hwy 64 A Plymouth NC
Derwood Sadler	2795 Holly Springs Ch Rd Williamston NC 27892
Belinda Anderson	210 Twin Hill Trail Southern Shores 27949
Branch W Vincent	120 Twisted Tree Court Southern Shores, NC 27949 (Dare)
Rogers Lipman Jr	Roper Po Box 336 27970
Ester Small	1240 Barkwood Rd Roper NC 27970
Mark Hanson	405 Piney Grove Ch Rd Jamesville 27846
Mackenzie Smith	Po Box 684 Plymouth NC 27962
Cleo P. Nixon	306 Downing Rd Roper, NC 27970

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

APRIL 5, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Benton	injured worker
Sarah Davis	Protect NC Workers
Jody Roberts	protect NC workers
William Purvington	injury Worker
Riccardo Nixon	protect nc workers
Veronica Zeilfelder	protect NC workers
David Neuman	Protect Worker
Nathan Jackson Jr	Protect Worker
Harvey Thomas	Prot ed Worker
Raymond Manning	Protect worker
John Jernigan	Leonard Jernigan lawyer

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
TODD YOHO	JERNIGAN COMPANY
Tony Vanette	Lowe's
Charlene ~~Vanett~~	LOCKS
Gerrius Davis	Shankle
Rita House	Shankle
Emory Johnson	
ANTHONY MATHIS	3000 ALICE FLAGLER Industrial NC
David Jacobs	1547 Elijah rd. Dillon N.C. 28369
Clara Jacobs	1547 Elijah rd Dillon N.C. 28369
Brittney Shankle	1227 Willow Bridge Ct Charlotte, NC 28216

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robert Ennis	8326 VIEWPOINT LANE CORNELIUS, NC 28031
Maggie Shankle	114 Kingsdown Ave. Charlotte, NC 28270
Dennis J. Cannon	116 Amanda Dr. Rockingham N. C 28379
TRAVIS PAYNE	P.O. Box 25186 RALEIGH NC 27611
Donald Ragavage	PFFPNC.
Duane Messner	PFFP
Kenneth H Drum	7071 Maple Glen Dr. Catawba, NC 28037
DAVID VTipil	311 Mizzen Rd Apt Cary NC 27518
T. Bazzik	8370 Piamont Blvd Raleigh NC 27612
Diana Menezes	115-1A "Abingdon Ct. Cary NC 27513

VISITOR REGISTRATION SHEET

Name of Committee _____ Date _____

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Charlene Shaw	DOT
~~ARTHER CARELL~~	~~6600 W. Cl~~
JEFFREY A GALLAHER	PFFPNC LOCAL 4249
Jacqueline Craig	Goodyear United Steelworkers Local 9157
Kim Cody	USW Local 959
Richard OQuinn	Sanford, NC 27332 injured worker 8516 Peach Tree Dr
include Les Dutcher	Attorney injured workers.
Alice Hudson	Grimes Teich Anderson Ashv
Gail Hale	2009 Fernwood Ct Henderson NC 27536
David T Malbrough	DeMayo Law Firm 1711 E Morehead St. Charlotte, NC 28234

VISITOR REGISTRATION SHEET

HOUSE HEALTH & HUMAN SERVICES
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Timothy W. Pierce	5626 Davis mill Rd Greensboro NC. 27406
Lee Ray Smith	5401 Spurrading Branch Rd Hope mills nc 28348
Maureen Geraghty	121 Cascade Ave, Winston-Salem 27127
Felipe Fierro	Raleigh Professional Fire Fighters Assoc LOCAL 548 I.A.F.F.
Corey McGee	RALEIGH PROFESSIONAL FIREFIGHTER ASSOC. LOCAL 548
John Rehbock	" "
John Romero	JACKSONVILL ASSOC of Prof F/F Paramedics c-4249
John D. Foster	Charlotte Firefighters Local 660
Keith WILDER	Raleigh Professional Fire Fighters Association Local #548

VISITOR REGISTRATION SHEET

Name of Committee _____ Date _____

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
JACK Knight	STOKesdale N.C.
MATT + DEANE HAGGINS	ASHEBORO N.C.
Jasmine Roach	Younce + Vtipil, PA 3701 Lake Boone Trail, Suite 300 Raleigh NC 27607
Carmella Williams	Younce + Vtipil, P.A.
Phyllis Reinhardt	455 Benjamin Trott Ln Salisbury NC 28147
George W. Rinehardt Sr	455 BENJAMIN-TROTT LANE SALISBURY, N.C. 28147 - PERSONAL
Adrienne Wilkerson	156 Buchanan Lane Clayton, NC 27527
CHARLES B Hutchens	YADKIN VILLE NC 27055 VOW
Melva T. Hutchens	YADKINVILLE N.C. VOW
Don. V Lonnie Simmons	Ramseur, NC
Jennifer B. Williams	P.O. Box 3131 Henderson N.C. 27536

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Paula Price	Greensboro N.C. Due to man firm
Marion B. Wright	Weyerhaeuser (retired) Plymouth, N.C.
Andrew Kenneally	Workers Compensation Research Institute (WCRI)
Mike Ziglar	Guest of Rep Folwell (Freedom Works)

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

APRIL 5, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Lee	VOW
Michael W. Lee	VOW
DZ Nelson	VOW
Rev. K. Nelson	VOW
Glen Gillette	Professional Fire Fighters and Paramedics of North Carolina
David Anders	" "
Jack Williams	VOW
Lu-Ann Faggman	Carolina State Strategies
Kathy Hamm	
MgWill	
Carla Marshburn	

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

APRIL 5, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Shirley J. Simpson	
Don DeHart SR.	Durham, N.C.
Leslie Wickham JR	Durham, N.C.
Shirley Goodman	Salisbury, NC
Victor Farah	Raleigh
Guy Cameron	Cary NC
Bill Wilson	AARP
Annaliese Ralph	DKNC
Jennifer Cohen	IFNC
Grant Eagan	NMRS
Doug File	Salisbury N.C.

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

APRIL 5, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tammy File	430 Scout Rd. Salisbury, NC 28146
William Allen	544 Efird ST. Winston-Salem, NC. 27105
Sara Fender	IFNC
E.R.W. [illegible]	2500 Yanceyville Rd WST. NC 27107 Tobacco Road 391
[illegible]	~~2211~~ 350 Holly SP. Ch. 12D 27892
Marjorie W. [illegible]	2500 Yanceyville Rd WST. NC 27107
D.W. Graham	1929 Old Blacksmith Rd, Bolton, NC. 28423
Alexis Clemmons	4140 Northwest Rd Leland NC 28451
Leonard Gresham	USW Local 9-738 Ridgelwood N.C. 28458
LINDA DeBerry	3915 IE Dallas Way HighPoint NC 27265
Mildred Ann Brown	144 Oak Forest Drive Kernersville, North Carolina, 27284

VISITOR REGISTRATION SHEET

Name of Committee | **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amy Buchanan	Deuterman Law Group 317 S. Greene St Greensboro, NC 27401
Shannan Donavan	Lee & Smith Attorneys At law firm Spartanburg S.C.
Barry Cotter	Wallace & Graham Salisbury N.C.
Kenneth Trumpower	
Betty Trumpower	
Tom Swink	
Claudette Allen	Wallace & Graham Salisbury NC 28144
Jeff Warren	Wallace & Graham Salisbury NC. 28138
David Warren	Wallace & Graham Salisbury NC 28138
Loretta Patrick	Wallace & Graham Salisbury, N. C.
Melinda Crumpler	Vance & Hipp, PA. 3701 Lake Boone Trail Ste 300 Raleigh, NC 27607

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ATTACHMENT II

HOUSE PAGES

NAME OF COMMITTEE: INSURANCE DATE: APRIL 5, 2011

1. NAME: Amanda Keysser
   County: Wake
   Sponsor: Ingle
2. NAME: Sarah Cook
   County: Johnston
   Sponsor: Daughtry
3. NAME:
   County:
   Sponsor:
4. NAME:
   County:
   Sponsor:
5. NAME:
   County:
   Sponsor:

SERGEANTS-AT-ARMS

1. Name: Bill MacRae
2. Name: Reginald Sills
3. Name: Garland Shepherd
4. Name:
5: Name:

Dr. RICHARD A. VICTOR, Executive Director Workers Compensation Research Institute

Dr. Victor has been the Executive Director of the Workers Compensation Research Institute (WCRI) since its inception in 1983.

The Institute, located in Cambridge, Massachusetts, is an independent, not-for-profit research organization providing high-quality objective information about public policy issues involving workers' compensation systems.

Dr. Victor is the author of numerous books and articles on worker's compensation issues.

Prior to working at the Institute, Dr. Victor spent seven years conducting research at The Rand Corporation in both Washington, D.C., and Santa Monica, California.

At Rand, he was a principal researcher at the Institute for Civil Justice.

Dr. Victor received his J.D. and Ph.D. (economics) degrees at the University of Michigan, where he was the George Humphrey Fellow in Law and Economic Policy.

How Workers' Compensation In North Carolina Compares To Other States

Testimony Before North Carolina House Insurance Committee,
April 5, 2011

Today's Outline

How do NC workers fare?
Is NC a high cost state for employers?
Where are NC costs higher than typical?

About the Workers Compensation Research Institute (WCRI)



High-level Summary For N. Carolina

- Important worker outcomes were average, except initial payment was slower
- Employers' average premiums were in the mid-range of states
- Average cost per claim was 19–45% higher than the median state
  - May suggest opportunities to reduce costs



High-level Summary For N. Carolina

- Main areas where costs higher than typical
  - Hospital costs—both inpatient and outpatient
  - Surgery rates higher than most states
  - Average income benefits per claim
    - Frequency and size of lump-sum settlements
    - Hybrid income benefit system
- Chiropractic care used more in other states
- Increasing litigiousness



About WCRI

- Not-for-profit public policy research institute – since 1983, Cambridge, MA
- Funding from diverse membership dues
  - Employers, insurers, TPAs
  - State governments – US, Canada, Australia
  - Health care provider and managed care organizations
  - Several state labor organizations



About WCRI

- Not make recommendations nor take positions on issues studied
- Studies quality-assured by external peer reviewers
- Focused on benefit delivery system, not on insurance mechanism or pricing

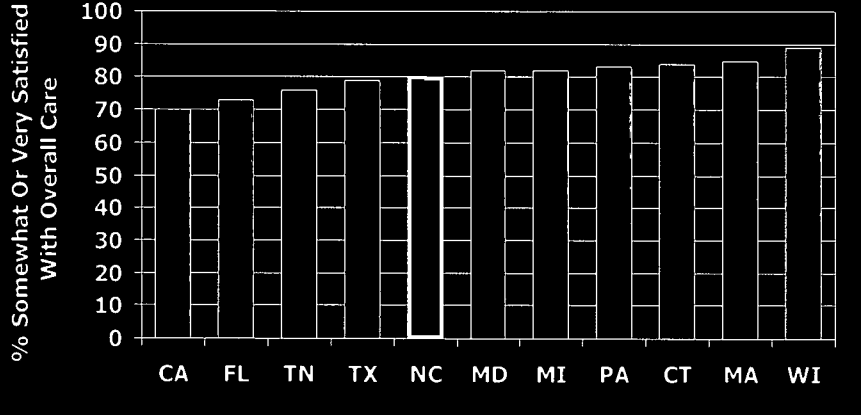


How Do NC Workers Fare?

- Satisfaction with healthcare was typical
- Recovery of health was typical
- Speed of return to work was average
- Access to care was average or below average
- First payment was slower than typical

WCRI

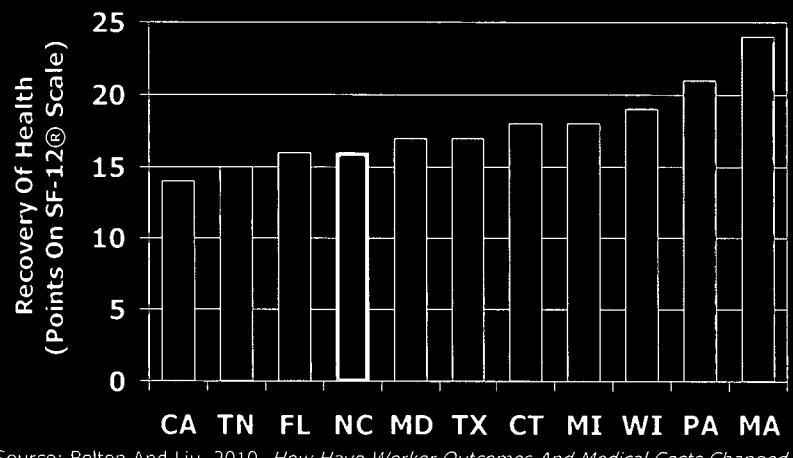
NC Workers Reported Typical Satisfaction With Healthcare



WCRI

Source: Belton And Liu. 2010. *How Have Worker Outcomes And Medical Costs Changed In Wisconsin?*

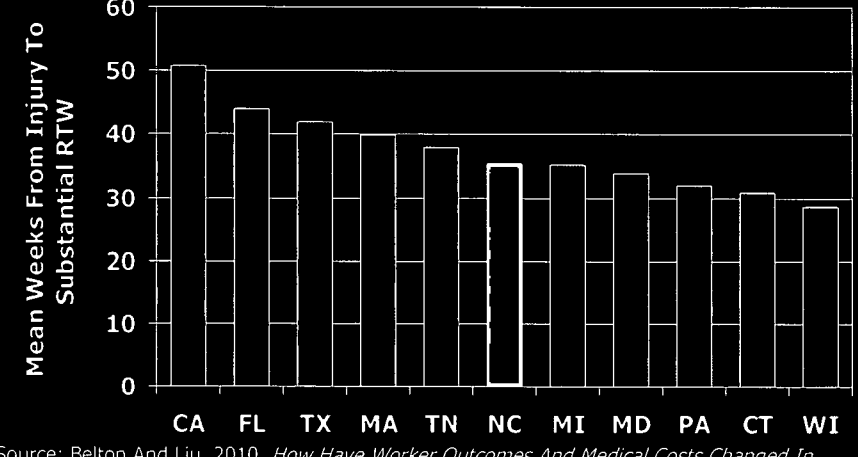
*NC Workers' Recovery Of Health Typical Of States Studied



WCRI

Source: Belton And Liu. 2010. *How Have Worker Outcomes And Medical Costs Changed In Wisconsin?*

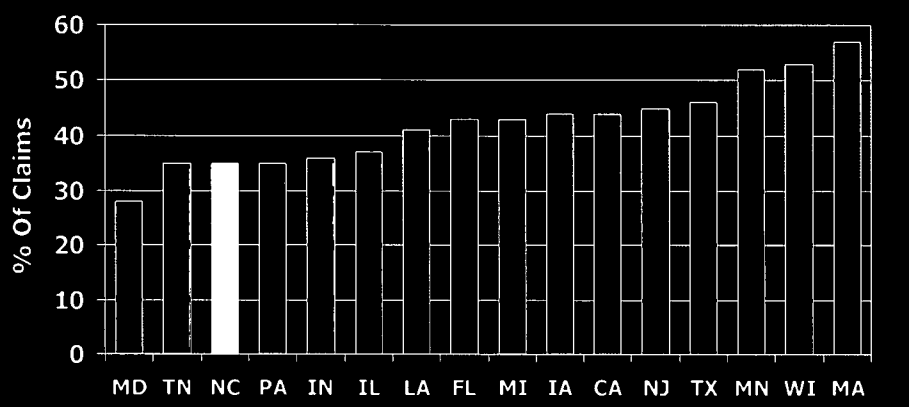
NC Workers Reported Average Speed Of Return To Work



WCRI

Source: Belton And Liu. 2010. *How Have Worker Outcomes And Medical Costs Changed In Wisconsin?*

NC Workers Received First Income Benefit Check Later Than Most States



WCRI

2008 Claims With First Indemnity Payment Within 14 Days Of Payor Notice, At 12 Months Of Experience With > 7 Days Of Lost Time, Not Adjusted For Case Mix

Today's Outline

- How do NC workers fare?
- Is NC a high cost state for employers?
- Where are NC costs higher than typical?

WCRI

Employers' Average Premiums Were Mid-range Of States

Cost Metric	NC vs. Median State	# States Compared
Insurance Premium Rate	+3%	50 + D.C.
Cost Per Worker	+9%	46

WCRI

NC Higher Cost Per Claim: Cost Reduction Opportunities Might Exist

Cost Metric	NC vs. Median State	# States Compared
Cost Per Worker	+9%	46
Insurance Premium Rate	+3%	50 + D.C.
Avg. Incurred Cost/Claim	+34%	46
Avg. Paid Cost/Claim	+19%	16
Avg. Paid Cost/Claim With > 7 Days Lost Time	+45%	16

WCRI

Today's Outline

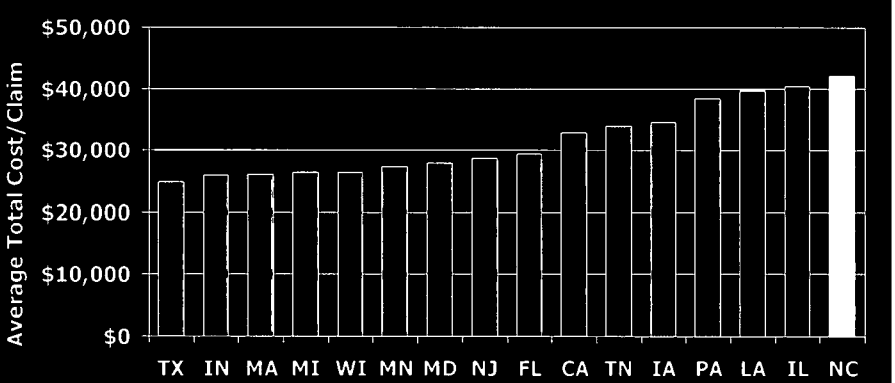
How do NC workers fare?

Is NC a high cost state for employers?

Where are NC costs higher than typical?

WCRI

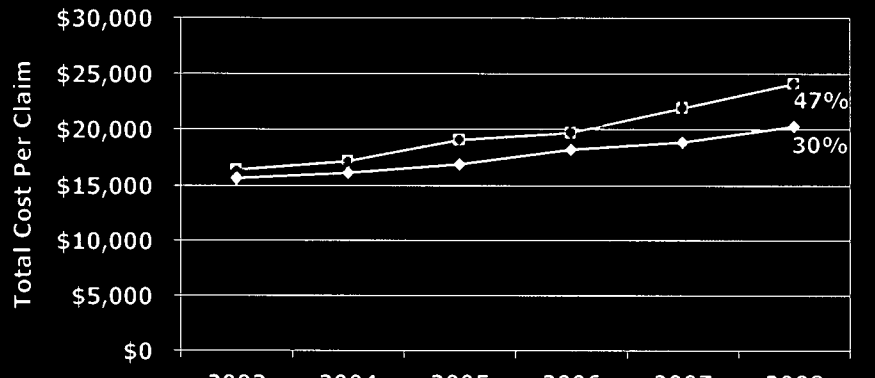
Total Costs Per Claim In NC Highest Of Study States



2006/09 Claims With > 7 Days Of Lost Time,
Adjusted For Injury/Industry Mix And Wages

WCRI

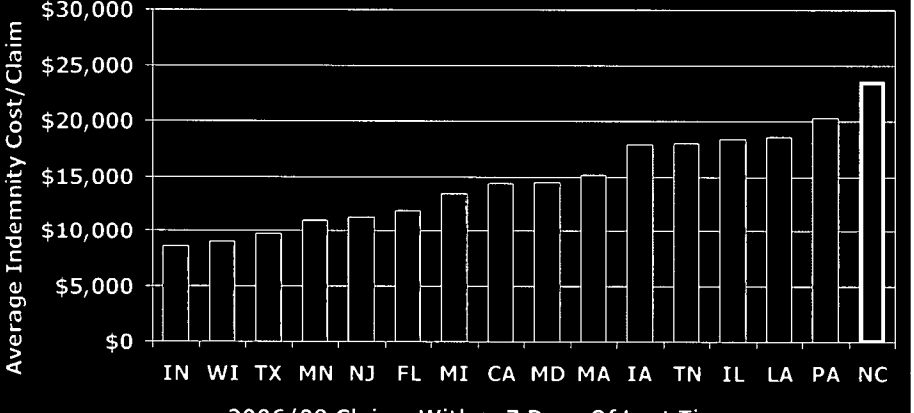
NC Total Costs Per Claim Grew Faster Than The Median State In The Study



WCRI

Claims With > 7 Days Of Lost Time At 12 Months Of Experience, Not Adjusted For Case Mix

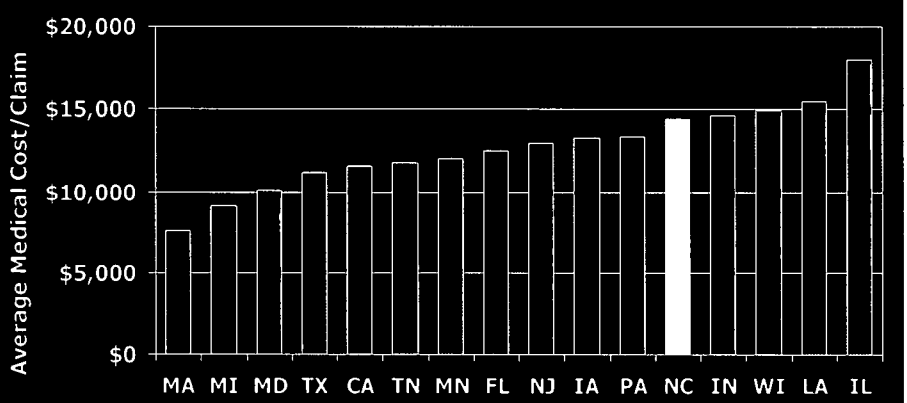
NC Had Highest Indemnity Benefits Paid Per Claim



WCRI

2006/09 Claims With > 7 Days Of Lost Time, Adjusted For Injury/Industry Mix And Wages

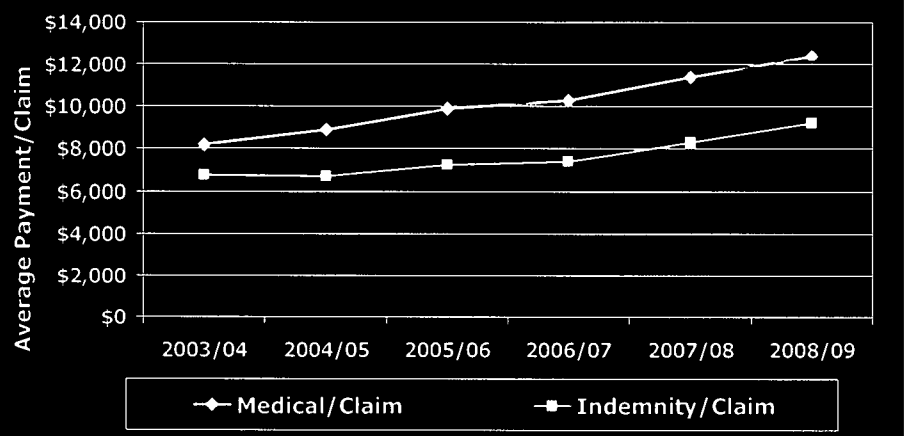
Medical Cost Per Claim In NC 13% Higher Than Median State



WCRI

2006/09 Claims With > 7 Days Of Lost Time,
Adjusted For Injury/Industry Mix And Wages

*North Carolina Medical And Indemnity Costs Per Claim Grew



WCRI

Claims With > 7 Days Of Lost Time At 12 Months Of Experience,
Not Adjusted For Injury/Industry Mix

Data And Methods

- Data reasonably representative of states' experience
  - Source: Insurers, self-insurers, state insurance funds
  - 56% of North Carolina claims; 44–80% across all 16 states
- Meaningful interstate comparisons
  - Definitions harmonized across states and data sources
  - Adjusted for interstate differences in:
    - Injury mix, industry mix, wage levels
  - Adjusted for differences in waiting periods



NC Hospitals Received Higher Payments Per Claim

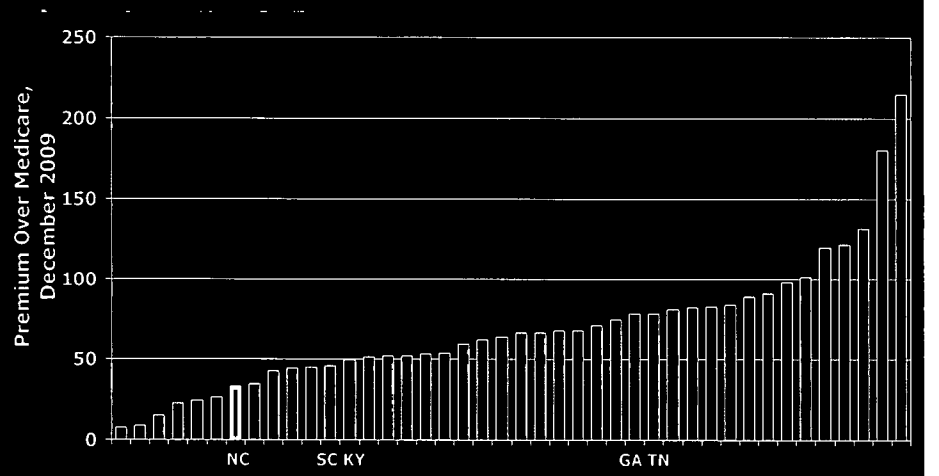
Average Payment Per Claim	North Carolina	16-State Median	Percent Difference
Nonhospital	$4,712	$5,018	-6%
Outpatient	$5,883	$3,848	53%
Inpatient	$29,214	$20,633	42%



2007/08 Claims With > 7 Days Of Lost Time, Adjusted For Injury/Industry Mix And Wages

Source: *CompScope™ Medical Benchmarks For North Carolina, 10th Edition* (2010)

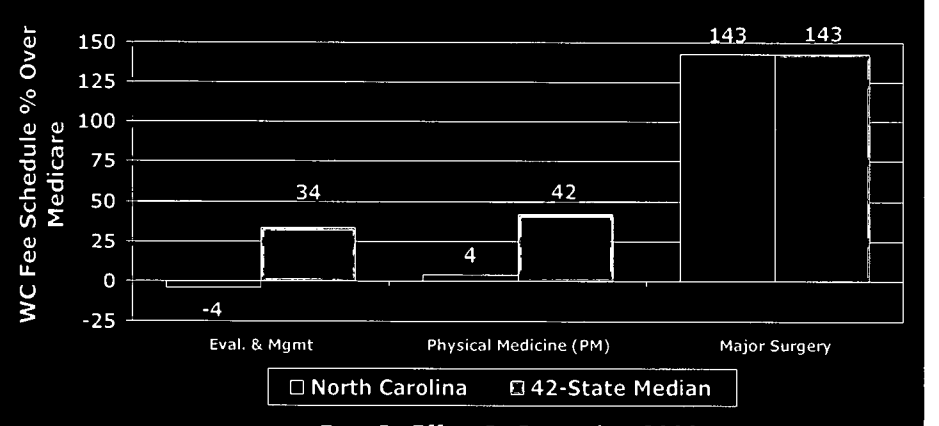
*For Nonhospital Providers, Fee Schedule Was Lower Than Median State



WCRI

Source: *Benchmarks For Designing Workers' Compensation Medical Fee Schedules: 2009*

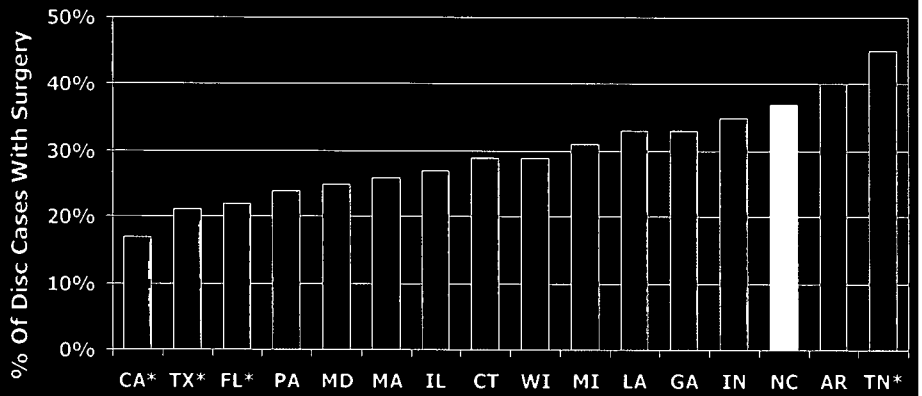
NC Nonhospital Fee Schedule Low For Primary Care & PM; Typical For Surgery



WCRI

Source: *Benchmarks For Designing WC Medical Fee Schedules: 2009* (2010)

Disc Cases: NC Surgery Rate Higher Than Median State



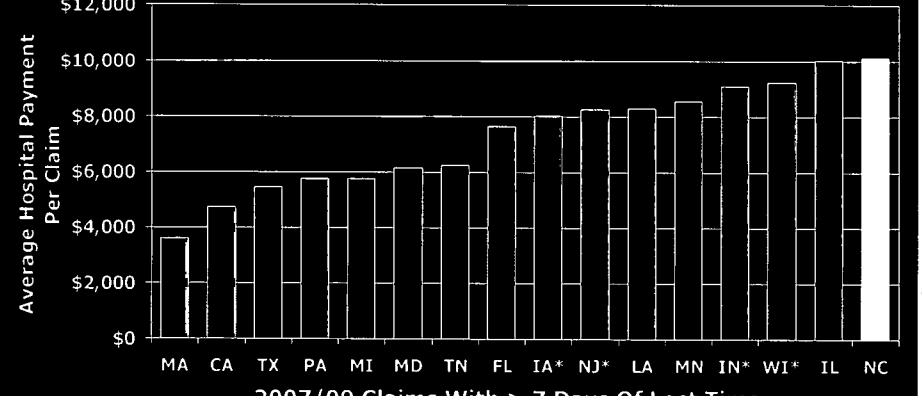
2000-2003 Claims With > 7 Days Of Lost Time In 16 States, Up To 12 Months Of Medical Treatment

* Data For CA, FL, TN, And TX Were Before Major Medical Reform

WCRI

Preliminary Findings—Subject To Change

Highest Hospital Payments Per Claim In North Carolina



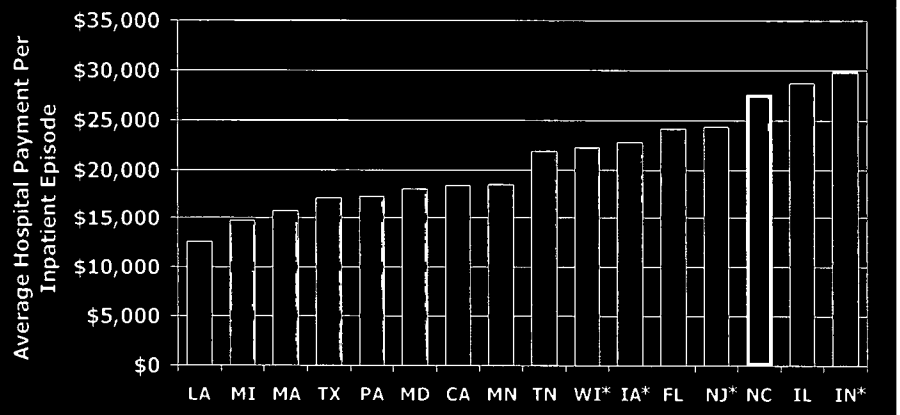
2007/09 Claims With > 7 Days Of Lost Time, Adjusted For Injury/Industry Mix

* No Specific WC Hospital Fee Regulation

WCRI

Preliminary Findings—Subject To Change

NC Hospital Payment Per Inpatient Episode Among The Highest



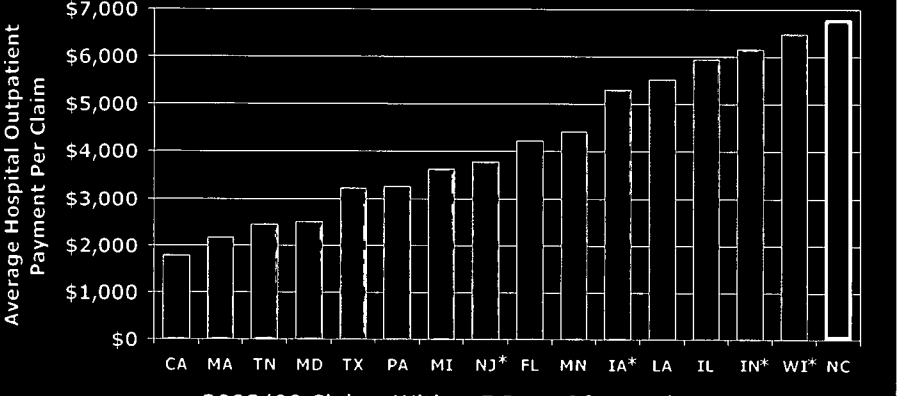
2007/09 Claims With > 7 Days Of Lost Time,
Adjusted For Injury/Industry Mix

* No Specific WC Hospital Inpatient Fee Regulation

WCRI

Preliminary Findings—Subject To Change

Highest Hospital Outpatient Payment Per Claim In NC

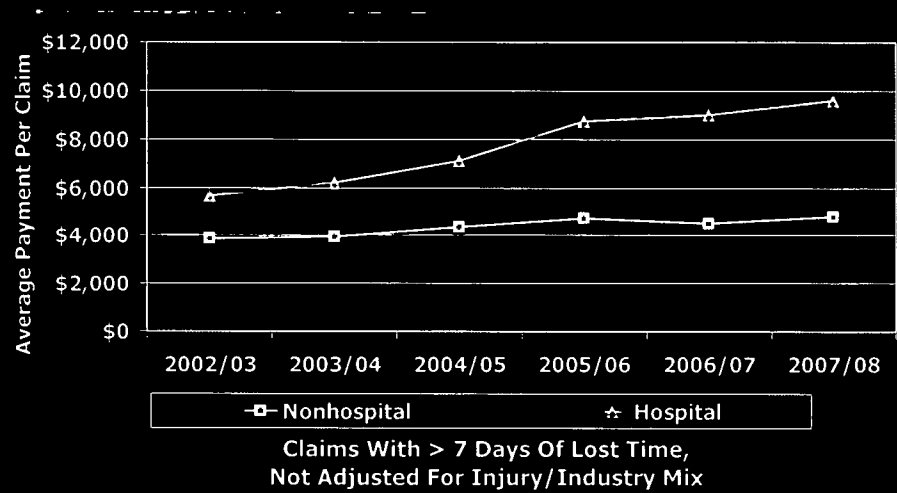


2008/09 Claims With > 7 Days Of Lost Time,
Adjusted For Injury/Industry Mix

* No Specific WC Hospital Outpatient Fee Regulation

WCRI

Hospital Payments Drove Growth In NC Medical Costs Per Claim



Claims With > 7 Days Of Lost Time,
Not Adjusted For Injury/Industry Mix

Source: *CompScope™ Medical Benchmarks For North Carolina, 10th Edition* (2010)

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*Hospital Fee Schedule Lowered Rates In July 2009

- *Hospital Inpatient*: DRG end cap lowered from 77.07% to 75% of charges (most hospitals)
- *Hospital Outpatient*: Reduced maximum rate
  - 79% of charges from 95% (most hospitals)
  - 87% of charges from 95% (critical care hospitals)
- *ASC:* Reduced rates to 79% of charges from 100%

WCRI

Preliminary Findings—Subject To Change

*Inferring Likely Impact Of 2009 Changes To Hospital Outpatient Fee Schedule: Examples

CPT Or R Code	Service	Actual Paid-To-Charge Ratio*	Applicable Fee Schedule Ratio
97110	Therapeutic Procedure (PT)	.70	.79-.87
610	MRI	.93	.79-.87
70450	CT Scan, Head Or Brain, 2 Views	.96	.79-.87
320	X-ray	.86	.79-.87
71020	Chest X-ray	.87	.79-.87
360	Operating Room	.92	.79-.87

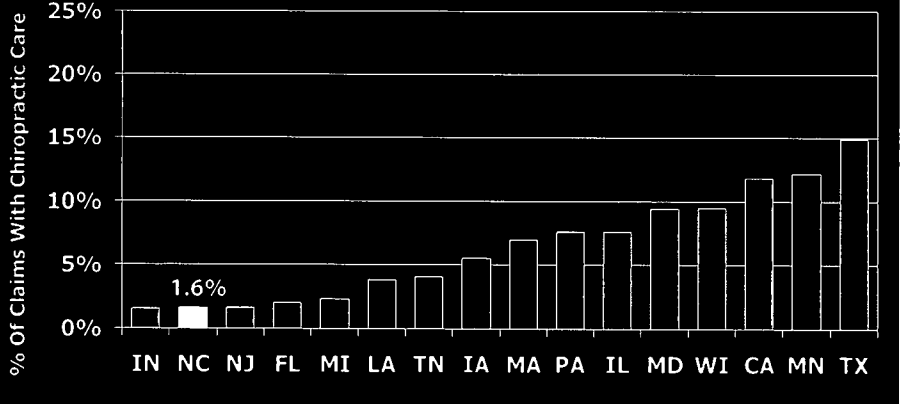
WCRI

***Pre-reform**

2008/09 Claims With > 7 Days Of Lost Time

Preliminary Findings—Subject To Change

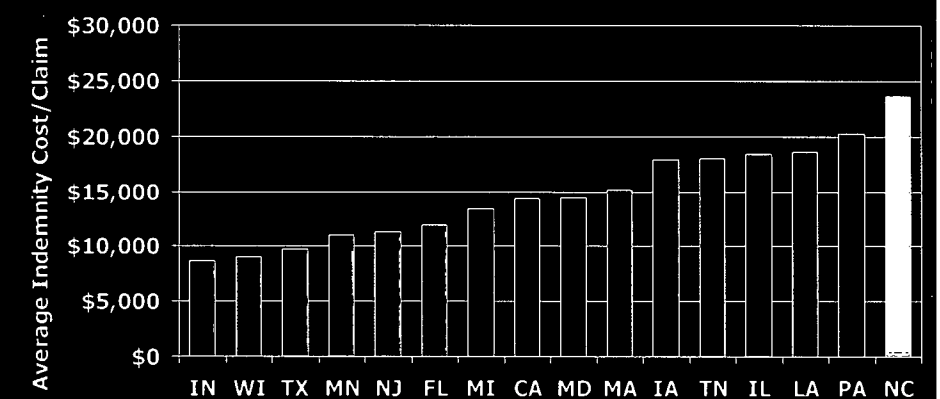
*NC Chiropractors Rarely Treat Injured Workers



WCRI

2008/09 Claims With > 7 Days Of Lost Time, Adjusted For Injury/Industry Mix

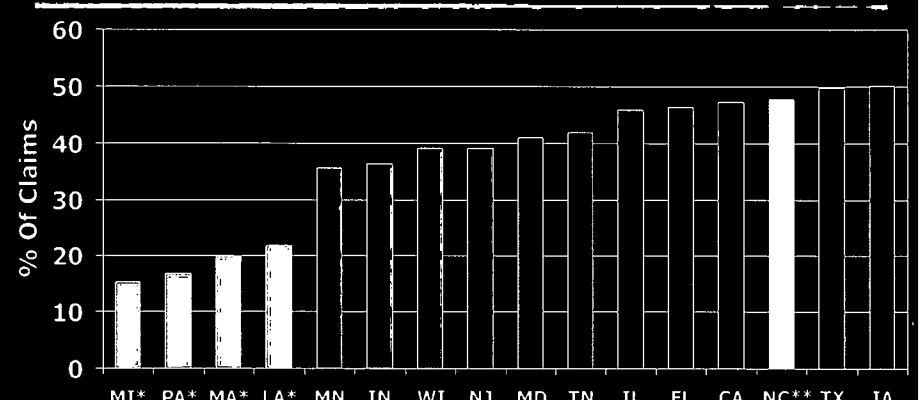
Highest Indemnity Benefits Paid Per Claim In NC



WCRI

2006/09 Claims With > 7 Days Of Lost Time,
Adjusted For Injury/Industry Mix And Wages

NC Workers More Often Received PPD Payments Or Lump-Sum Settlements

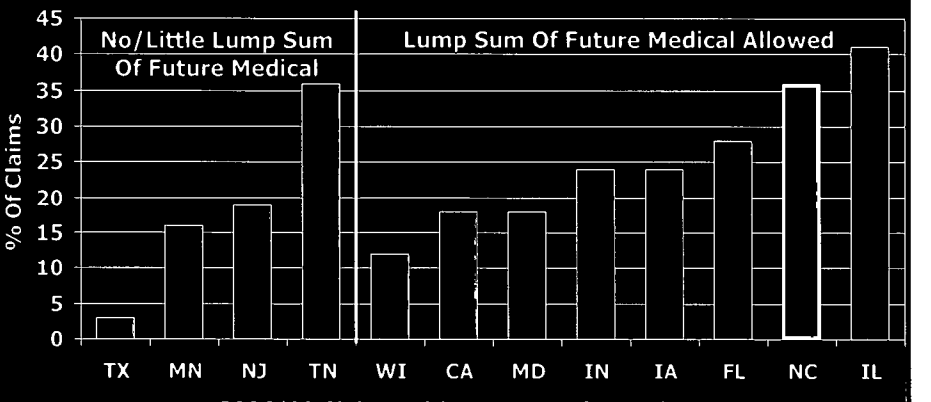


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2006/09 Claims With > 7 Days Of Lost Time,
Adjusted For Injury/Industry Mix And Wages

* Wage-Loss Benefit System ** Wage-Loss And PPD

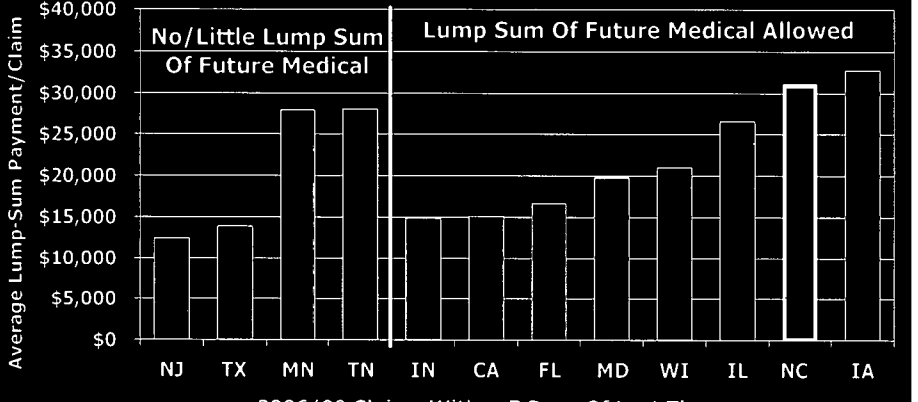
Lump-Sum Settlements Occur More Often In North Carolina



2006/09 Claims With > 7 Days Of Lost Time, Adjusted For Injury/Industry Mix And Wages

WCRI

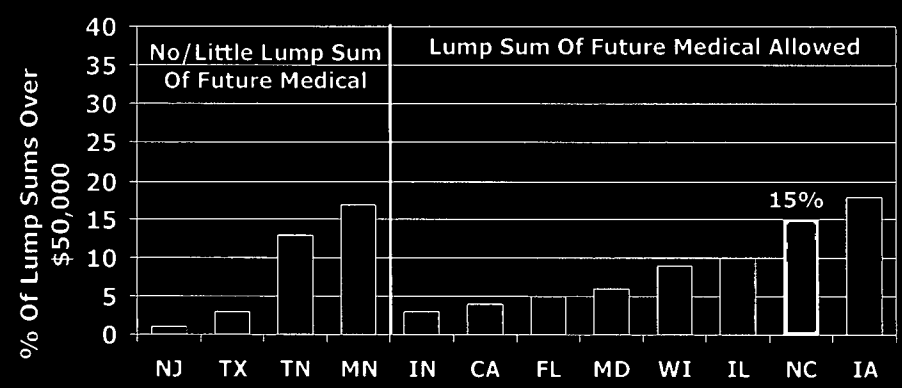
Lump-Sum Payments Larger In NC



2006/09 Claims With > 7 Days Of Lost Time, Adjusted For Injury/Industry Mix And Wages

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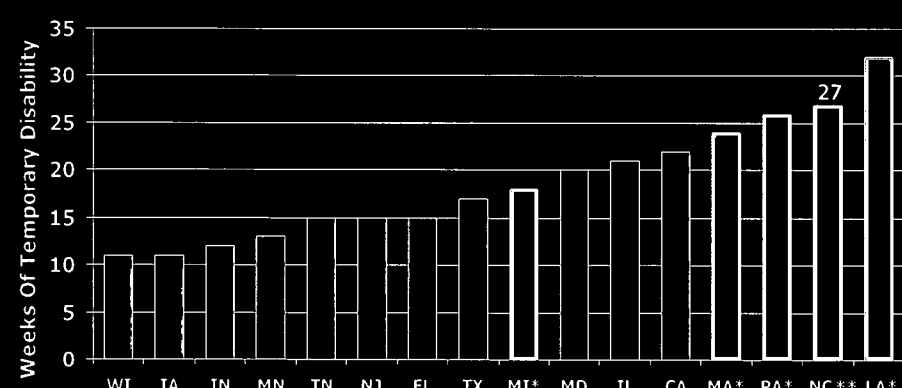
*Lump Sums In NC More Likely To Exceed $50,000



Claims With Lump-Sum Settlements,
2006/09 Claims With > 7 Days Of Lost Time

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*NC Had Longer Duration Of Temporary Disability Payments

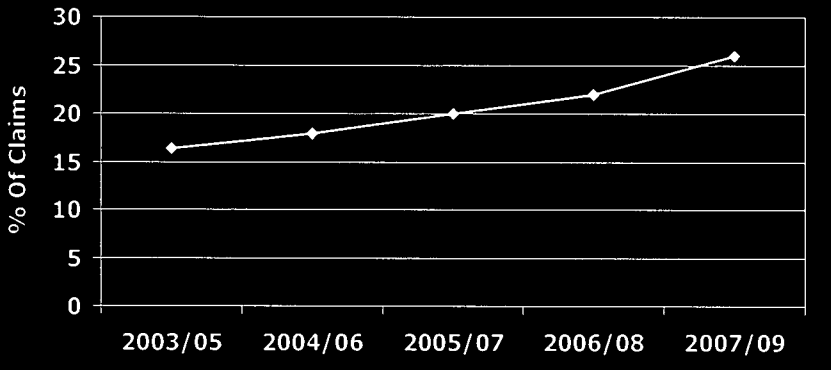


2006/09 Claims With > 7 Days Of Lost Time,
Adjusted For Injury/Industry Mix And Wages

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* Wage-Loss Benefit System ** Wage-Loss And PPD

*Litigiousness Increased
(% Of Claims With Defense Attorney)



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Claims With > 7 Days Of Lost Time At 24 Months Of Experience

High-level Summary For N. Carolina

- Important worker outcomes were average, except initial payment was slower
- Employers' average premiums were in the mid-range of states
- Average cost per claim was 19-45% higher than the median state
  - May suggest opportunities to reduce costs

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High-level Summary For N. Carolina

- Main areas where costs higher than typical
  - Hospital costs—both inpatient and outpatient
  - Surgery rates higher than most states
  - Average income benefits per claim
    - Frequency and size of lump-sum settlements
    - Hybrid income benefit system
- Chiropractic care used more in other states
- Increasing litigiousness



*Recent WCRI Studies That Include North Carolina Information

- Comparing Outcomes for Injured Workers (2010)
- CompScope™ Benchmarks, 11th Edition (2011)
- CompScope™ Medical Benchmarks, 11th Edition (forthcoming)
- Prescription Benchmarks for North Carolina (2010)
- Benchmarks for Designing Workers' Compensation Medical Fee Schedules (2010)
- National Inventory of WC Fee Schedules for Hospitals and Ambulatory Surgical Centers (2010)



*Recent WCRI Studies That Include North Carolina Information

- Workers' Compensation Medical Cost Containment: National Inventory (2009)
- WCRI Medical Price Index (annual)
- Interstate Variations in Medical Practice Patterns for Low Back Conditions (2008)

WCRI

For More Information About WCRI

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Deputy Director
rtanabe@wcrinet.org

Richard Victor
Executive Director
rvictor@wcrinet.org

WCRI

MINUTES

HOUSE COMMITTEE ON INSURANCE

April 12, 2011

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 12, 2011, at 1:00 pm. The following members were present: Representatives Dockham, Chair, Blust, Brown, Bryant, Collins, Crawford, Current; Faison, Floyd, Folwell, Glazier, Graham, Hamilton, Howard, Hurley, Insko, McElraft, McGuirt, Mills, Murry, Pierce, Setzer, Shepard, Steen, Stevens, Warren, Wilkins, and Wray. Tim Hovis and Bill Patterson, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes. (Attachment I)

Representative Dockham, Chair, called the meeting to order at 1:00 pm. He introduced the pages and the Sergeant of Arms staff. (Attachment II) The following bill was considered:

HB 115, entitled, A BILL TO BE ENTITLED AN ACT TO PRESERVE STATE-BASED AUTHORITY TO REGULATE THE NORTH CAROLINA HEALTH INSURANCE MARKET AND TO PREVENT FEDERAL ENCROACHMENT ON STATE AUTHORITY BY ESTABLISHING THE NORTH CAROLINA BENEFIT EXCHANGE.

Representative Dockham, bill sponsor, presented a proposed committee substitute. Representative Wilkins moved for adoption of the committee substitute for discussion only. The motion passed. The Chair indicated that due to the complexity of this legislation and time constraints, and to give members a chance to review the committee substitute in more detail, no amendments will be accepted or vote taken at this meeting. The bill will be taken up for a vote in the next House Committee on Insurance meeting. Representative Dockham recognized Amy Jo Johnson, Committee Staff Counsel, to explain the committee substitute. (Attachment III)

Representative Dockham welcomed questions from the committee and discussion followed.

There being no further business, the Chair adjourned the meeting at 1:45 pm.

Respectfully submitted,

Representative Jerry C. Dockham, Chair

Regina Irwin, Committee Assistant

Attachments

AGENDA

HOUSE COMMITTEE ON INSURANCE

April 12, 2011

Room 1228

1:00 pm

OPENING REMARKS

Representative Jerry Dockham, Chairman
Insurance Committee

AGENDA ITEMS

HB 115 - NORTH CAROLINA HEALTH BENEFIT EXCHANGE
Representative Jerry Dockham, Sponsor
Representative Harold Brubaker, Sponsor
Representative Michael Wray, Sponsor
Representative Tom Murry, Sponsor

ADJOURNMENT

ATTACHMENT I

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

APRIL 12, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Clyp Bryant	NCMS
Amy Whited	NCMS
Alex Miller	KLG
Cynthia Barnett	Christian Science Committee on Publication, NC
SARAH SONKE	1400 Hillsborough Raleigh NC
RICHARD PARRISH	NMSS-NC
Adam Searcy	
Abby Emanuelson	NMSS-NC
Christine Wreason	American Cancer Society
Sandy Greene	NC Council of Churches
MaryBe McMillan	NC AFL-CIO

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

APRIL 12, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Nicole Fisher	John Locke Fdtn
Matt Wolfe	Parker Poe
Bill Cox	DSI
John Minnich	CSC
Faye Sitwell	GA
Room Killian	Nelson Mullins
Con Teague	"
David Heron	NC Center for Nonprofits
Ed Turlington	Brooks Pierce
Jamie Fitzgerald	MLC
Sara Dixon	Intern

VISITOR REGISTRATION SHEET

INSURANCE — APRIL 12, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dana Simpson	Smith Anderson
Mari Wilder	Novant
Jon Weller	HBC
Barbara Hurst	NCRTV
Amy McConkey	NC Ben Assn
Mason Hall	Smith Anderson
Ralph Burbage	Rep. Dixon
Angie Harris	WM
ROBERT BARATTA	MEDCO / CAPITAL RESULTS
Meg McDonald	Capitol Results
Joseph Coletti	John Locke Foundation

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

APRIL 12, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Allen Feezor	DHHS
Catherine Moore	NC Nurses Association
Tina Gordon	NC Nurses
Sherman McCoy	Aetna/Wicle
John Dewitt	Governor's Office
Jean Holliday	NCDOI
Julia Lerche	NCDOI
Ben Popkin	NCDOI
Rose Williams	NCDOI
Louis Bdo	NCDOI
Barbara Conley	BCBSNC

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

APRIL 12, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carye Dunn	DRNC
Annaliese Dolph	DRNC
Barbara Morales Burke	Blue Cross Blue Shield NC
	BCBSNC
Kathryn Williams	BCBSNC
Randy Pridgen	Capital Health Mgmt
	Inclusive Health
	DHHS
	AFC

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

APRIL 12, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sarah Preston	ACLU-NC
Melissa Reed	PPHS
Kira Miskimmin	PPHS
Penny Hufft	School of Gov.
Jessica Ramsaur	NCIMS
Evelyn Hutchins	BB&T
Joel Mayhard	HCTA
Mark Stevens	SEANC
J Goodman	NC Chamber
David Barnes	PS
Kevin Byng	NCCC

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

APRIL 12, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Bowdish	AstraZeneca
Ken Melton	K. M. A.
Becki Gray	John Locke Foundation

PLEASE PRINT

ATTACHMENT II

HOUSE PAGES

NAME OF COMMITTEE: INSURANCE DATE: APRIL 12, 2011

1. NAME: Savanah Carlyle
   County: Guilford
   Sponsor: Bill Owens
2. NAME: Danielle Henderson
   County: Pitt
   Sponsor: Bill Cook
3. NAME:
   County:
   Sponsor:
4. NAME:
   County:
   Sponsor:
5. NAME:
   County:
   Sponsor:

SERGEANTS-AT-ARMS

1. Name: Bill MacRae
2. Name: Reginald Sills
3. Name: Ken Kirby
4. Name:
5: Name:

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 115
Committee Substitute Favorable 3/30/11
PROPOSED COMMITTEE SUBSTITUTE H115-CSTK-4 [v.4]

4/11/2011 2:40:57 PM

Short Title: North Carolina Health Benefit Exchange. (Public)

Sponsors:

Referred to:

February 17, 2011

A BILL TO BE ENTITLED

AN ACT TO PRESERVE STATE-BASED AUTHORITY TO REGULATE THE NORTH CAROLINA HEALTH INSURANCE MARKET AND TO PREVENT FEDERAL ENCROACHMENT ON STATE AUTHORITY BY ESTABLISHING THE NORTH CAROLINA BENEFIT EXCHANGE.

The General Assembly of North Carolina enacts:

SECTION 1. The purpose of this act is to provide for the establishment of the North Carolina Health Benefits Exchange Authority (Exchange Authority). The purpose of the Exchange Authority is to facilitate the purchase and sale of qualified health plans in the individual and small employer market by providing education, outreach, and technical assistance. The General Assembly believes it is in the best interest of the State, and thus the purpose of the Exchange Authority, to promote competition and choice in the health care marketplace and to facilitate innovation by offering products with variation in price and design. The Exchange Authority shall accomplish its purpose through a robust portal that provides meaningful guidance to health benefit plans that meet the needs of the health care marketplace of this State and not through the limitations of health benefit plan options to qualified individuals or qualified employers or by excluding health benefit plans who meet the premium and solvency requirements approved by the North Carolina Department of Insurance. In establishing the Exchange Authority, it is the intent of the General Assembly to reduce the number of uninsured individuals in this State, promote improved competition in the health care marketplace, reduce health care costs by, among other things, improving reimbursements to health care providers for uncompensated care, increasing consumer education, increasing transparency, and assisting individuals and employers in accessing health coverage, premium tax credits, and cost-sharing reductions.

SECTION 2. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 8. North Carolina Health Benefit Exchange Act.

"**§ 58-50-300. Definitions.**

The following definitions apply to this Part:

(1) Agent. – Defined in G.S. 58-33-10(1).

(2) Board. – The Board of Directors of the North Carolina Health Benefit Exchange Authority.

(3) Broker. – Defined in G.S. 58-33-10(3).

(4) Commissioner. – The Commissioner of Insurance of North Carolina or the Commissioner's authorized designee.

(5) Educated Health Care Consumer. – An individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical, and scientific matters.

(6) Essential Health Benefits. – Defined under section 1302(b) of the Federal Act.

(7) Exchange Authority. – The North Carolina Health Benefit Exchange Authority established pursuant to G.S. 58-50-310 and includes the Individual Exchange and the SHOP Exchange, unless otherwise specified.

(8) Executive Director. – The individual selected by a majority vote of the Board members and hired to serve as the Executive Director of the Exchange Authority.

(9) Federal Act. – The federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as further amended, as well as any regulations or guidance issued under those acts.

(10) Grandfathered Health Plan Coverage or Grandfathered Health Plan. – Defined in 45 C.F.R. Part 147.140(a).

(11) Health Benefit Plan. – Defined in G.S. 58-3-167(a)(1).

(12) Health Care Provider. – Defined in G.S. 58-50-270(3a).

(13) Health Insurer or Insurer. – Defined in G.S. 58-68-25(a)(6) and, for the purposes of this act, the terms also include qualified nonprofit health insurance issuers (CO-OP Insurers) as provided in section 1322 of the Federal Act, and multistate Qualified Health Plans as provided in section 1334 of the Federal Act.

(14) Individual Exchange. – The Exchange through which Qualified Individuals may purchase coverage established pursuant to this Part.

(15) Plan of Operation. – The articles, bylaws, and operating rules and procedures adopted by the Board in accordance with this Part.

(16) Qualified Dental Plan. – A limited scope dental plan that has been certified in accordance with G.S. 58-50-350.

(17) Qualified Employer. – A Small Employer that elects to make its full-time employees eligible for one or more Qualified Health Plans offered through the SHOP Exchange, and at the option of the employer, some or all of its part-time employees.

(18) Qualified Health Plan. – A Health Benefit Plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and G.S. 58-50-350.

(19) Qualified Individual. – An individual, including a minor, who meets all of the following requirements:

a. Is seeking to enroll in a Qualified Health Plan offered to individuals through the Individual Exchange.

b. Resides in this State pursuant to G.S. 58-50-175(18).

c. At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges.

d. Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

(20) Secretary. – The Secretary of the federal Department of Health and Human Services.

(21) SHOP Exchange. – The Small Business Health Options Program established in G.S. 58-50-34(13) that is designed to assist Qualified Employers in the State who are Small Employers in facilitating the enrollment of their employees in Qualified Health Plans offered in the small group market in the State.

(22) Small Employer. – An employer as such term is defined in G.S. 58-50-110(22), subject to the requirements of the Federal Act and the Public Health Service Act (PHSA).

"**§ 58-50-310. Exchange established; Board of Directors; Plan of Operation.**

(a) There is hereby created a nonprofit entity to be known as the North Carolina Health Benefit Exchange Authority, which is subject to the supervision of the Commissioner. Notwithstanding that the Exchange Authority may be supported in whole or in part from State or federal funds, the Exchange Authority is not an instrumentality of the State or federal government and shall be operated by the Board. The purpose of the Exchange Authority is to do the following:

(1) Create and administer an Individual Exchange and a SHOP Exchange which shall be operated as two separate health benefit exchanges and shall not be operated as one health benefit exchange.

(2) Facilitate the purchase and sale of Qualified Health Plans to Qualified Individuals and Qualified Employers.

(3) Assist Qualified Individuals in enrollment in Qualified Health Plans and assist Qualified Employers in facilitating the enrollment of their employees in Qualified Health Plans.

(b) There is established the North Carolina Health Benefit Exchange Authority Board. The Board shall have the duties and powers as established by this section.

(1) The North Carolina Health Benefit Exchange Authority Board shall consist of the Commissioner of Insurance, the Director of the Division of Medical Assistance, who shall both serve as ex officio nonvoting members of the Board, and 11 additional members appointed as follows:

a. Four members appointed by the President Pro Tempore of the Senate as follows:

1. One member who represents the medical provider community, as recommended by the North Carolina Medical Society.

2. One member who represents an insurer, and is not a licensed health insurance agent, as recommended by the North Carolina Association of Health Plans.

3. One member who represents business, as recommended by the North Carolina Chamber.

4. One member who represents the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider and shall reasonably be expected to qualify for coverage in the Individual Exchange or SHOP Exchange. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member.

b. Four members appointed by the Speaker of the House of Representatives as follows:

1. One member who represents the medical provider community, as recommended by the North Carolina Hospital Association.
2. One member who represents the insurance industry and is not a licensed health insurance agent.
3. One member who represents small business, as recommended by the National Federation of Independent Business.
4. One member who represents the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider and shall reasonably be expected to qualify for coverage in the Individual Exchange or SHOP Exchange. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member.

c. Three members appointed by the Governor, who do not represent the categories listed in sub-subdivision a. and sub-subdivision b. of this subdivision, as follows:

1. One member who has expertise and experience in the development and operation of State-scale information technology systems capable of conducting electronic funds transfers, secure data transfers, and other electronic functions relating to the creation and ongoing operations of the Exchange Authority.
2. One member who has expertise and experience in rural health policy, rural health economics, or rural health care finance as recommended by the North Carolina Rural Economic Development Center.
3. One member who has experience and expertise as a licensed health insurance agent in the State of North Carolina, as recommended by the North Carolina Association of Health Underwriters, the National Association of Insurance and Financial Advisors – North Carolina, and the Independent Insurance Agents of North Carolina.

(2) The initial appointments by the General Assembly upon the recommendation of the Speaker of the House of Representatives and the President Pro Tempore of the Senate shall be made no later than 30 days after enactment of this Part and shall serve a term of three years. The initial appointments by the Governor shall be made no later than 30 days after enactment of this Part and shall be for a term of two years. All succeeding appointments shall be for terms of three years. Members shall not serve for more than two successive terms. A Board member's term shall continue until the member's successor is appointed by the original appointing authority. Vacancies shall be filled by the appointing authority for the unexpired portion of the term in which they occur. A Board member may be removed by the member's appointing authority or by the Commissioner for cause. The Board shall meet at least quarterly upon the call of the chair. A majority of the total membership of the Commission shall constitute a quorum. The Commissioner shall appoint a chair to serve for the initial two years of the Exchange Authority's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms.

Board members shall receive travel allowances under G.S. 138-5 when traveling to and from meetings of the Board but shall not receive any subsistence allowance or per diem under subdivision (a)(1) of that section.

(3) The Board shall employ or fix compensation of the Executive Director.

(4) The Board shall appoint appropriate legal, actuarial, and other persons, entities, or committees as necessary to provide technical assistance in the operation, policy, contractual design, and other functions of the Exchange Authority.

(5) The Board shall adopt bylaws, policies, and procedures as may be necessary or convenient.

(6) Each member of the Board shall comply with the conflict of interest rules and recusal procedures set forth in the Plan of Operation.

(7) No member of the Board or staff shall make, participate in making, or in any way attempt to use his or her official position to influence the making of any decision that he or she knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on him or her or a member of his or her immediate family, or which will have reasonable foreseeable material effect on any business entity in which the member or his or her immediate family is director, officer, partner, trustee, employee, or holds any position of management.

(8) Each member of the Board shall have the responsibility and duty to meet the requirements of this Part, the Federal Act, and all applicable State and federal laws, rules, and regulations to serve the public interest of the individuals and employers seeking health care coverage through the Exchange Authority, and to ensure the operational well-being and fiscal solvency of the Exchange Authority.

(c) The Board shall submit to the Commissioner a Plan of Operation for the Exchange Authority and any amendments.

(1) The Commissioner shall review and approve or disapprove the Plan of Operation within 90 days after its submission or resubmission. If the Commissioner fails to act within 90 days of submission, the Plan of Operation shall be deemed approved. If the Commissioner disapproves any part of the Plan of Operation, the Commissioner shall provide specific reasons for the disapproval and provide the Board an opportunity to revise and resubmit the Plan of Operation. The Plan of Operation shall become effective upon approval in writing by the Commissioner. If the Board fails to submit a Plan of Operation within 180 days after the appointment of the Board that is approved by the Commissioner, or at any time thereafter fails to submit amendments as required by statute or federal law to the Plan of Operation, the Commissioner shall adopt temporary rules necessary to effectuate the provisions of this section. The rules shall continue in force until modified by the Commissioner or superseded by a Plan of Operation submitted by the Board and approved by the Commissioner.

(2) The Plan of Operation shall establish policies and procedures for operation of the Exchange Authority, including, but not limited to, the following:

a. Process by which the Board sets policies and conducts business, including bylaws.

b. Process for certifying Qualified Health Plans.

c. Plans for determining the need for and selection of eligible entities with whom to contract for performance of Exchange Authority functions or operations.

d. Fiscal operations of the Exchange Authority, addressing the collection, handling, disbursing, accounting, and auditing of assets and monies of the Exchange Authority and any eligible entity with whom the Exchange Authority contracts.

e. Statement acknowledging the fiduciary duty owed by the Exchange Authority to persons receiving Qualified Health Plan coverage through the Exchange Authority.

f. Process for evaluating the effectiveness of the Executive Director and the overall operations of the Exchange Authority.

g. Provide for conflict of interest rules and recusal procedures that require a Board member to recuse himself or herself from an official matter, whenever the Board member or his or her immediate family has any financial involvement or interest in that matter.

h. Identify an approach for coordinating efforts with the Department of Health and Human Services to fairly allocate administrative costs for eligibility determinations in the Exchange Authority and Medicaid.

i. Provide for other matters as may be necessary or proper for the execution of the Executive Director's powers, duties, and obligations under this act.

j. Appeals processes authorized by this Part, including appeals of tax credit eligibility, cost-sharing subsidy, mandate waiver determination, affordability determinations pursuant to G.S. 58-50-340 and appeals of Insurer noncertification or decertification pursuant to G.S. 58-50-350.

"**§ 58-50-320. Exchange Authority general powers.**

(a) The Exchange Authority shall have the general powers and authority granted under the laws of this State and the specific authority to do all of the following:

(1) Contract with an eligible entity for any of its functions described in this act. For the purposes of this act, an eligible entity has the same meaning as section 1311(f)(3)(B) of the Federal Act.

(2) Take legal action as necessary.

(3) Enter into information-sharing agreements with federal and State agencies and other state exchanges to carry out its responsibilities under this act provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all State and federal laws and regulations.

"**§ 58-50-330. General requirements.**

(a) The Exchange Authority shall make Qualified Health Plans available to Qualified Individuals and Qualified Employers beginning with effective dates on or after January 1, 2014.

(b) The Exchange Authority shall not make available any Health Benefit Plan that is not a Qualified Health Plan. The Exchange Authority shall allow a Health Insurer to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange Authority, either separately or in conjunction with a Qualified Health Plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

(c) The Exchange Authority, or any Insurer offering Qualified Health Plans through the Exchange Authority, shall not impose any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986 without regard to

paragraph (1)(C) or (D) thereof) or such coverage has become affordable within the meaning of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

(d) The Exchange Authority may make a Qualified Health Plan available notwithstanding any provision of law that may require benefits other than the Essential Health Benefits specified under section 1302(b) of the Federal Act.

(1) Nothing in this section shall preclude a Qualified Health Plan from including benefits in addition to Essential Health Benefits, including wellness programs.

(2) To the extent that State law or regulation requires that a Qualified Health Plan include benefits in addition to the Essential Health Benefits, the State shall make payments to defray the cost of any additional benefits directly to an individual enrolled in a Qualified Health Plan or on behalf of an individual directly to the Health Insurer in whose Qualified Health Plan such individual is enrolled.

(3) To the extent that funding to defray the cost for such additional benefits is not provided, notwithstanding any requirements in Chapter 58 of the General Statutes, a Health Insurer is not required to include such additional benefits in a Qualified Health Plan, may discontinue such benefits at the time such funding is no longer available, and shall provide written or electronic notice of discontinuation of such benefits to insureds and contracted Health Care Providers as soon as is reasonably practicable. The Exchange Authority shall not require that a Qualified Health Plan provide such additional benefits when funding to defray the cost for such additional benefits is not provided.

(e) Nothing in this Part, and no action taken by the Exchange Authority pursuant to the Part, shall be construed to conflict with, preempt, limit, or supersede any applicable health insurance laws of this State or regulations adopted and orders issued by the Commissioner. Nothing in this Part shall be construed to conflict with, limit, or supersede the statutory or regulatory authority vested with the North Carolina Department of Insurance. Except as expressly provided to the contrary by federal law, Insurers and any other entities or persons participating in the Exchange Authority in this State shall comply fully with all applicable provisions of Chapter 58 of the General Statutes and all related regulations adopted and orders issued by the Commissioner. Participation in the Exchange Authority in any way, including payment or receipt of payment in relation to a Qualified Health Benefits Plan, does not exempt any Insurer, entity, or person from complying fully with Chapter 58 of the General Statutes and all related regulations adopted and orders issued by the Commissioner.

(f) The Executive Director shall make an annual report to the Governor, Speaker of the House of Representatives, the President Pro Tempore of the Senate, and the Commissioner by March 1 of each year. The report shall summarize the activities of the Exchange Authority in the preceding calendar year, including information about the number and types of plans offered; number of Insurers; summary information about premiums, enrollment levels and enrollment/disenrollment activity, duration of coverage; and cost of operating the Exchange Authority.

(g) Neither the Board nor the employees of the Exchange Authority are liable for any obligations of the Exchange Authority. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the Exchange Authority or its agents or employees, the Board, the Executive Director, or the Commissioner or the Commissioner's representatives for any action taken by them in good faith in the performance of their powers and duties under this Part.

(h) The Exchange Authority, including the Board and its employees, is subject to the provisions of Article 33C of Chapter 143 of the General Statutes.

(i) The Executive Director, with the approval of the Board, shall operate the Exchange Authority in a manner so that the estimated cost of operating the Exchange Authority during any calendar year is not anticipated to exceed the total income the Exchange Authority expects to receive from any revenue available to the Exchange Authority.

(j) The Board shall provide for other matters as may be necessary and proper for the execution of the Executive Director's powers, duties, and obligations under this Part.

(k) All documents, papers, letters, maps, books, photographs, films, sound recordings, magnetic or other tapes, electronic data-processing records, artifacts, or other documentary material, regardless of physical form or characteristics within the possession of the Exchange Authority, including its employees and the Board, are subject to the provisions of Chapter 132 of the General Statutes except to the extent that these public records are protected under State or federal law, or are confidential or proprietary property of a person as defined in G.S. 66-152.

(l) The members of the Board and the Executive Director are public servants under G.S. 138A-3(30) and are subject to the provisions of Chapter 138A of the General Statutes.

"**§ 58-50-340. General duties.**

The Exchange Authority shall do the following:

(1) Facilitate the purchase and sale of Qualified Health Plans.

(2) Assist qualified individuals in this State with enrollment in Qualified Health Plans.

(3) Assist qualified employers in this State with enrollment of their employees in Qualified Health Plans.

(4) Implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and this Part, of health benefit plans as Qualified Health Plans.

(5) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance in a manner that is accessible to individuals with different communication needs and that effectively communicates information in a manner that is appropriate to the needs of the population being served by the Exchange Authority.

(6) Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act.

(7) Maintain an Internet Web site through which enrollees and prospective enrollees of Qualified Health Plans and individuals eligible for Medicaid or North Carolina Health Choice may obtain standardized comparative information on such plans.

(8) Assign a rating to each Qualified Health Plan offered through the Exchange Authority in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act, and determine each Qualified Health Plan's level of coverage in accordance with regulations issued by the Secretary under section 1302(d)(2)(A) of the Federal Act.

(9) Use a standardized format for presenting health benefit options in the Exchange Authority, including the use of the uniform outline of coverage established under section 2715 of the PHSA that supports consumer choice by making comprehensive information about health plans available in an objective, easy-to-understand format.

(10) In accordance with section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act, or any applicable State or local public program and if, through screening of the application by the Exchange

Authority, the Exchange Authority determines that any individual is eligible for any such program, enroll that individual in that program.

(11) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act.

(12) Establish an Individual Exchange, through which Qualified Individuals may enroll in any qualified plan offered through the Individual Exchange for which they are eligible.

(13) Establish a SHOP Exchange through which Qualified Employers may make its employees eligible for one or more Qualified Health Plans offered through the SHOP Exchange or through which Qualified Employers may specify a level of coverage so that any of its employees may enroll in any Qualified Health Plan offered through the SHOP Exchange at the specified level of coverage.

(14) Subject to section 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because of either of the following:

a. There is no affordable Qualified Health Plan available through the Exchange Authority, or the individual's employer, covering the individual.

b. The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty.

(15) Transfer to the federal Secretary of the Treasury the following:

a. A list of the individuals who are issued a certification under subdivision (14) of this subsection, including the name and taxpayer identification number of each individual.

b. The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because of either of the following:

1. The employer did not provide minimum essential coverage.

2. The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code of 1986 to either be unaffordable to the employee or not provide the required minimum actuarial value.

c. The name and taxpayer identification number of the following:

1. Each individual who notifies the Exchange Authority under section 1411(b)(4) of the Federal Act that he or she has changed employers.

2. Each individual who ceases coverage under a Qualified Health Plan during a plan year and the effective date of that cessation.

(16) Provide to each employer the name of each employee of the employer described in sub-sub-subdivision b.2. of subdivision (15) of this subsection who ceases coverage under a Qualified Health Plan during a plan year and the effective date of the cessation.

(17) Perform duties required of the Exchange Authority by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions.

(18) Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act, and standards developed by the Secretary, and award grants to enable Navigators who are licensed by the North Carolina Department of Insurance to do the following:

a. Conduct public education activities to raise awareness of the availability of Qualified Health Plans.

b. Distribute fair and impartial information concerning enrollment in Qualified Health Plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act.

c. Facilitate enrollment in Qualified Health Plans.

d. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHSA, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their Health Benefit Plan, coverage, or a determination under that plan or coverage.

e. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange Authority.

(19) Take into account any excess of premium growth outside of the Exchange Authority as compared to the rate of such growth inside the Exchange Authority when determining under section 1302(f)(2)(B) of the Federal Act whether to recommend to the General Assembly that Qualified Health Plans be offered in the large group market through the SHOP Exchange.

(20) Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, and collect the amount credited from the offering employer and remit the amount of the free choice voucher to the appropriate Health Insurer.

(21) Consult with stakeholders relevant to carrying out the activities required under this act, including, but not limited to, the following:

a. Educated health care consumers who are enrollees in Qualified Health Plans.

b. Individuals and entities with experience in facilitating enrollment in Qualified Health Plans.

c. Representatives of small businesses and self-employed individuals.

d. Representatives of Health Insurers that offer Qualified Health Plans through the Exchange Authority.

e. Representatives of Health Insurers that are not offering qualified plans through the Exchange Authority.

f. Representatives of Health Care Providers.

g. The Division of Medical Assistance.

h. The North Carolina Department of Insurance.

i. Advocates for enrolling hard to reach populations.

(22) Meet all of the following financial integrity requirements:

a. Keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the Secretary, the Governor, the Commissioner, and the General Assembly a report concerning such accountings.

b. Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Federal Act and allow the Secretary, in coordination with the Inspector General of the U.S. Department of Health and Human Services, to do all of the following:

1. Investigate the affairs of the Exchange Authority.
2. Examine the properties and records of the Exchange Authority.
3. Require periodic reports in relation to the activities undertaken by the Exchange Authority.

c. In carrying out its activities under this act, not use any funds intended for the administrative and operational expenses of the Exchange Authority for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or State legislative and regulatory modifications.

(23) Meet the following fiduciary duties and liability:

a. Any person who acts on behalf of an Exchange Authority shall act as a fiduciary. Such person shall ensure that the Exchange Authority is operated (i) solely in the interests of individuals participating in qualified health plans offered through the Exchange Authority and (ii) for the exclusive purpose of facilitating the purchase of Qualified Health Plans.

b. Any person who acts as a fiduciary on behalf of the Exchange Authority who breaches any of their responsibilities, obligations, or duties imposed by this section shall be liable to make good to the Exchange Authority, the Qualified Health Plans offered through the Exchange Authority, or participants of Qualified Health Plans offered through the Exchange Authority any losses resulting from each breach and shall be subject to such other legal or equitable relief as the court may deem appropriate, including removal of such fiduciary.

(24) With respect to eligibility determinations, provide for (i) review of enrollee appeals of Exchange Authority premium tax credit and cost-sharing reductions and mandate exemption determinations and establish procedures for identifying and confirming income levels of applicants for Exchange Authority coverage and eligibility for receipt of premiums and tax credits and (ii) employer appeals of employer-sponsored plan availability or affordability determinations.

(25) Conduct a review of the costs and benefits of collecting and distributing premiums for small businesses. No later than January 1, 2015, the Exchange Authority shall report the results of the review, including analysis of the financial impact of such collection and distribution, and its recommendations to the North Carolina General Assembly. The Exchange Authority may implement and carry out a process for collecting and distributing premiums if it has sufficient funding to implement the initiative and upon approval by vote by both chambers of the North Carolina General Assembly.

(26) In conjunction with North Carolina Department of Health and Human Services, study the feasibility of offering a Basic Health Plan pursuant to section 1331 of the Federal Act and make a recommendation to the 2013 Regular Session of the 2013 General Assembly.

(27) Provide for publicity and outreach campaigns to raise awareness of the existence of the Exchange Authority and disseminate information regarding eligibility criteria, enrollment procedures, availability of premium tax credits and cost-sharing reductions, small employer tax credits, and other relevant information.

"**§ 58-50-350. Health Benefit Plan certification.**

(a) The Exchange Authority shall certify a Health Benefit Plan as a Qualified Health Plan if the Department of Insurance determines that it satisfies the requirements set forth in subdivisions (1) through (6) of this subsection unless the Exchange Authority determines that making the plan available through the Exchange Authority is not in the interest of Qualified Individuals and Qualified Employers in this State.

(1) The plan provides the Essential Health Benefits package described in section 1302(a) of the Federal Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of Qualified Dental Plans, as provided in subsection (e) of this section, if both of the following occur:

a. The Exchange Authority has determined that at least one Qualified Dental Plan is available to supplement the plan's coverage.

b. The Insurer makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange Authority, that the plan does not provide the full range of essential pediatric benefits, and that Qualified Dental Plans providing those benefits and other dental benefits not covered by the plan are offered through the Exchange Authority.

(2) The premium rates and insurance policy forms, certifications, applications and riders have been approved by the Commissioner.

(3) The plan provides at least a bronze level of coverage, unless the plan is certified as a qualified catastrophic plan, meets the requirements of section 1302(e) of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage.

(4) The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the Federal Act, and if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act.

(5) The Health Insurer offering the plan meets the following requirements:

a. Is licensed and in good standing to offer health insurance coverage in this State.

b. Offers at least one Qualified Health Plan in the silver level and at least one plan in the gold level through each component of the Exchange Authority in which the Insurer participates, where "component" refers to the SHOP Exchange and the Individual Exchange.

c. Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange Authority and without regard to whether the plan is offered directly from the Insurer or through an insurance producer.

d. Does not charge any cancellation fees or penalties in violation of G.S. 58-50-330(c).

e. Complies with the regulations developed by the Secretary under section 1311(d) of the Federal Act and such other requirements as the Exchange Authority may establish.

(6) The plan meets the requirements of certification as promulgated by regulation pursuant to this section and by the Secretary under section 1311(c) of the Federal Act.

(b) The Exchange Authority shall not exclude a health plan through the imposition of premium price controls nor shall it exclude a health plan based on the following:

(1) That the plan is a fee-for-service plan.

(2) That the Health Benefit Plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange Authority determines are inappropriate or too costly.

(c) The Exchange Authority shall require each Health Insurer seeking certification of a plan as a Qualified Health Plan to do the following:

(1) Submit a justification for any premium increase before implementation of that increase. The Insurer shall prominently post such information on its Internet Web site. The Exchange Authority shall take this information, along with the information and the recommendations provided to the Exchange Authority by the Commissioner under section 2794(b) of the PHSA, relating to patterns or practices of excessive or unjustified premium increases, into consideration when determining whether to continue to allow the Insurer to make plans available through the Exchange Authority. In no case shall an Exchange Authority impose any premium price controls or restrict premiums that otherwise meet the requirements of State law.

(2) Make available to the public and submit to the Exchange Authority, the Secretary, and the Commissioner, accurate and timely disclosure of the following:

a. Claims payment policies and practices.

b. Periodic financial disclosures.

c. Data on enrollment.

d. Data on disenrollment.

e. Data on the number of claims that are denied.

f. Data on rating practices.

g. Information on cost-sharing and payments with respect to any out-of-network coverage.

h. Information on enrollee and participant rights under title I of the Federal Act.

i. Other information as determined appropriate by the Secretary.

The information shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act.

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, co-payments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet Web site and through other means for individuals without access to the Internet.

(d) The Exchange Authority shall establish and publish a transparent, objective process for denying certification or decertifying Qualified Health Plans.

(1) The Exchange Authority shall give each Health Insurer the opportunity to appeal a decertification decision or the denial of certification as a Qualified Health Plan.

(2) The Exchange Authority shall give each Health Insurer that appeals a decertification decision or the denial of certification the opportunity for the following:

a. The submission and consideration of facts, arguments, or proposals of adjustment of the health plan or plans at issue.

b. A hearing and a decision on the record, to the extent that the Exchange Authority and the Health Insurer are unable to reach agreement following the submission of the information in sub-subdivision a. of this subdivision.

(3) Any hearing held pursuant to subdivision (2) of this subsection shall be conducted by an impartial party agreed to by the Exchange Authority and the Health Insurer. If the Exchange Authority and the Health Insurer cannot agree on an impartial party, then the hearing must be held by an administrative law judge.

(4) The hearing decision may be appealed to the North Carolina Court of Appeals by the aggrieved party.

(e) The Exchange Authority shall not exempt any Health Insurer seeking certification of a Qualified Health Plan, regardless of the type or size of the Insurer, from State licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among Health Insurers participating in the Exchange Authority.

(1) The provisions of this act that are applicable to Qualified Health Plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of subdivisions (2), (3), and (4) of this subsection or by regulations adopted by the Commissioner.

(2) The Insurer shall be licensed to offer dental coverage but need not be licensed to offer other health benefits.

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by Health Benefit Plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to section 1302(b)(1)(J) of the Federal Act and such other dental benefits as the Exchange Authority or the Secretary may specify by regulation.

(4) Insurers may jointly offer a comprehensive plan through the Exchange Authority in which the dental benefits are provided by an Insurer through a Qualified Dental Plan and the other benefits are provided by an Insurer through a Qualified Health Plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

"**§ 58-50-360. Choice.**

(a) In accordance with section 1312(f)(2)(A) of the Federal Act, a Qualified Employer may either designate one or more Qualified Health Plans from which its employees may choose or designate any level of coverage to be made available to employees through the SHOP Exchange.

(b) In accordance with section 1312(b) of the Federal Act, a Qualified Individual enrolled in any Qualified Health Plan may pay any applicable premium owed by such individual to the Health Insurer issuing such Qualified Health Plan.

(c) In accordance with section 1312(c) of the Federal Act, the following risk pools are established:

(1) Individual Market. – A Health Insurer shall consider all enrollees in all health plans other than Grandfathered Health Plans offered by such Insurer in the individual market, including those enrollees who do not enroll in such plans through the Individual Exchange, to be members of a single risk pool.

(2) Small Group Market. – A Health Insurer shall consider all enrollees in all health plans other than Grandfathered Health Plans offered by such Insurer in the small group market, including those enrollees who do not enroll in such plans through the SHOP Exchange, to be members of a single risk pool.

(d) In accordance with section 1312(d) of the Federal Act, this section shall not prohibit either of the following:

(1) A Health Insurer from offering outside of the Individual Exchange or the SHOP Exchange a health plan to a Qualified Individual or a Qualified Employer.

(2) A Qualified Individual from enrolling in, or a Qualified Employer from selecting for its employees, a health plan offered outside of the Exchange Authority.

(e) This section shall not limit the operation of any requirement under State law or regulation with respect to any policy or plan that is offered outside of the Exchange Authority with respect to any requirement to offer benefits.

(f) Nothing in this section shall restrict the choice of a Qualified Individual to enroll or not to enroll in a Qualified Health Plan or to participate in the Individual Exchange.

(g) Nothing in this section shall compel an individual to enroll in a Qualified Health Plan or to participate in the Exchange Authority.

(h) A Qualified Individual may enroll in any Qualified Health Plan, except that in the case of a catastrophic plan described in section 1302(e) of the Federal Act, a Qualified Individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1312(e)(2) of the Federal Act.

(i) Nothing in this act or the Federal Act shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any Health Benefit Plan that is offered outside of the Exchange Authority.

(j) In accordance with section 1312(e) of the Federal Act, the Exchange Authority shall allow Agents or Brokers to do the following:

(1) To enroll Qualified Individuals and Qualified Employers in any Qualified Health Plan offered through the Exchange Authority for which the individual or employer is eligible.

(2) To assist Qualified Individuals in applying for premium tax credits and cost-sharing reductions for any Qualified Health Plan purchased through the Individual Exchange.

(k) Any compensation to Agents and Brokers paid under this Part shall be determined by the insurer.

"**§ 58-50-370. Funding; publication of costs.**

(a) Beginning in 2014, the funding stream that supports the North Carolina Health Insurance Risk Pool shall be utilized to support the operations of the Exchange Authority. Beginning in 2015, the funding stream that supports the North Carolina Health Insurance Risk Pool shall be utilized to support the operations of the Exchange Authority that serve those individuals with incomes less than or equal to four hundred percent (400%) of the federal poverty level and Qualified Employers receiving a tax credit for the purchase of insurance pursuant to the Federal Act. The proportional cost associated with serving individuals with incomes over four hundred percent (400%) of the federal poverty level and the Qualified Employers not receiving a tax credit pursuant to the Federal Act shall be funded by an annual user fee paid by the individual or the employer to the Exchange Authority. The user fee

assessed by the Exchange Authority shall be no greater than the anticipated expenses for serving this market for the applicable fiscal year and must be approved by the Commissioner. Additionally, the Exchange Authority is authorized to utilize grant funding for operations, including, but not limited to, grant funding from the Federal Department of Health and Human Services. The Exchange Authority is also authorized to collect and use advertising fees to help support operations of the Exchange Authority.

(b) Prior to the commencement of the 2013 Regular Session of the 2013 General Assembly, the Exchange Authority shall examine its potential operational costs and propose to the General Assembly any additional changes to the funding stream necessary to ensure its solvency.

(c) As required by section 1311(d)(5)(A) of the Federal Act, the Exchange Authority shall be self-sustaining by January 1, 2015. A budget for the Exchange Authority shall be prepared by the Exchange Authority and submitted to the Commissioner annually for approval at least 120 days before the beginning of the next fiscal year.

(d) Services performed by the Exchange Authority on behalf of other State or federal programs shall be paid for by those State or federal programs.

(e) Any unspent funding by the Exchange Authority shall be used for future operation of the Exchange Authority or reducing future user fees.

(f) The Exchange Authority shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange Authority, and the administrative costs of the Exchange Authority, on an Internet Web site to educate consumers on such costs. This information shall include information on monies lost to waste, fraud, and abuse.

(g) The Exchange Authority is exempt from any and all State taxes.

"**§ 58-50-380. Regulations.**

The Commissioner shall promulgate regulations pursuant to Chapter 150B of the General Statutes, including temporary rules, to implement the provisions of this Part.

"**§ 58-50-390. Audit.**

An audit of the Exchange Authority shall be conducted annually under the oversight of the State Auditor. The cost of the audit shall be reimbursed to the State Auditor from Exchange Authority funds.

SECTION 3. Nothing in this Act shall be construed to interfere with payments to federally qualified health centers. If any item or service covered by a qualified health plan is provided by a federally qualified health center, as defined in section 1905(1)(2)(B) under the Social Security Act 42 U.S.C. 1396d(1)(2)(B), to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or services an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Social Security Act for such item or service.

SECTION 4. Severability. – If any provision of this act is held invalid by a court of competent jurisdiction, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, is repealed. If section 1311 of the federal Patient Protection and Affordable Care Act or the federal Patient Protection and Affordable Care Act in its entirety is repealed or held invalid by a court of competent jurisdiction, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, is repealed. If funding is not provided as set forth in the federal Patient Protection and Affordable Care Act, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, shall not be enforceable.

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

HOUSE BILL 115:
North Carolina Health Benefit Exchange

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	April 11, 2011
Introduced by:	Reps. Dockham, Brubaker, Wray, Murry	**Prepared by:**	Amy Jo Johnson
Analysis of:	PCS to Second Edition H115-CSTK-4		Staff Attorney

SUMMARY: The PCS to House Bill 115 adds a new Part to Article 50 of Chapter 58 of the General Statutes creating the North Carolina Health Benefit Exchange.

CURRENT LAW: The federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, P.L. 111-152, (hereafter "The ACA") directs that States may set up Health Benefit Exchanges for individuals and small businesses to purchase health insurance. An Exchange for small businesses is known as the Small Business Health Options Program or "SHOP" Exchange. A state is not required to create its own Exchange. If a state does not create its own exchange, the federal government will create one for the state. If the state chooses to create its own Exchange, the Exchange(s) must be functional by 2014, at the time when citizens and legal immigrants will be required to pay a penalty if they do not have qualified health insurance unless they meet specific exemptions. A state's Health Benefit Exchange must ensure that it is financially self-sufficient beginning January 1, 2015. Section 1311(d) of the ACA outlines certain Exchange requirements and functions.

BILL ANALYSIS:

§58-50-300. Definitions. This definition section applies only to the newly created Part 8 of Article 50 of Chapter 58 of the General Statutes.

- A "qualified employer" is a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the SHOP Exchange.
- A "qualified individual" is to be defined as an individual, including a minor, who meets all of the following requirements: is seeking to enroll in a qualified health plan offered to individuals through the Exchange, resides in this State, is not incarcerated at the time of enrollment, other than incarceration pending the disposition of charges, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.
- A "Small employer" is any individual actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than 50 eligible employees, the majority of whom are employed within this State, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists.

§58-50-310. Exchange established; board of directors; plan of operation. The Exchange Authority may be supported in whole or in part by State funds but is not an instrumentality of the State. The Exchange Authority is subject to the supervision of the Commissioner of Insurance. This section of the

bill also directs that the Exchange Authority will be operated by the Board of Directors. The Exchange Authority will create two separate Exchanges: the Individual Exchange and the SHOP Exchange.

The Board consists of the following 13 members:

- The Commissioner of Insurance, serving as an ex officio, nonvoting member.
- The Director of the Division of Medical Assistance, serving as an ex officio, nonvoting member.
- Four members appointed by the President Pro Tempore of the Senate:
  - One member who represents the medical provider community, recommended by the North Carolina Medical Society.
  - One member who represents an insurer, and is not a licensed health insurance agent, as recommended by the North Carolina Association of Health Plans.
  - One member who represents business, as recommended by the North Carolina Chamber.
  - One member of the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, who can reasonably be expected to qualify for coverage in the Exchanges.
- Four members appointed by the Speaker of the House of Representatives:
  - One member who represents the medical provider community, as recommended by the North Carolina Hospital Association.
  - One member who represents the insurance industry and is not a licensed health insurance agent.
  - One member who represents small business, as recommended by the National Federation of Independent Business.
  - One member of the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, who can reasonably be expected to qualify for coverage in the Exchanges.
- Three members appointed by the Governor:
  - One member who has expertise and experience in the development and operation of State-scale information technology systems.
  - One member who has expertise and experience in rural health policy, rural health economics, or rural health care finance as recommended by the North Carolina Rural Economic Development Center.
  - One member who has expertise and experience as a licensed health insurance agent in this State, as recommended by the North Carolina Association of Health Underwriters, the National Association of Insurance and Financial Advisors – North Carolina, and the Independent Insurance Agents of North Carolina.

Initial appointments are staggered, after which all succeeding appointments will be for three years. Members are not allowed to serve for more than two consecutive terms. A Board member may not influence any decision that might have a material financial effect on him or her or a member of his or her immediate family.

The Board is required to submit to the Commissioner a Plan of Operation for the Exchange. The Plan of Operation will be effective upon written approval of the Commissioner. The Plan of Operation must include policies and procedures for fiscal operations of the Exchange Authority, a statement acknowledging the fiduciary duty owed by the Exchange Authority to persons it services, and an approach to coordinate with DHHS to fairly allocate administrative costs for eligibility determinations in the Exchange Authority and Medicaid.

§ 58-50-320. Exchange Authority general powers. The Exchange Authority has the power and authority to enter into contracts, to take legal action, and to enter into information-sharing agreements with federal and State agencies and other state exchanges.

§ 58-50-330. General requirements. The Exchange Authority will make qualified health plans available January 1, 2014. The Exchange Authority cannot charge a fee if an individual enrolls in another type of minimum essential coverage if that individual has become newly eligible or insurance has become affordable through their employer. A qualified health plan may include benefits above and beyond the essential benefits, and if a state law or regulation requires doing so, the state will make payment to defray the cost. If payments to defray the costs are not made, the insurer is not required to include those additional benefits in their health plans. Nothing in this Part is meant to conflict with or limit any state insurance laws or regulations adopted by the Commissioner. The Exchange Authority is subject to the Public Meetings laws and Public Records laws. Additionally, the members of the Board and the Executive Director are public servants for purposes of the State Ethics Act.

§ 58-50-340. General duties. Among its duties, the Exchange Authority will facilitate the purchase and sale of qualified health plans, operate a toll-free telephone hotline and an internet web-site, rate qualified health plans, inform individuals of eligibility requirements under Medicaid and CHIP and enroll individuals qualifying for those plans, provide pertinent information to the federal Secretary of the Treasury including information regarding exempted individuals and individuals receiving premium tax credits, take into account any excess of premium growth when recommending to the General Assembly whether or not to open the SHOP Exchange to the large group market, and meet financial integrity requirements and fiduciary duty requirements. Additionally, the Exchange Authority shall also conduct a review of costs and benefits of collecting and distributing premiums for small business, as well as study the feasibility of offering a Basic Health Plan and make recommendations on both issues to the General Assembly.

§ 58-50-350. Health Benefit Plan certification. The conditions under which the Exchange Authority will certify a health benefit plan as a qualified health plan include approval of the Commissioner of specific requirements unless the Exchange Authority determines that making the plan available is not in the interest of qualified individuals and employers. Additionally, the Exchange Authority will require each insurer to submit a justification for any premium increases. There are limits as to why the Exchange Authority may exclude a plan. The Exchange Authority is not allowed to impose premium price controls. The Exchange Authority must establish a process for certifying and decertifying claims, including an appeals process.

§ 58-50-360. Choice. There will be two risk pools: one for the Individual Exchange and one for the SHOP Exchange. Both risk pools will consist of all enrollees within that market, including those not purchased on the Exchange. Agents and brokers will be allowed to enroll on the Exchange Authority.

§ 58-50-370. Funding; Publication of costs. The Exchange Authority utilizes the funding stream which currently supports the North Carolina Health Insurance Risk Pool for the operations of the Exchange beginning in 2014. In 2015, that funding stream will support operation of the Exchange Authority that serves individuals with incomes less than 400% of the federal poverty level as well as qualified employers receiving a tax credit. All other users shall pay an annual user fee to the Exchange Authority, which must be approved by the Commissioner. Services performed by the Exchange Authority on behalf of other state or federal programs shall be paid for by those state or federal programs. The Exchange is exempt from all State taxes.

§ 58-50-380. Regulations. The Commissioner may promulgate regulations to implement the provisions of the bill.

§ 58-50-390. Audit. There will be an annual audit of the Exchange Authority by the State Auditor.

Nothing in the Act will be construed to interfere with payments to Federally-qualified health centers.

The bill contains a severability clause. If the any portion of the act is found invalid, then the whole act is repealed. If the ACA is repealed or found invalid, then this act is repealed. If the ACA is not funded, the this act is unenforceable.

EFFECTIVE DATE: This act is effective when it becomes law.

H115-SMTK-10(CSTK-4) v4

HOUSE BILL 115
Committee Substitute Favorable 3/30/11

Short Title: North Carolina Health Benefit Exchange. (Public)

Sponsors:

Referred to:

February 17, 2011

A BILL TO BE ENTITLED

AN ACT TO PRESERVE STATE-BASED AUTHORITY TO REGULATE THE NORTH CAROLINA HEALTH INSURANCE MARKET AND TO PREVENT FEDERAL ENCROACHMENT ON STATE AUTHORITY BY ESTABLISHING THE NORTH CAROLINA BENEFIT EXCHANGE.

The General Assembly of North Carolina enacts:

SECTION 1. The purpose of this act is to provide for the establishment of the North Carolina Health Benefits Exchange Authority (Exchange Authority). The purpose of the Exchange Authority is to facilitate the purchase and role of qualified health plans in the individual and small employer market by providing education, outreach, and technical assistance. The General Assembly believes it is in the best interest of the State, and thus the purpose of the Exchange Authority, to promote competition and choice in the health care marketplace and to facilitate innovation by offering products with variation in price and design. The Exchange Authority shall accomplish its purpose through a robust portal that provides meaningful guidance to health benefit plans that meet the needs of the health care marketplace of this State and not through the limitations of health benefit plan options to qualified individuals or qualified employers or by excluding health benefit plans who meet the premium and solvency requirements approved by the North Carolina Department of Insurance. In establishing the Exchange Authority, it is the intent of the General Assembly to reduce the number of uninsured individuals in this State, promote improved competition in the health care marketplace, reduce health care costs by, among other things, improving reimbursements to health care providers for uncompensated care, increasing consumer education, increasing transparency, and assisting individuals and employers in accessing health coverage, premium tax credits, and cost-sharing reductions.

SECTION 2. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 8. North Carolina Health Benefit Exchange Act.

"**§ 58-50-300. Definitions.**

The following definitions apply to this Part:

(1) Agent. – Defined in G.S. 58-33-10(1).

(2) Board. – The Board of Directors of the North Carolina Health Benefit Exchange Authority.

(3) Broker. – Defined in G.S. 58-33-10(3).

(4) Commissioner. – The Commissioner of Insurance of North Carolina or the Commissioner's authorized designee.

(5) Educated Health Care Consumer. – An individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical, and scientific matters.

(6) Essential Health Benefits. – Defined under section 1302(b) of the Federal Act.

(7) Exchange Authority. – The North Carolina Health Benefit Exchange Authority established pursuant to G.S. 58-50-310 and includes the Individual Exchange and the SHOP Exchange, unless otherwise specified.

(8) Executive Director. – The individual selected by a majority vote of the Board members and hired to serve as the Executive Director of the Exchange Authority.

(9) Federal Act. – The federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as further amended, as well as any regulations or guidance issued under those acts.

(10) Grandfathered Health Plan Coverage or Grandfathered Health Plan. – Defined in 45 C.F.R. Part 147.140(a).

(11) Health Benefit Plan. – Defined in G.S. 58-3-167(a)(1).

(12) Health Care Provider. – Defined in G.S. 58-50-270(3a).

(13) Health Insurer or Insurer. – Defined in G.S. 58-68-25(a)(6) and, for the purposes of this act, the terms also include qualified nonprofit health insurance issuers (CO-OP Insurers) as provided in section 1322 of the Federal Act, and multistate Qualified Health Plans as provided in section 1334 of the Federal Act.

(14) Individual Exchange. – The Exchange through which Qualified Individuals may purchase coverage established pursuant to this Part.

(15) Plan of Operation. – The articles, bylaws, and operating rules and procedures adopted by the Board in accordance with this Part.

(16) Qualified Dental Plan. – A limited scope dental plan that has been certified in accordance with G.S. 58-50-350.

(17) Qualified Employer. – A Small Employer that elects to make its full-time employees eligible for one or more Qualified Health Plans offered through the SHOP Exchange, and at the option of the employer, some or all of its part-time employees.

(18) Qualified Health Plan. – A Health Benefit Plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and G.S. 58-50-350.

(19) Qualified Individual. – An individual, including a minor, who meets all of the following requirements:

a. Is seeking to enroll in a Qualified Health Plan offered to individuals through the Individual Exchange.

b. Resides in this State pursuant to G.S. 58-50-175(18).

c. At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges.

d. Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

(20) Secretary. – The Secretary of the federal Department of Health and Human Services.

(21) SHOP Exchange. – The Small Business Health Options Program established in G.S. 58-50-340(a)(13) that is designed to assist Qualified Employers in

the State who are Small Employers in facilitating the enrollment of their employees in Qualified Health Plans offered in the small group market in the State.

(22) Small Employer. – An employer as such term is defined in G.S. 58-50-110(22), subject to the requirements of the Federal Act and the Public Health Service Act (PHSA).

"**§ 58-50-310. Exchange established; Board of Directors; Plan of Operation.**

(a) There is hereby created a nonprofit entity to be known as the North Carolina Health Benefit Exchange Authority, which is subject to the supervision of the Commissioner. Notwithstanding that the Exchange Authority may be supported in whole or in part from State or federal funds, the Exchange Authority is not an instrumentality of the State or federal government and shall be operated by the Board. The purpose of the Exchange Authority is to do the following:

(1) Create and administer an Individual Exchange and a SHOP Exchange which shall be operated as two separate health benefit exchanges and shall not be operated as one health benefit exchange.

(2) Facilitate the purchase and sale of Qualified Health Plans to Qualified Individuals and Qualified Employers.

(3) Assist Qualified Individuals in enrollment in Qualified Health Plans and assist Qualified Employers in facilitating the enrollment of their employees in Qualified Health Plans.

(b) There is established the North Carolina Health Benefit Exchange Authority Board. The Board shall have the duties and powers as established by this section.

(1) The North Carolina Health Benefit Exchange Authority Board shall consist of the Commissioner of Insurance, the Director of the Division of Medical Assistance, who shall both serve as ex officio nonvoting members of the Board, and 11 additional members appointed as follows:

a. Four members appointed by the President Pro Tempore of the Senate as follows:

1. One member who represents the medical provider community, as recommended by the North Carolina Medical Society.

2. One member who represents an insurer, as recommended by the North Carolina Association of Health Plans.

3. One member who represents business, as recommended by the North Carolina Chamber.

4. One member who represents the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider and shall reasonably be expected to qualify for coverage in the Individual Exchange or SHOP Exchange. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member.

b. Four members appointed by the Speaker of the House of Representatives as follows:

1. One member who represents the medical provider community, as recommended by the North Carolina Hospital Association.

2. One member who represents the insurance industry.

3. One member who represents small business, as recommended by the National Federation of Independent Business.
4. One member who represents the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider and shall reasonably be expected to qualify for coverage in the Individual Exchange or SHOP Exchange. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member.

c. Three members appointed by the Governor who do not represent the categories listed in sub-subdivision a. and sub-subdivision b. of this subdivision and have expertise and experience in one or more of the subject area groupings: development and operation of State-scale information technology systems capable of conducting electronic funds transfers, secure data transfers, and other electronic functions relating to the creation and ongoing operations of the Exchange Authority; health economics or health care finance; actuarial science or risk management; health policy analysis or health law; or as a health insurance agent.

(2) The initial appointments by the General Assembly upon the recommendation of the Speaker of the House of Representatives and the President Pro Tempore of the Senate shall be made no later than 30 days after enactment of this Part and shall serve a term of three years. The initial appointments by the Governor shall be made no later than 30 days after enactment of this Part and shall be for a term of two years. All succeeding appointments shall be for terms of three years. Members shall not serve for more than two successive terms. A Board member's term shall continue until the member's successor is appointed by the original appointing authority. Vacancies shall be filled by the appointing authority for the unexpired portion of the term in which they occur. A Board member may be removed by the member's appointing authority or by the Commissioner for cause. The Board shall meet at least quarterly upon the call of the chair. A majority of the total membership of the Commission shall constitute a quorum. The Commissioner shall appoint a chair to serve for the initial two years of the Exchange Authority's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms. Board members shall receive travel allowances under G.S. 138-5 when traveling to and from meetings of the Board but shall not receive any subsistence allowance or per diem under subdivision (a)(1) of that section.

(3) The Board shall employ or fix compensation of the Executive Director.

(4) The Board shall appoint appropriate legal, actuarial, and other persons, entities, or committees as necessary to provide technical assistance in the operation, policy, contractual design, and other functions of the Exchange Authority.

(5) The Board shall adopt bylaws, policies, and procedures as may be necessary or convenient.

(6) Each member of the Board shall comply with the conflict of interest rules and recusal procedures set forth in the Plan of Operation.

(7) No member of the Board or staff shall make, participate in making, or in any way attempt to use his or her official position to influence the making of any

decision that he or she knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on him or her or a member of his or her immediate family, or which will have reasonable foreseeable material effect on any business entity in which the member or his or her immediate family is director, officer, partner, trustee, employee, or holds any position of management.

(8) Each member of the Board shall have the responsibility and duty to meet the requirements of this Part, the Federal Act, and all applicable State and federal laws, rules, and regulations to serve the public interest of the individuals and employers seeking health care coverage through the Exchange Authority, and to ensure the operational well-being and fiscal solvency of the Exchange Authority.

(c) The Board shall submit to the Commissioner a Plan of Operation for the Exchange Authority and any amendments.

(1) The Commissioner shall review and approve or disapprove the Plan of Operation within 90 days after its submission or resubmission. If the Commissioner fails to act within 90 days of submission, the Plan of Operation shall be deemed approved. If the Commissioner disapproves any part of the Plan of Operation, the Commissioner shall provide specific reasons for the disapproval and provide the Board an opportunity to revise and resubmit the Plan of Operation. The Plan of Operation shall become effective upon approval in writing by the Commissioner. If the Board fails to submit a Plan of Operation within 180 days after the appointment of the Board that is approved by the Commissioner, or at any time thereafter fails to submit amendments as required by statute or federal law to the Plan of Operation, the Commissioner shall adopt temporary rules necessary to effectuate the provisions of this section. The rules shall continue in force until modified by the Commissioner or superseded by a Plan of Operation submitted by the Board and approved by the Commissioner.

(2) The Plan of Operation shall establish policies and procedures for operation of the Exchange Authority, including, but not limited to, the following:

a. Process by which the Board sets policies and conducts business, including bylaws.

b. Process for certifying Qualified Health Plans.

c. Plans for determining the need for and selection of eligible entities with whom to contract for performance of Exchange Authority functions or operations.

d. Fiscal operations of the Exchange Authority, addressing the collection, handling, disbursing, accounting, and auditing of assets and monies of the Exchange Authority and any eligible entity with whom the Exchange Authority contracts.

e. Statement acknowledging the fiduciary duty owed by the Exchange Authority to persons receiving Qualified Health Plan coverage through the Exchange Authority.

f. Process for evaluating the effectiveness of the Executive Director and the overall operations of the Exchange Authority.

g. Provide for conflict of interest rules and recusal procedures that require a Board member to recuse himself or herself from an official matter, whenever the Board member or his or her immediate family has any financial involvement or interest in that matter.

h. Identify an approach for coordinating efforts with the Department of Health and Human Services to fairly allocate administrative costs for eligibility determinations in the Exchange Authority and Medicaid.

i. Provide for other matters as may be necessary or proper for the execution of the Executive Director's powers, duties, and obligations under this act.

j. Appeals processes authorized by this Part, including appeals of tax credit eligibility, cost-sharing subsidy, mandate waiver determination, affordability determinations pursuant to G.S. 58-50-340 and appeals of Insurer noncertification or decertification pursuant to G.S. 58-50-350.

"**§ 58-50-320. Exchange Authority general powers.**

(a) The Exchange Authority shall have the general powers and authority granted under the laws of this State and the specific authority to do all of the following:

(1) Contract with an eligible entity for any of its functions described in this act. For the purposes of this act, an eligible entity has the same meaning as section 1311(f)(3)(B) of the Federal Act.

(2) Take legal action as necessary.

(3) Enter into information-sharing agreements with federal and State agencies and other state exchanges to carry out its responsibilities under this act provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all State and federal laws and regulations.

"**§ 58-50-330. General requirements.**

(a) The Exchange Authority shall make Qualified Health Plans available to Qualified Individuals and Qualified Employers beginning with effective dates on or after January 1, 2014.

(b) The Exchange Authority shall not make available any Health Benefit Plan that is not a Qualified Health Plan. The Exchange Authority shall allow a Health Insurer to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange Authority, either separately or in conjunction with a Qualified Health Plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

(c) Neither the Exchange Authority nor an Insurer offering Qualified Health Plans through the Exchange Authority may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

(d) The Exchange Authority may make a Qualified Health Plan available notwithstanding any provision of law that may require benefits other than the Essential Health Benefits specified under section 1302(b) of the Federal Act.

(1) Nothing in this section shall preclude a Qualified Health Plan from including benefits in addition to Essential Health Benefits, including wellness programs.

(2) To the extent that State law or regulation requires that a Qualified Health Plan include benefits in addition to the Essential Health Benefits, the State shall make payments to defray the cost of any additional benefits directly to an individual enrolled in a Qualified Health Plan or on behalf of an individual directly to the Health Insurer in whose Qualified Health Plan such individual is enrolled.

(3) To the extent that funding to defray the cost for such additional benefits is not provided, notwithstanding any requirements in Chapter 58 of the General Statutes, a Health Insurer is not required to include such additional benefits in a Qualified Health Plan, may discontinue such benefits at the time such funding is no longer available, and shall provide written or electronic notice of discontinuation of such benefits to insureds and contracted Health Care Providers as soon as is reasonably practicable. The Exchange Authority shall not require that a Qualified Health Plan provide such additional benefits when funding to defray the cost for such additional benefits is not provided.

(e) Nothing in this Part, and no action taken by the Exchange Authority pursuant to the Part, shall be construed to conflict with, preempt, limit, or supersede any applicable health insurance laws of this State or regulations adopted and orders issued by the Commissioner. Nothing in this Part shall be construed to conflict with, limit, or supersede the statutory or regulatory authority vested with the North Carolina Department of Insurance. Except as expressly provided to the contrary by federal law, Insurers and any other entities or persons participating in the Exchange Authority in this State shall comply fully with all applicable provisions of Chapter 58 of the General Statutes and all related regulations adopted and orders issued by the Commissioner. Participation in the Exchange Authority in any way, including payment or receipt of payment in relation to a Qualified Health Benefits Plan, does not exempt any Insurer, entity, or person from complying fully with Chapter 58 of the General Statutes and all related regulations adopted and orders issued by the Commissioner.

(f) The Executive Director shall make an annual report to the Governor, Speaker of the House of Representatives, the President Pro Tempore of the Senate, and the Commissioner by March 1 of each year. The report shall summarize the activities of the Exchange Authority in the preceding calendar year, including information about the number and types of plans offered; number of Insurers; summary information about premiums, enrollment levels and enrollment/disenrollment activity, duration of coverage; and cost of operating the Exchange Authority.

(g) Neither the Board nor the employees of the Exchange Authority are liable for any obligations of the Exchange Authority. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the Exchange Authority or its agents or employees, the Board, the Executive Director, or the Commissioner or the Commissioner's representatives for any action taken by them in good faith in the performance of their powers and duties under this Part.

(h) The Exchange Authority, including the Board and its employees, is subject to the provisions of Article 33C of Chapter 143 of the General Statutes.

(i) The Executive Director, with the approval of the Board, shall operate the Exchange Authority in a manner so that the estimated cost of operating the Exchange Authority during any calendar year is not anticipated to exceed the total income the Exchange Authority expects to receive from any revenue available to the Exchange Authority.

(j) The Board shall provide for other matters as may be necessary and proper for the execution of the Executive Director's powers, duties, and obligations under this Part.

(k) All documents, papers, letters, maps, books, photographs, films, sound recordings, magnetic or other tapes, electronic data-processing records, artifacts, or other documentary material, regardless of physical form or characteristics within the possession of the Exchange Authority, including its employees and the Board, are subject to the provisions of Chapter 132 of the General Statutes except to the extent that these public records are protected under State or federal law, or are confidential or proprietary property of a person as defined in G.S. 66-152.

(l) The members of the Board and the Executive Director are public servants under G.S. 138A-3(30) and are subject to the provisions of Chapter 138A of the General Statutes.

"**§ 58-50-340. General duties.**

(a) The Exchange Authority shall do the following:

(1) Facilitate the purchase and sale of Qualified Health Plans.

(2) Assist qualified individuals in this State with enrollment in Qualified Health Plans.

(3) Assist qualified employers in this State with enrollment of their employees in Qualified Health Plans.

(4) Implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and this Part, of health benefit plans as Qualified Health Plans.

(5) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance in a manner that is accessible to individuals with different communication needs and that effectively communicates information in a manner that is appropriate to the needs of the population being served by the Exchange Authority.

(6) Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act.

(7) Maintain an Internet Web site through which enrollees and prospective enrollees of Qualified Health Plans and individuals eligible for Medicaid or North Carolina Health Choice may obtain standardized comparative information on such plans.

(8) Assign a rating to each Qualified Health Plan offered through the Exchange Authority in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act, and determine each Qualified Health Plan's level of coverage in accordance with regulations issued by the Secretary under section 1302(d)(2)(A) of the Federal Act.

(9) Use a standardized format for presenting health benefit options in the Exchange Authority, including the use of the uniform outline of coverage established under section 2715 of the PHSA that supports consumer choice by making comprehensive information about health plans available in an objective, easy-to-understand format.

(10) In accordance with section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act, or any applicable State or local public program and if, through screening of the application by the Exchange Authority, the Exchange Authority determines that any individual is eligible for any such program, enroll that individual in that program.

(11) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act.

(12) Establish an Individual Exchange, through which Qualified Individuals may enroll in any qualified plan offered through the Individual Exchange for which they are eligible.

(13) Establish a SHOP Exchange through which Qualified Employers may make its employees eligible for one or more Qualified Health Plans offered through the SHOP Exchange or through which Qualified Employers may specify a level of coverage so that any of its employees may enroll in any Qualified Health Plan offered through the SHOP Exchange at the specified level of coverage.

(14) Subject to section 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because of either of the following:

a. There is no affordable Qualified Health Plan available through the Exchange Authority, or the individual's employer, covering the individual.

b. The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty.

(15) Transfer to the federal Secretary of the Treasury the following:

a. A list of the individuals who are issued a certification under subdivision (14) of this subsection, including the name and taxpayer identification number of each individual.

b. The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because of either of the following:

1. The employer did not provide minimum essential coverage.

2. The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code of 1986 to either be unaffordable to the employee or not provide the required minimum actuarial value.

c. The name and taxpayer identification number of the following:

1. Each individual who notifies the Exchange Authority under section 1411(b)(4) of the Federal Act that he or she has changed employers.

2. Each individual who ceases coverage under a Qualified Health Plan during a plan year and the effective date of that cessation.

(16) Provide to each employer the name of each employee of the employer described in sub-sub-subdivision b.2. of subdivision (15) of this subsection who ceases coverage under a Qualified Health Plan during a plan year and the effective date of the cessation.

(17) Perform duties required of the Exchange Authority by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions.

(18) Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act, and standards developed by the Secretary, and award grants to enable Navigators who are certified and trained by the North Carolina Department of Insurance to do the following:

a. Conduct public education activities to raise awareness of the availability of Qualified Health Plans.

b. Distribute fair and impartial information concerning enrollment in Qualified Health Plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act.

c. Facilitate enrollment in Qualified Health Plans.

d. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHSA, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their Health Benefit Plan, coverage, or a determination under that plan or coverage.

e. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange Authority.

(19) Take into account any excess of premium growth outside of the Exchange Authority as compared to the rate of such growth inside the Exchange Authority when determining under section 1302(f)(2)(B) of the Federal Act whether to recommend to the General Assembly that Qualified Health Plans be offered in the large group market through the SHOP Exchange.

(20) Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, and collect the amount credited from the offering employer and remit the amount of the free choice voucher to the appropriate health carrier.

(21) Consult with stakeholders relevant to carrying out the activities required under this act, including, but not limited to, the following:

a. Educated health care consumers who are enrollees in Qualified Health Plans.

b. Individuals and entities with experience in facilitating enrollment in Qualified Health Plans.

c. Representatives of small businesses and self-employed individuals.

d. Representatives of Health Insurers that offer Qualified Health Plans through the Exchange Authority.

e. Representatives of Health Insurers that are not offering qualified plans through the Exchange Authority.

f. Representatives of Health Care Providers.

g. The Division of Medical Assistance.

h. The North Carolina Department of Insurance.

i. Advocates for enrolling hard to reach populations.

(22) Meet all of the following financial integrity requirements:

a. Keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the Secretary, the Governor, the Commissioner, and the General Assembly a report concerning such accountings.

b. Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Federal Act and allow the Secretary, in coordination with the Inspector General of the U.S. Department of Health and Human Services, to do all of the following:

1. Investigate the affairs of the Exchange Authority.

2. Examine the properties and records of the Exchange Authority.

3. Require periodic reports in relation to the activities undertaken by the Exchange Authority.

c. In carrying out its activities under this act, not use any funds intended for the administrative and operational expenses of the Exchange

Authority for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or State legislative and regulatory modifications.

(23) Meet the following fiduciary duties and liability:

a. Any person who acts on behalf of an Exchange Authority shall act as a fiduciary. Such person shall ensure that the Exchange Authority is operated (i) solely in the interests of individuals participating in qualified health plans offered through the Exchange Authority and (ii) for the exclusive purpose of facilitating the purchase of Qualified Health Plans.

b. Any person who acts as a fiduciary on behalf of the Exchange Authority who breaches any of their responsibilities, obligations, or duties imposed by this section shall be liable to make good to the Exchange Authority, the Qualified Health Plans offered through the Exchange Authority, or participants of Qualified Health Plans offered through the Exchange Authority any losses resulting from each breach and shall be subject to such other legal or equitable relief as the court may deem appropriate, including removal of such fiduciary.

(24) With respect to eligibility determinations, provide for (i) review of enrollee appeals of Exchange Authority premium tax credit and cost-sharing reductions and mandate exemption determinations and establish procedures for identifying and confirming income levels of applicants for Exchange Authority coverage and eligibility for receipt of premiums and tax credits and (ii) employer appeals of employer-sponsored plan availability or affordability determinations.

(25) Conduct a review of the costs and benefits of collecting and distributing premiums for small businesses. No later than January 1, 2015, the Exchange Authority shall report the results of the review, including analysis of the financial impact of such collection and distribution, and its recommendations to the North Carolina General Assembly. The Exchange Authority may implement and carry out a process for collecting and distributing premiums if it has sufficient funding to implement the initiative and upon approval by vote by both chambers of the North Carolina General Assembly.

(26) Study the feasibility of offering a Basic Health Plan pursuant to section 1331 of the Federal Act and make a recommendation to the 2013 Regular Session of the 2013 General Assembly.

(27) Provide for publicity and outreach campaigns to raise awareness of the existence of the Exchange Authority and disseminate information regarding eligibility criteria, enrollment procedures, availability of premium tax credits and cost-sharing reductions, small employer tax credits, and other relevant information.

"**§ 58-50-350. Health Benefit Plan certification.**

(a) The Exchange Authority shall certify a Health Benefit Plan as a Qualified Health Plan if the Department of Insurance determines that it satisfies the requirements set forth in subdivisions (1) through (6) of this subsection unless the Exchange Authority determines that making the plan available through the Exchange Authority is not in the interest of Qualified Individuals and Qualified Employers in this State.

(1) The plan provides the Essential Health Benefits package described in section 1302(a) of the Federal Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of Qualified Dental

Plans, as provided in subsection (e) of this section, if both of the following occur:

a. The Exchange Authority has determined that at least one Qualified Dental Plan is available to supplement the plan's coverage.

b. The Insurer makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange Authority, that the plan does not provide the full range of essential pediatric benefits, and that Qualified Dental Plans providing those benefits and other dental benefits not covered by the plan are offered through the Exchange Authority.

(2) The premium rates and contract language have been approved by the Commissioner.

(3) The plan provides at least a bronze level of coverage, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage.

(4) The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the Federal Act, and if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act.

(5) The Health Insurer offering the plan meets the following requirements:

a. Is licensed and in good standing to offer health insurance coverage in this State.

b. Offers at least one Qualified Health Plan in the silver level and at least one plan in the gold level through each component of the Exchange Authority in which the Insurer participates, where "component" refers to the SHOP Exchange and the Individual Exchange.

c. Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange Authority and without regard to whether the plan is offered directly from the Insurer or through an insurance producer.

d. Does not charge any cancellation fees or penalties in violation of G.S. 58-50-330(c).

e. Complies with the regulations developed by the Secretary under section 1311(d) of the Federal Act and such other requirements as the Exchange Authority may establish.

(6) The plan meets the requirements of certification as promulgated by regulation pursuant to this section and by the Secretary under section 1311(c) of the Federal Act.

(b) The Exchange Authority shall not exclude a health plan through the imposition of premium price controls nor shall it exclude a health plan based on the following:

(1) That the plan is a fee-for-service plan.

(2) That the Health Benefit Plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange Authority determines are inappropriate or too costly.

(c) The Exchange Authority shall require each Health Insurer seeking certification of a plan as a Qualified Health Plan to do the following:

(1) Submit a justification for any premium increase before implementation of that increase. The Insurer shall prominently post such information on its Internet Web site. The Exchange Authority shall take this information, along

with the information and the recommendations provided to the Exchange Authority by the Commissioner under section 2794(b) of the PHSA, relating to patterns or practices of excessive or unjustified premium increases, into consideration when determining whether to continue to allow the Insurer to make plans available through the Exchange Authority. In no case shall an Exchange Authority impose any premium price controls or restrict premiums that otherwise meet the requirements of State law.

(2) Make available to the public and submit to the Exchange Authority, the Secretary, and the Commissioner, accurate and timely disclosure of the following:

a. Claims payment policies and practices.
b. Periodic financial disclosures.
c. Data on enrollment.
d. Data on disenrollment.
e. Data on the number of claims that are denied.
f. Data on rating practices.
g. Information on cost-sharing and payments with respect to any out-of-network coverage.
h. Information on enrollee and participant rights under title I of the Federal Act.
i. Other information as determined appropriate by the Secretary.

The information shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act.

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, co-payments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet Web site and through other means for individuals without access to the Internet.

(d) The Exchange Authority shall establish and publish a transparent, objective process for denying certification or decertifying Qualified Health Plans.

(1) The Exchange Authority shall give each Health Insurer the opportunity to appeal a decertification decision or the denial of certification as a Qualified Health Plan.

(2) The Exchange Authority shall give each Health Insurer that appeals a decertification decision or the denial of certification the opportunity for the following:

a. The submission and consideration of facts, arguments, or proposals of adjustment of the health plan or plans at issue.
b. A hearing and a decision on the record, to the extent that the Exchange Authority and the Health Insurer are unable to reach agreement following the submission of the information in sub-subdivision a. of this subdivision.

(3) Any hearing held pursuant to subdivision (2) of this subsection shall be conducted by an impartial party agreed to by the Exchange Authority and the Health Insurer. If the Exchange Authority and the Health Insurer cannot agree on an impartial party, then the hearing must be held by an administrative law judge.

(4) The hearing decision may be appealed to the North Carolina Court of Appeals by the aggrieved party.

(e) The Exchange Authority shall not exempt any Health Insurer seeking certification of a Qualified Health Plan, regardless of the type or size of the Insurer, from State licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among Health Insurers participating in the Exchange Authority.

(1) The provisions of this act that are applicable to Qualified Health Plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of subdivisions (2), (3), and (4) of this subsection or by regulations adopted by the Commissioner.

(2) The Insurer shall be licensed to offer dental coverage but need not be licensed to offer other health benefits.

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by Health Benefit Plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to section 1302(b)(1)(J) of the Federal Act and such other dental benefits as the Exchange Authority or the Secretary may specify by regulation.

(4) Insurers may jointly offer a comprehensive plan through the Exchange Authority in which the dental benefits are provided by an Insurer through a Qualified Dental Plan and the other benefits are provided by an Insurer through a Qualified Health Plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

"**§ 58-50-360. Choice.**

(a) In accordance with section 1312(f)(2)(A) of the Federal Act, a Qualified Employer may either designate one or more Qualified Health Plans from which its employees may choose or designate any level of coverage to be made available to employees through the SHOP Exchange.

(b) In accordance with section 1312(b) of the Federal Act, a Qualified Individual enrolled in any Qualified Health Plan may pay any applicable premium owed by such individual to the Health Insurer issuing such Qualified Health Plan.

(c) In accordance with section 1312(c) of the Federal Act, the following risk pools are established:

(1) Individual Exchange. – A Health Insurer shall consider all enrollees in all health plans other than Grandfathered Health Plans offered by such Insurer in the individual market, including those enrollees who do not enroll in such plans through the Individual Exchange, to be members of a single risk pool.

(2) SHOP Exchange. – A Health Insurer shall consider all enrollees in all health plans other than Grandfathered Health Plans offered by such Insurer in the small group market, including those enrollees who do not enroll in such plans through the SHOP Exchange, to be members of a single risk pool.

(d) In accordance with section 1312(d) of the Federal Act, this section shall not prohibit either of the following:

(1) A Health Insurer from offering outside of the Individual Exchange or the SHOP Exchange a health plan to a Qualified Individual or a Qualified Employer.

(2) A Qualified Individual from enrolling in, or a Qualified Employer from selecting for its employees, a health plan offered outside of the Exchange Authority.

(e) This section shall not limit the operation of any requirement under State law or regulation with respect to any policy or plan that is offered outside of the Exchange Authority with respect to any requirement to offer benefits.

(f) Nothing in this section shall restrict the choice of a Qualified Individual to enroll or not to enroll in a Qualified Health Plan or to participate in the Individual Exchange.

(g) Nothing in this section shall compel an individual to enroll in a Qualified Health Plan or to participate in the Exchange Authority.

(h) A Qualified Individual may enroll in any Qualified Health Plan, except that in the case of a catastrophic plan described in section 1302(e) of the Federal Act, a Qualified Individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1312(e)(2) of the Federal Act.

(i) Nothing in this act or the Federal Act shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any Health Benefit Plan that is offered outside of the Exchange Authority.

(j) In accordance with section 1312(e) of the Federal Act, the Exchange Authority shall allow Agents or Brokers to do the following:

(1) To enroll Qualified Individuals and Qualified Employers in any Qualified Health Plan offered through the Exchange Authority for which the individual or employer is eligible.

(2) To assist Qualified Individuals in applying for premium tax credits and cost-sharing reductions for any Qualified Health Plan purchased through the Individual Exchange.

(k) Any compensation to Agents and Brokers paid under this Part shall be determined by the insurer.

"**§ 58-50-370. Funding; publication of costs.**

(a) Beginning in 2014, the funding stream that supports the North Carolina Health Insurance Risk Pool shall be utilized to support the operations of the Exchange Authority. Beginning in 2015, the funding stream that supports the North Carolina Health Insurance Risk Pool shall be utilized to support the operations of the Exchange Authority that serve those individuals with incomes less than or equal to four hundred percent (400%) of the federal poverty level and Qualified Employers receiving a tax credit for the purchase of insurance pursuant to the Federal Act. The proportional cost associated with serving individuals with incomes over four hundred percent (400%) of the federal poverty level and the Qualified Employers not receiving a tax credit pursuant to the Federal Act shall be funded by an annual user fee paid by the individual or the employer to the Exchange Authority. The user fee assessed by the Exchange Authority shall be no greater than the anticipated expenses for serving this market for the applicable fiscal year and must be approved by the Commissioner. Additionally, the Exchange Authority is authorized to utilize grant funding for operations, including, but not limited to, grant funding from the Department of Health and Human Services. The Exchange Authority is also authorized to collect and use advertising fees to help support operations of the Exchange Authority.

(b) Prior to the commencement of the 2013 Regular Session of the 2013 General Assembly, the Exchange Authority shall examine its potential operational costs and propose to the General Assembly any additional changes to the funding stream necessary to ensure its solvency.

(c) As required by section 1311(d)(5)(A) of the Federal Act, the Exchange Authority shall be self-sustaining by January 1, 2015. A budget for the Exchange Authority shall be prepared by the Exchange Authority and submitted to the Commissioner annually for approval.

(d) Services performed by the Exchange Authority on behalf of other State or federal programs shall be paid for by those State or federal programs.

(e) Any unspent funding by the Exchange Authority shall be used for future operation of the Exchange Authority or reducing future user fees.

(f) The Exchange Authority shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange Authority, and the administrative costs

of the Exchange Authority, on an Internet Web site to educate consumers on such costs. This information shall include information on monies lost to waste, fraud, and abuse.

(g) The Exchange Authority is exempt from any and all State taxes.

"**§ 58-50-380. Regulations.**

The Commissioner shall promulgate regulations pursuant to Chapter 150B of the General Statutes, including temporary rules, to implement the provisions of this Part.

"**§ 58-50-390. Audit.**

An audit of the Exchange Authority shall be conducted annually under the oversight of the State Auditor. The cost of the audit shall be reimbursed to the State Auditor from Exchange Authority funds.

SECTION 3. Nothing in this Act shall be construed to interfere with payments to federally qualified health centers. If any item or service covered by a qualified health plan is provided by a federally qualified health center, as defined in section 1905(1)(2)(B) under the Social Security Act 42 U.S.C. 1396d(1)(2)(B), to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or services an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Social Security Act for such item or service.

SECTION 4. Severability. – If any provision of this act is held invalid by a court of competent jurisdiction, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, is repealed. If section 1311 of the federal Patient Protection and Affordable Care Act or the federal Patient Protection and Affordable Care Act in its entirety is repealed or held invalid by a court of competent jurisdiction, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, is repealed. If funding is not provided as set forth in the federal Patient Protection and Affordable Care Act, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, shall not be enforceable.

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

MINUTES

HOUSE COMMITTEE ON INSURANCE

April 19, 2011

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 19, 2011, at 1:00 pm. The following members were present: Representatives Dockham, Chair, Blust, Brown, Bryant, Collins, Current, Faison, Floyd, Folwell, Glazier, Graham, Hamilton, Howard, Hurley, Insko, McElraft, McGuirt, Mills, Murry, Pierce, Setzer, Shepard, Steen, Stevens, Warren, Wilkins, and Wray. Tim Hovis and Bill Patterson, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes. (Attachment I)

Representative Dockham, Chair, called the meeting to order at 1:00 pm. He introduced the pages and the Sergeant of Arms staff. (Attachment II) The following bills were considered:

SB 323, entitled, A BILL TO BE ENTITLED AN ACT TO MAKE CHANGES IN THE INSURANCE LAWS TO PRIVATIZE ONLINE AND ADMINISTRATIVE PROCESSES FOR LICENSE APPLICANTS, CODIFY THE EXISTING SENIORS' HEALTH INSURANCE INFORMATION PROGRAM, ENSURE ACCURACY IN CERTIFICATES OF INSURANCE, REQUIRE PRIOR APPROVAL OF SMALL GROUP HEALTH INSURANCE RATES AND ENCOURAGE THE SALE OF CHILD-ONLY HEALTH INSURANCE POLICIES, AMEND THE RISK-BASED CAPITAL LAW TO MAINTAIN NAIC ACCREDITATION, PROVIDE AN EXEMPTION FOR LICENSING OF CLAIMS INPUT EMPLOYEES FOR PORTABLE ELECTRONIC DEVICES, PROHIBIT FEDERAL PREEMPTION OF CROP ADJUSTERS' REGULATION, AND EASE THE REGULATORY BURDEN ON THE NORTH CAROLINA SELF-INSURANCE SECURITY ASSOCIATION AND THE ASSOCIATION AGGREGATE SECURITY SYSTEM. Senator Apodaca, bill sponsor, was not available to explain the bill. A proposed committee substitute was presented. Representative Murry moved to adopt the proposed committee substitute for consideration. The motion passed. Representative Dockham explained the proposed committee substitute. The House committee substitute makes the following changes to Senate Bill 323 second edition. It replaces the language of SB 323 with provisions identical to SB 265 (State Health Plan/Appropriations and Transfer) with the following changes: It directs the State Treasurer to strive to maintain low premiums by finding operational savings in the plan and directs the Treasurer to implement a program for long-term care benefits and establish separate premium rates for the benefits. He indicated that it was still a work in progress which could result in a no-premium option for active and retired employees. Alternatives are still being discussed by House Speaker Thom Tillis in talks with employee groups. After some discussion, Representative Dockham invited representatives of active and retired state employees to speak on the proposed committee substitute.

Ardis Watkins, Director, Legislative Affairs, State Employees Association of NC (SEANC) specified that even though this legislation gets SEANC members that much closer to accomplishing their number one legislative priority for this session, the bill's inclusion of health care premiums is giving a lot of people mixed feelings.

Pam Deardorff, NC Retired School Personnel, Ed Regan, NC Retired Governmental Employees Association, Brian Lewis, NC Association of Educators, spoke very strongly in opposition of premiums to be paid by active and retired state employees.

Due to time constraints Rep. Dockham requested that Members pass the House committee substitute for SB 323. Representative Howard moved for a favorable report as to House committee substitute bill, which changes the title, unfavorable as to Senate committee substitute bill and recommendation that the House committee substitute bill be re-referred to the Committee on APPROPRIATIONS. At the request of Representative Glazier a roll call vote was taken. (Attachment III) The motion passed.

HB 115, entitled, A BILL TO BE ENTITLED AN ACT TO PRESERVE STATE-BASED AUTHORITY TO REGULATE THE NORTH CAROLINA HEALTH INSURANCE MARKET AND TO PREVENT FEDERAL ENCROACHMENT ON STATE AUTHORITY BY ESTABLISHING THE NORTH CAROLINA BENEFIT EXCHANGE.

Representative Dockham, bill sponsor, presented a proposed committee substitute. Representative Howard moved for adoption of the committee substitute for discussion only. The motion passed. Representative Dockham informed the members that no amendments will be accepted or votes taken at this meeting. The Chair invited the public to speak on the bill. The following people spoke in opposition of HB 115. (Attachment IV)

There being no further business, the Chair adjourned the meeting at 1:50 pm.

Respectfully submitted,

Representative Jerry C. Dockham, Chair

Regina Irwin, Committee Assistant

Attachments

AGENDA

HOUSE COMMITTEE ON INSURANCE

April 19, 2011

Room 1228

1:00 pm

OPENING REMARKS

Representative Jerry Dockham, Chairman
Insurance Committee

AGENDA ITEMS

SB 323 **INSURANCE AMENDMENTS.-AB**
Senator Tom Apodaca, Sponsor

HB 115 **NORTH CAROLINA HEALTH BENEFIT EXCHANGE.**
Representative Dockham, Sponsor
Representative Brubaker, Sponsor
Representative Wray, Sponsor
Representative Murry, Sponsor

ADJOURNMENT

ATTACHMENT I

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

APRIL 19, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Adam Linker	NC Justice Center
Emily Stetson	BONC
Gus Montana	HCFANC, PNHP
Scott Scheirer	SELF
Paul Stock	NCBIA
Fred Baron	Baron & Baron
J Goodnight	NC Chamber
Peggy Magner	
Leanne Lucier	NCSBA
	AHIA
Jeff Hayard	GPM / Aetna
David Herndon	NC Center for Nonprofits

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

APRIL 19, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Reggie Parker	NMSS NC
Christine Keasley	UNC School of Public Health Student
Rose Williams	NCDOJ
Louis Belo	" "
Julia Lerche	" "
Shannon McCoy	Nationwide
Ben Poplon	NCDOI
Bud Netter	Amer. Heart Assn
Kevin Rogers	Action NC
Mark Flury	BCBSNC
Elizabeth Robinson	NCBMA
Chuck Stone	SEANC
Mitch Leonard	SEANC
Christine Wilson	American Cancer Society

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

APRIL 19, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sarah Preston	ACLU-NC
Tom Vitagliano	AGC
MaryBe McMillan	NC AFL-CIO
Annaliese Dolph	DRNC
Lou Meyers	Small Business 2912 Guess Rd. Durham NC 27705
John R Hodges	SELF (CITIZENS WITH NO VOICE) 411 WESTWOOD DR., EFLAND, N.C. 27243
Lonna Harkrader	OFA - Durham
Rene Cummins	ADA-CIL
Fred Johnson	ADA-CIL
Lendy Pridgen	Capital Health Mgmt
Jennifer Cohen	IFNC

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

APRIL 19, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Leslie Boyd	Life o' Mike Inc., Asheville
Laura Martin	Reesenews, UNC-Chapel Hill
[signature]	Colonial Life
Sandy Sheerin	NC Council of Churches
Caroline Denning	NMSS-NC
Abby Enamorado	NMSS-NC
Trish Miller	NMSS-NC
Richard Nixon	[illegible]
Charles Wilkins	NFLIC
Ardis Watkins	SEANC
Suzanne Beasley	SEANC

VISITOR REGISTRATION SHEET

INSURANCE — APRIL 19, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Starling	NCDST
Katherine Ross	PPAB
Becky Gr	9 2 7
Stan Williams	NC Sierra Club
Steve Woodson	NCFB
[illegible]	BCBSNC
Tim KENT	NC Beer & Wine
Barbara Canales	BCBSNC
Jon Carr	American Cancer Society

VISITOR REGISTRATION SHEET

INSURANCE — APRIL 19, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Mitchell	Astellas
Amy Whited	NC med society
Melissa Reed	PPHS
Elizabeth Page	WCHIRP
Brent Pasche	Young Moore
Moore [illegible]	Smith Anderson
Steve Gallyon	Wake Forest Baptist
Bob Jackson	AARP NC
Bill Wilson	AARP
Matt Ingalsbe	Hemophilia of North Carolina
Sue Cowell	Hemophilia of NC
SOLARI John Dean	DST Governor's Office

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

APRIL 19, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joseph Coletti	John Locke Foundation
Marty Bocock	AHIP
[illegible]	NMRS
Joann Stevens	NCNA / Stevens lobby
Thomas Hardaway	PhRMA
Joe Lanier	Nelson Mullins
Ashley Snott	BCBSNC
BJ Miller	Moses Cone
David Barnes	PS
Nicole Fisher	John Locke Foundation
[illegible]	Staff
Ed [illegible]	[illegible]
Andy Ellen	NCPhRMA

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

APRIL 19, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lacey Barnes	SHP
Carol Durrell	SHP
Mona Moon	SHP
Carlini Smart	SHP
Cynthia Barnett	Duke Christian Science Committee on Publication NC
Emily Grimm	MWC
Marlee Foster	Pfizer
Ken Melton	K. M. A.
John Minnich	CSC
BILL COX	DSI
Linda Bond	NCAE2

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

APRIL 19, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Holton	DST
Marge Foreman	NCAE
Donna Clark	
Sara Fender	IFNC
Karen Paquette	Cisco
Sondra Stein	LWV ODC Durham, NC
Anne Rogers	State Health Plan
LOTTIA CRABTREE	"
Tracy Stephenson	"
Beverly Harris	"
J W Walker	"
Forrest Gillam	Governor's Office
Jane Fitzgerald	MLC

VISITOR REGISTRATION SHEET

INSURANCE — APRIL 19, 2011

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

PLEASE PRINT

ATTACHMENT II

HOUSE PAGES

NAME OF COMMITTEE: INSURANCE DATE: APRIL 19, 2011

1. NAME: Mary Frances Foster
   County: Cleveland
   Sponsor: T. Moore
2. NAME: Erin Wilson
   County: Cleveland
   Sponsor: T. Moore
3. NAME: Ian Ratcliff
   County: Wake
   Sponsor: N. Dollar
4. NAME: David Ojo
   County: Cumberland
   Sponsor: Diane Parfitt
5. NAME:
   County:
   Sponsor:

SERGEANTS-AT-ARMS

1. Name: Bill MacRae
2. Name: Lawrence Elliott
3. Name: Garland Shepherd
4. Name:
5. Name:

ATTACHMENT III

ROLL CALL VOTE

16 YES 11 NO = 27 (TOTAL)

HB# ____
SB# 323

HOUSE STANDING COMMITTEE ON INSURANCE

House Subcommittee on _____

YES	NO	MEMBER (last name)	YES	NO	MEMBER (last name)
✓		DOCKHAM	✓		SETZER
✓		BLUST	✓		SHEPARD
✓		BROWN	✓		STEEN
		BRUBAKER	✓		STEVENS
	✓	BRYANT			WAINWRIGHT
✓		BURR	✓		WARREN
✓		COLLINS		✓	WILKINS
		CRAWFORD		✓	WRAY
✓		CURRENT			
	✓	FAISON			
	✓	FLOYD			
✓		FOLWELL			
	✓	GLAZIER			
	✓	GRAHAM			
	✓	HAMILTON			
✓		HOWARD			
✓		HURLEY			
	✓	INSKO			
		JACKSON			
		JOHNSON			
✓		MCELRAFT			
	✓	MCGUIRT			
		MILLS			
✓		MURRY			
	✓	PIERCE			

ATTACHMENT IV

REQUEST TO SPEAK ON HB 115

PLEASE PRINT

NAME	AGENCY/COMPANY	TEL. #
Christine Weason	America Cancer Society	919.[redacted] 270.4428
Trish Miller ~~Abby Emanuelson~~	National MS Society	919-389-3553
~~Bill Wilson~~ Bob Jackson	AARP	919 508-0299
Candy Irving	NC Council of Churches	919 787-2254
Adam Searing	NC Justice Center	919 856-2568
Kevin Rogers	Action NC	919 295-3870
Leslie Boyeal		828 243-6712
Donna Clark	White Lake	828 230-5555

REQUEST TO SPEAK ON HB 115

PLEASE PRINT

NAME	AGENCY/COMPANY	TEL. #
✓ Susan Cowell	Executive Director Hemophilia of NC	919 319-0014
✓ Lea Meyers	Small Business	919 477-7725
✓ Christine Kearsley	UNC School of Public Health	339 225-0029
Mathew right no show	US Health care Warrenty Exchange	910 713-5233
✓ John Rhodes	Private Citizen	919 563-4932
✓ Sondra Stein		919 309-4720

Trish Miller, Wake County
NC House Insurance Committee
Public Comment on HB 115
April 18, 2011

Good afternoon my name is Trish Miller.

As a former business owner, we had to keep prices competitive and our products accessible to buyers. North Carolina's Health Benefit Exchange will be this marketplace and health plans in the exchange must offer consumers easy to understand plans that provide clear benefits and value to patients. The marketplace must also be transparent and offer choices that bring down the cost of health care.

In February of 2004, I was diagnosed with Multiple Sclerosis, a disabling disease of the central nervous system. Due to MS and other health conditions, my health insurance premiums eventually rose to over $3,000 per month. Purchasing health insurance through the small business was cost prohibitive and the company downsized so I applied for Medicare at age_____

Small business owners and individuals like me need to be recognized as part of the debate and part of the Exchange. Consumer representation and health experts are essential to the Exchange administering Board. Insurers will be financially impacted by the decisions of the Board and

their ability to remain impartial will be challenged. Do the "right thing" and provide balanced oversight on the Healthcare Exchange Board of Directors by increasing the number of "Experts" without professional conflicts to the Board.

And when a person or small business purchases insurance, they need to have independent navigators that advise on all the products on the exchange, including public program like Medicaid. Currently, we have a cadre of trained individuals at SHIIP that guide seniors and people with disabilities in their purchase of Medicare plans including the Part D prescription drug program.

Finally, if the exchange is going to work the user fees should not be carried on the backs of small business owners and families making more than $88,000 a year. The cost must be spread among all consumers of health insurance in North Carolina. If not, those who can afford to opt out of the exchange and the entire system will fail. Taxing only the individuals who would enter the exchange keeps people out of the insurance pool and the sickest in.

Thank You....

My name is Sandy Irving from the North Carolina Council of Churches

Appreciate opportunity to share with you.

The NCCC, envision a state where each person is afforded health, wholeness and human dignity. Holy scriptures of all faiths call us to be concerned about the health and well-being of everyone.

Our current system of health care, excludes too many, distributes services unjustly, rations care inequitably and offers compassion only to those who can afford it.

The health insurance companies and providers have created and benefited from this broken system.

HB 115 continues to benefit those currently in control of this broken system.

Insurance Companies must not have a vote on the Exchange Board. The Exchange must promote real competition and protect consumers.

I urge you to read the book, Deadly Spin by Wendell Potter—I know you are busy, so if you only have time to read 2 pages—I encourage you to read p12 and 221 to get a feel of the PR efforts to which companies will go in order to maintain control.

The vision of the NCCC embraces a health care system which is inclusive, accessible, affordable and accountable. HB115 does not implement this vision. The legislature must create an exchange that protects consumers and provides health care for everyone, at an affordable price. It must be implemented in ways that protect and benefit the most vulnerable around us by providing a health care system that is grounded in the sacred bonds of our common humanity.

Public Comments on HB115 before the Insurance Committee, North Carolina House of Representatives

Representative Dockham, Honorable Members, Fellow Citizens:

I want to speak against H115 because I do not think it establishes a Health Benefits Exchange that works in the best interests of NC citizens.

The purpose of the Affordable Care Act – whatever you think about it – is to make sure that every citizen in NC – rich and poor, old and young, newcomer, longtime resident – has access to high quality affordable health care – for every day health care needs and for health care emergencies.

Like many other free market, capitalist countries we have chosen not to provide health care directly but to establish an exchange that offers consumers the chance to choose from among a number of affordable, high quality insurance options.

For health care reform to work, it seems to me that the main purpose of the Exchange should to establish a balance between the interests of insurance companies – which are focused on making profits – and the interests of people in need of health insurance – who need access to affordable, accessible health care.

Many countries have struggled with the best way to achieve this balance. Personally, I think Switzerland's approach is best suited to the U.S. It establishes strong constraints on companies who offer what the Affordable Care Act calls *essential* services – setting limits on what they can charge for these *essential* services. So companies on their exchange for essential services compete not on price but on service and quality. Their profits are based on how well they serve their customers.

I would like to see an exchange in North Carolina that takes this kind of approach to implementing health care reform in our state.

To achieve this goal we need a board that represents the interests of health care consumers by mitigating the forces of the free market somewhat in order to assure that every North Carolinian has access to health care when and where they need it.

We need a board that is not composed of health insurers and business organizations but of individuals with expertise in health care systems, quality control in health care delivery, health care economics, and consumer communication. A board, in other words, equipped to evaluate what each insurer who wants to sell insurance on

the exchange purports to offer and whether that offer meets the stringent, consumer-friendly conditions set by the board. And a board equipped to present the offers of each insurance company in a way that every person seeking insurance can understand and evaluate to see how well it meets their own needs.

The purpose of health care reform is to look out for the interests of the consumer – within the constraints of a market system. In Switzerland, the government balances the constraints they place on insurance companies for the *essential* package by allowing them to offer supplemental packages on the usual unconstrained market.

But this is not the only place that companies make a profit. It turns out that the companies that offer excellent service and quality health care options to a greatly expanded consumer market end up making substantial profits on the increased quantity of insurance they sell.

Insurance companies can do the same thing here – on an exchange that controls and monitors the conditions under which they offer health care insurance to ensure that the best interests of the consumers of health care are met.

Let's not fool ourselves. Unless we have an exchange in North Carolina that operates in this way, we will have business as usual in North Carolina. Not affordable, accessible health care that the new law guarantees to every American citizen. Let's amend H115 so it meets these goals or let's start over and build a real Exchange that meets the needs of North Carolinians in search of better health care.

Thank you.

Sondra G. Stein
905 E Oak Drive
Durham, NC 27705
919-309-4720

2011 COMMITTEE REPORT

HOUSE OF REPRESENTATIVES

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

By Representative Dockham (Chair) for the Committee on INSURANCE.

☒ Senate Committee Substitute for

SB 323 A BILL TO BE ENTITLED AN ACT TO MAKE CHANGES IN THE INSURANCE LAWS TO PRIVATIZE ONLINE AND ADMINISTRATIVE PROCESSES FOR LICENSE APPLICANTS, CODIFY THE EXISTING SENIORS' HEALTH INSURANCE INFORMATION PROGRAM, ENSURE ACCURACY IN CERTIFICATES OF INSURANCE, REQUIRE PRIOR APPROVAL OF SMALL GROUP HEALTH INSURANCE RATES AND ENCOURAGE THE SALE OF CHILD-ONLY HEALTH INSURANCE POLICIES, AMEND THE RISK-BASED CAPITAL LAW TO MAINTAIN NAIC ACCREDITATION, PROVIDE AN EXEMPTION FOR LICENSING OF CLAIMS INPUT EMPLOYEES FOR PORTABLE ELECTRONIC DEVICES, PROHIBIT FEDERAL PREEMPTION OF CROP ADJUSTERS' REGULATION, AND EASE THE REGULATORY BURDEN ON THE NORTH CAROLINA SELF-INSURANCE SECURITY ASSOCIATION AND THE ASSOCIATION AGGREGATE SECURITY SYSTEM.

☒ With a favorable report as to House committee substitute bill, which changes the title, 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.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S D

SENATE BILL 323
Insurance Committee Substitute Adopted 3/24/11
PROPOSED HOUSE COMMITTEE SUBSTITUTE S323-PCS85171-ME-14

Short Title: State Hlth Plan/ Appropriations & Transfer II. (Public)

Sponsors:

Referred to:

March 14, 2011

AN ACT TO MAKE APPROPRIATIONS AND ADJUSTMENTS FOR THE 2011-2013 FISCAL BIENNIUM TO THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES; AND TO TRANSFER THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES TO THE OFFICE OF STATE TREASURER.

The General Assembly of North Carolina enacts:

PART I. APPROPRIATIONS AND CONTRIBUTIONS FOR 2011-2013 FISCAL BIENNIUM

APPROPRIATIONS FROM GENERAL FUND AND HIGHWAY FUND

SECTION 1.1.(a) General Fund Appropriation. – 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 eight million sixty-one thousand seven hundred ninety-eight dollars ($8,061,798) for the 2011-2012 fiscal year and the sum of one hundred one million seven hundred eighty-two thousand six hundred seventy dollars ($101,782,670) for the 2012-2013 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2011-2013 fiscal biennium.

SECTION 1.1.(b) Highway Fund Appropriation. – 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 three hundred seventy-six thousand two hundred seventeen dollars ($376,217) for the 2011-2012 fiscal year and the sum of four million seven hundred forty-nine thousand eight hundred fifty-eight dollars ($4,749,858) for the 2012-2013 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2011-2013 fiscal biennium.

SECTION 1.1.(c) All other agency funds required to fund the premium increase enacted in this act, other than funds appropriated in subsections (a) and (b) of this section, are appropriated for the 2011-2013 fiscal biennium.

PREMIUM ADJUSTMENTS

SECTION 1.2.(a) Partially Contributory Coverage. – The State Health Plan for Teachers and State Employees may charge up to the following monthly premium rates for partially contributory coverage under G.S. 135-45.2(a1), as enacted by Section 1.6 of this act, for the 2011-2012 and 2012-2013 fiscal years:

	FY 2011-2012		FY 2012-2013	
	Basic	Standard	Basic	Standard
Employee Contribution				
Non-Medicare Eligible or Medicare Secondary	$10.86	$21.72	$11.43	$22.85
Medicare Primary	$8.27	$16.54	$8.70	$17.40
Retiree Contribution				
Non-Medicare Eligible	$0.00	$21.72	$0.00	$22.85
Medicare Eligible	$0.00	$16.54	$0.00	$17.40

SECTION 1.2.(b) Contributory Coverage. – Premium rates for contributory coverage established in accordance with G.S. 135-44.6 may be increased by up to five and two-tenths percent (5.2%) for contributory coverage for the 2011-2012 fiscal year and may be increased by up to an additional five and two-tenths percent (5.2%) over the premium rate for contributory coverage for the 2012-2013 fiscal year.

DEDUCTIBLE, COINSURANCE, AND CO-PAYMENT ADJUSTMENTS

SECTION 1.3.(a) Effective July 1, 2011, 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 nine hundred thirty-three dollars ($933.00) for member-only coverage and to one thousand eight hundred sixty-six dollars ($1,866) 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 seven hundred ninety-three dollars ($3,793) for member-only coverage and to seven thousand five hundred eighty-six dollars ($7,586) 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 eighty-seven dollars ($87.00) per covered individual.

d. Increase the in-network primary care co-payment to thirty-five dollars ($35.00) per covered individual.

e. Increase the in-network specialist co-payment to eighty-one dollars ($81.00) per covered individual, except that for mental health and substance abuse services, chiropractic services, and physical therapy, occupational therapy, and speech therapy services, the in-network specialist co-payment shall be sixty-four dollars ($64.00) per covered individual.

f. Increase the in-network and out-of-network inpatient co-payment to two hundred ninety-one dollars ($291.00) per covered individual.

g. Increase the in-network and out-of-network emergency room co-payment to two hundred ninety-one dollars ($291.00) per covered individual.

h. Increase prescription drug co-payments as required under G.S. 135-45.6(b)(1) as amended by this section.

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 2010-2011 benefit year.

(2) Standard Plan (80/20):

a. Increase the in-network annual deductible to seven hundred dollars ($700.00) for member-only coverage and to one thousand four hundred dollars ($1,400) 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 three thousand two hundred ten dollars ($3,210) for member-only coverage and to six thousand four hundred twenty dollars ($6,420) 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 eighty-seven dollars ($87.00) per covered individual.

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

e. Increase the in-network specialist co-payment to seventy dollars ($70.00) per covered individual, except that for mental health and substance abuse services, chiropractic services, and physical therapy, occupational therapy, and speech therapy services, the in-network specialist co-payment shall be fifty-two dollars ($52.00) per covered individual.

f. Increase the in-network and out-of-network inpatient co-payment to two hundred thirty-three dollars ($233.00) per covered individual.

g. Increase the in-network and out-of-network emergency room co-payment to two hundred thirty-three dollars ($233.00) per covered individual.

h. Increase prescription drug co-pays as required under G.S. 135-45.6(b)(1) as amended by this act.

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 2010-2011 benefit year.

SECTION 1.3.(b) G.S. 135-45.6(b)(1) reads as rewritten:

"(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-five dollars ($35.00)~~ forty dollars ($40.00) for each preferred branded prescription without a generic equivalent, and ~~fifty-five dollars ($55.00)~~ sixty-four dollars ($64.00) for each nonpreferred branded 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."

LIMITATION ON AUTHORITY TO CHANGE BENEFITS

SECTION 1.4. 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, 2009,~~ July 1, 2011, that would result in a net increased cost to the Plan or in a reduction in benefits to Plan members unless and until the proposed changes are directed to be made in an act of the General Assembly."

REPEAL COMPREHENSIVE WELLNESS INITIATIVE

SECTION 1.5. Section 2(b) of S.L. 2009-16, as amended by S.L. 2009-571, is repealed.

IMPLEMENT MONTHLY CONTRIBUTION BY EMPLOYEES AND CERTAIN RETIREES

SECTION 1.6.(a) G.S. 135-45(b) reads as rewritten:

"(b) Individuals eligible for coverage under G.S. 135-45.2 on a ~~fully or partially~~ partially, one-half, or fully contributory basis are eligible to participate in any plan authorized under this section."

SECTION 1.6.(b) G.S. 135-45.2 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:

~~(1) All permanent full-time employees of an employing unit who meet the following conditions:~~

~~a. Paid from general or special State funds, or~~

~~b. Paid from non-State funds and in a group for which his or her employing unit has agreed to provide coverage.~~

~~Employees of State agencies, departments, institutions, boards, and commissions not otherwise covered by the Plan who are employed in permanent job positions on a recurring basis and who work 30 or more hours per week for nine or more months per calendar year are covered by the provisions of this subdivision.~~

~~(2) Permanent hourly employees as defined in G.S. 126-5(c4) who work at least one-half of the workdays of each pay period.~~

(3) Retired teachers, State employees, members of the General Assembly, and retired State law enforcement officers who retired under the Law Enforcement Officers' Retirement System prior to January 1, 1985. Except as otherwise provided in this subdivision, on and after January 1, 1988, a retiring employee or retiree must have completed at least five years of contributory retirement service with an employing unit prior to retirement from any State-supported retirement system in order to be eligible for group benefits under this Part as a retired employee or retiree. For employees first hired on and after October 1, 2006, and members of the General Assembly first taking office on and after February 1, 2007, future coverage as retired employees and retired members of the General Assembly is subject to a requirement that the future retiree have 20 or more years of retirement service credit in order to be covered by the provisions of this subdivision.

(4) Surviving spouses of:

a. Deceased retired employees, provided the death of the former plan member occurred prior to October 1, 1986; and

b. Deceased teachers, State employees, and members of the General Assembly who are receiving a survivor's alternate benefit under any of the State-supported retirement programs, provided the death of the former plan member occurred prior to October 1, 1986.

~~(5) Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except for legislative interns and pages.~~

~~(6) Members of the General Assembly.~~

~~(7) Notwithstanding the provisions of subsection (e) of this section, employees on official leave of absence while completing a full-time program in school administration in an approved program as a Principal Fellow in accordance with Article 5C of Chapter 116 of the General Statutes.~~

~~(8) Notwithstanding the provisions of 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, 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. An employee formerly covered by the provisions of this section shall not be eligible for coverage under this subdivision if the employee is provided health benefit coverage on a non-contributory basis by a subsequent employer.~~

~~(9) Any member enrolled pursuant to subdivision (1) or (2) of this subsection who is on approved leave of absence with pay or receiving workers' compensation.~~

~~(10) Employees on approved Family and Medical Leave.~~

(a1) Partially Contributory Coverage. – The following persons are eligible for coverage under the Plan, on a partially contributory basis, subject to the provisions of G.S. 135-45.4:

(1) All permanent full-time employees of an employing unit who meet either of the following conditions:

a. Paid from general or special State funds.

b. Paid from non-State funds and in a group for which his or her employing unit has agreed to provide coverage.

Employees of State agencies, departments, institutions, boards, and commissions not otherwise covered by the Plan who are employed in permanent job positions on a recurring basis and who work 30 or more hours per week for nine or more months per calendar year are covered by the provisions of this subdivision.

(2) Permanent hourly employees who work at least one-half of the workdays of each pay period.

(3) Retired teachers, State employees, members of the General Assembly, and retired State law enforcement officers who retired under the Law Enforcement Officers' Retirement System prior to January 1, 1985. Except as otherwise provided in this subdivision, on and after January 1, 1988, a retiring employee or retiree must have completed at least five years of

contributory retirement service with an employing unit prior to retirement from any State-supported retirement system in order to be eligible for group benefits under this Part as a retired employee or retiree. For employees first hired on and after October 1, 2006, and members of the General Assembly first taking office on and after February 1, 2007, future coverage as retired employees and retired members of the General Assembly is subject to a requirement that the future retiree have 20 or more years of retirement service credit in order to be covered by the provisions of this subdivision.

(4) Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except for legislative interns and pages.

(5) Members of the General Assembly.

(6) Notwithstanding the provisions of subsection (e) of this section, employees on official leave of absence while completing a full-time program in school administration in an approved program as a Principal Fellow in accordance with Article 5C of Chapter 116 of the General Statutes.

(7) Notwithstanding the provisions of G.S. 135-45.12, employees formerly covered by the provisions of this subsection, other than retired employees, who have been employed for 12 or more months by an employing 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. An employee formerly covered by the provisions of this subsection shall not be eligible for coverage under this subdivision if the employee is provided health benefit coverage on a noncontributory basis by a subsequent employer.

(8) Any member enrolled pursuant to subdivision (1) or (2) of this subsection who is on approved leave of absence with pay or receiving workers' compensation.

(9) Employees on approved Family and Medical Leave.

(b) ~~Partially Contributory.~~ One-Half Contributory Coverage. – The following persons are eligible for coverage under the ~~Plan~~ Plan, on a ~~partially~~ one-half contributory ~~basis~~ basis, subject to the provisions of G.S. 135-45.4:

(1) A school employee in a job-sharing position as ~~defined in G.S. 135-45.4.~~ described in G.S. 115C-326.5. If these employees elect to participate in the Plan, the employing unit shall pay fifty percent (50%) of the Plan's total ~~noncontributory~~ employer premiums. Individual employees shall pay the balance of the total ~~noncontributory~~ premiums not paid by the employing unit.

(2) ~~Subject to the provisions of G.S. 135-45.4, employees~~ Employees and members of the General Assembly with 10 but less than 20 years of retirement service credit provided the employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007. For such future retirees, the State shall pay fifty percent (50%) of the Plan's total ~~noncontributory~~ employer premiums. Individual retirees shall pay the balance of the total ~~noncontributory~~ premiums not paid by the State.

(c) Fully ~~Contributory.~~ Contributory Coverage. – The following ~~person~~ persons shall be eligible for coverage under the Plan, on a fully contributory basis, subject to the provisions of G.S. 135-45.4:

(1) Former members of the General Assembly who enroll before October 1, 1986.

(2) For enrollments after September 30, 1986, former members of the General Assembly if covered under the Plan at termination of membership in the General Assembly. To be eligible for coverage as a former member of the General Assembly, application must be made within 30 days of the end of the term of office. Only members of the General Assembly covered by the Plan at the end of the term of office are eligible. If application is not made within the specified time period, the member forfeits eligibility.

(3) Surviving spouses of deceased former members of the General Assembly who enroll before October 1, 1986.

(4) Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except for legislative interns and pages.

(5) For enrollments after September 30, 1986, surviving spouses of deceased former members of the General Assembly, if covered under the Plan at the time of death of the former member of the General Assembly.

(6) All permanent part-time employees (designated as half-time or more) of an employing unit who ~~meets~~ meet the conditions outlined in ~~subdivision (a)(1)a. above,~~ sub-subdivision (a1)(1)a. of this section and who are not covered by the provisions of ~~G.S. 135-45.2(a)(1).~~ subdivision (a1)(1) of this section.

(7) The spouses and eligible dependent children of enrolled teachers, State employees, retirees, former members of the General Assembly, former employees covered by the provisions of ~~G.S. 135-45.2(a)(8),~~ former subdivision (a)(8) or subdivision (a1)(7) of this section, Disability Income Plan beneficiaries, enrolled continuation members, and members of the General Assembly. Spouses of surviving dependents are not eligible, nor are dependent children if they were not covered at the time of the member's death. Surviving spouses may cover their dependent children provided the children were enrolled at the time of the member's death or enroll within 90 days of the member's death.

(8) Blind persons licensed by the State to operate vending facilities under contract with the Department of Health and Human Services, Division of Services for the Blind and its successors, who are:

a. Operating such a vending facility;

b. Former operators of such a vending facility whose service as an operator would have made these operators eligible for an early or service retirement allowance under Article 1 of this Chapter had they been members of the Retirement System; and

c. Former operators of such a vending facility who attain five or more years of service as operators and who become eligible for and receive a disability benefit under the Social Security Act upon cessation of service as an operator.

Spouses, dependent children, surviving spouses, and surviving dependent children of such members are not eligible for coverage.

(9) Surviving spouses of deceased retirees and surviving spouses of deceased teachers, State employees, and members of the General Assembly provided

the death of the former Plan member occurred after September 30, 1986, and the surviving spouse was covered under the Plan at the time of death.

(10) Any eligible dependent child of the deceased retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary, provided the child was covered at the time of death of the retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary, (or was in posse at the time and is covered at birth under this Part), or was covered under the Plan on September 30, 1986. An eligible surviving dependent child can remain covered until ~~age 19, or~~ age 26 ~~if a full-time student,~~ or indefinitely if certified as incapacitated under ~~G.S. 135-45.1(5)b.~~ G.S. 135-45.2(d).

(11) Retired teachers, State employees, and members of the General Assembly with less than 10 years of retirement service credit, provided the teachers and State employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007.

(12) Notwithstanding the provisions of G.S. 135-45.12 former employees covered by the provisions of ~~G.S. 135-45.2~~ this section and their spouses and eligible dependent children who were covered by the Plan at the time of the former employees' separation from service pursuant to ~~G.S. 135-45.2,~~ this section, following expiration of the former employees' coverage provided by ~~G.S. 135-45.2.~~ this section. Election of coverage under this subdivision shall be made within 90 days after the termination of coverage provided under ~~G.S. 135-45.2.~~ this section.

(13) Firefighters, rescue squad workers, and members of the National Guard, their eligible spouses, and eligible dependent children.

...."

ALLOW COVERAGE FOR CHILDREN UP TO 26 YEARS OLD, IN COMPLIANCE WITH FEDERAL AFFORDABLE CARE ACT

SECTION 1.7.(a) G.S. 135-45.1(10) reads as rewritten:

"(10) Dependent child. – Subject to the eligibility requirements of G.S. 135-45.2(d), any of the following:

a. A ~~natural,~~ natural or legally ~~adopted, or foster~~ adopted child or children of the employee ~~and or spouse, unmarried,~~ up to the first of the month following ~~his or her 19th~~ the child's 26th 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.~~ employee.

b. A foster child or children of the employee up to the first month following the child's 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for the child's maintenance and support.

c. ~~Dependent child also includes a~~ 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.

d. ~~Dependent child also includes a~~ A stepchild ~~of the member~~ who primarily resides with a 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.~~

e. ~~Dependent child shall also include any~~ Any child under age 19 who has reached his or her 18th birthday, provided the employee was legally responsible for ~~such~~ the child's maintenance and support on his or her 18th birthday. ~~Dependent~~

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 1.7.(b) 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.

A dependent child shall not be eligible for coverage under the Plan if the dependent child is eligible for employer based health care outside of the State Health Plan for Teachers and State Employees. Coverage of a dependent child may be extended beyond the ~~19th~~ 26th birthday ~~under the following conditions:~~

~~(1)~~ ~~If the dependent is a full-time student, through the end of the month following the student's 26th 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 or injury 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 or injury.~~

~~(2)~~ ~~The~~ if 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.~~ G.S. 135-45.2(c)(7)."

SECTION 1.7.(c) G.S. 135-45.3 reads as rewritten:

"**§ 135-45.3. Enrollment.**

(a) Except as otherwise required by applicable federal law, new employees must be given the opportunity to enroll or decline enrollment for themselves and their dependents within 30 days from the date of employment or from first becoming eligible on a ~~noncontributory~~ partially contributory basis. Coverage may become effective on the first day of the month following date of entry on payroll or on the first day of the following month. New employees not enrolling themselves and their dependents age 19 and older within 30 days, or not adding dependents when first eligible as provided herein may enroll on the first day of any month but will be subject to a 12-month waiting period for preexisting health conditions,

except for employees who elect to change their coverage in accordance with rules established by the Executive Administrator and Board of Trustees for optional or alternative plans available under the Plan. Children born to covered employees having coverage type (2) or (3), as outlined in G.S. 135-45.4(d) shall be automatically covered at the time of birth without any waiting period for preexisting health conditions. Children born to covered employees having coverage type (1) shall be automatically covered at birth without any waiting period for preexisting health conditions so long as the claims processor receives notification within 30 days of the date of birth that the employee desires to change from coverage (1) to coverage type (2) or (3), provided that the employee pays any additional premium required by the coverage type selected retroactive to the first day of the month in which the child was born.

(b) Except as otherwise required by applicable federal law, newly acquired dependents (spouse/child) age 19 and older 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.

(c) Eligible dependents younger than age 19 may be enrolled at any time and shall not be subject to any waiting period for a preexisting condition.

~~(c)~~(d) 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."

SECTION 1.7.(d) G.S. 135-45.4 reads as rewritten:

"**§ 135-45.4. Effective dates of coverage.**

(a) Employees and Retired Employees. –

...

(3) Employees not enrolling or adding dependents age 19 and older when first eligible in accordance with G.S. 135-45.3 may enroll later on the first of any following month but will be subject to a 12-month waiting period for a preexisting health condition, except employees who elect to change their coverage in accordance with rules adopted by the Executive Administrator and Board of Trustees for optional alternative plans offered under the Plan.

...

(b) Waiting Periods and Preexisting Conditions. –

(1) New employees and dependents age 19 and older enrolling when first eligible are subject to no waiting period for preexisting conditions under the Plan.

(2) Employees not enrolling or not adding dependents age 19 and older 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.

(3) Retiring employees and dependents enrolled when first eligible after an employee's retirement are subject to no waiting period for preexisting conditions under the Plan. Retiring employees not enrolled or not adding

dependents age 19 and older when first eligible after an employee's retirement may enroll later on the first of any following month, but will be subject to a 12-month waiting period for preexisting conditions except as provided in subdivision (a)(3) of this section.

...

(5) To administer the 12-month waiting period for preexisting conditions for employees and dependents age 19 and older 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.

(c) Dependents of Employees and Retired Employees. –

...

(5) Employees not adding dependents age 19 and older when first eligible may enroll later on the first of any following month, but dependents will be subject to a 12-month waiting period for preexisting health conditions except as provided in subdivision (a)(3) of this section.

..."

SALARY-RELATED CONTRIBUTIONS

SECTION 1.8.(a) Effective for the 2011-2013 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, as defined in G.S. 135-45.1 or in G.S. 135-48.1 as enacted by this act, 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 1.8.(b) Effective July 1, 2011, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2011-2012 fiscal year are: (i) ten and sixty-one hundredths percent (10.61%) – Teachers and State Employees; (ii) fifteen and sixty-one hundredths percent (15.61%) – State Law Enforcement Officers; (iii) twelve and thirty-six hundredths percent (12.36%) – University Employees'

Optional Retirement System; (iv) twelve and thirty-six hundredths percent (12.36%) – Community College Optional Retirement Program; (v) twenty and eleven hundredths percent (20.11%) – Consolidated Judicial Retirement System; and (vi) five and zero hundredths percent (5.00%) – Legislative Retirement System. Each of the foregoing contribution rates includes five and zero hundredths percent (5.00%) 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 1.8.(c) Effective July 1, 2012, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2012-2013 fiscal year are: (i) ten and ninety-one hundredths percent (10.91%) – Teachers and State Employees; (ii) fifteen and ninety-one hundredths percent (15.91%) – State Law Enforcement Officers; (iii) twelve and sixty-six hundredths percent (12.66%) – University Employees' Optional Retirement System; (iv) twelve and sixty-six hundredths percent (12.66%) – Community College Optional Retirement Program; (v) twenty and forty-one hundredths percent (20.41%) – Consolidated Judicial Retirement System; and (vi) five and thirty hundredths percent (5.30%) – Legislative Retirement System. Each of the foregoing contribution rates includes five and thirty hundredths percent (5.30%) 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 1.8.(d) Effective July 1, 2011, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2011-2012 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand seven hundred sixty-eight dollars ($3,768) and (ii) non-Medicare-eligible employees and retirees – four thousand nine hundred fifty-two dollars ($4,952).

SECTION 1.8.(e) Effective July 1, 2012, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2012-2013 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand nine hundred sixty-five dollars ($3,965) and (ii) non-Medicare-eligible employees and retirees – five thousand two hundred eleven dollars ($5,211).

REMOVE SPECIAL EXEMPTION FROM PUBLIC RECORDS LAW FOR STATE HEALTH PLAN CONTRACTS

SECTION 1.9.(a) 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 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~~ Statutes. No provision of law, however, shall ~~not~~ be construed to prevent or restrict the release of any information ~~made not a public record under this subsection~~ in a Plan contract to the State Auditor, the Attorney General, the Director of the State Budget, the Plan's Executive Administrator, and 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 Article 3 of Chapter 143 of the General Statutes. However, the Executive Administrator and Board of Trustees shall: (i) submit all proposed statewide and agency term contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subsection to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all proposed contracts to be awarded by the Executive Administrator and Board of Trustees under this section a standard clause which provides that the State Auditor and internal auditors of the Plan may audit the records of the contractor during the term of the contract to verify accounts and data affecting fees and performance. The Executive Administrator and Board of Trustees shall not award a cost plus percentage of cost agreement or contract for any purpose. 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 1.9.(b) Contracts with the State Health Plan retain the trade secret protections provided under G.S. 132-1.2.

SECTION 1.9.(c) This section is effective when it becomes law.

ADDITIONAL CHANGES TO EXISTING STATE HEALTH PLAN STATUTES

SECTION 1.10.(a) G.S. 135-44.4(18) reads as rewritten:

"(18) Determining administrative and medical policies that are not in direct conflict with Part 3 of this Article after consultation with the Claims Processor and the Plan's consulting actuary when Plan costs are involved. Notwithstanding this provision, the Executive Administrator and Board of Trustees may authorize coverage or payment of claims that have been denied as a result of administrative errors or system issues."

SECTION 1.10.(b) Subsection (a) of this section becomes effective July 1, 2010.

SECTION 1.10.(c) G.S. 135-45.1(15) reads as rewritten:

"(15) Health Benefits ~~Representative.~~ Representative or HBR. – The employee designated by the employing unit to administer the Plan for the unit and its employees. The HBR is responsible for enrolling new ~~employees,~~ employees and dependents in accordance with the eligibility requirements under this Article, reporting changes, explaining benefits, reconciling group statements, and remitting group fees. The State Retirement System is the Health Benefits Representative for retired State employees."

EFFECTIVE DATE FOR PART I

SECTION 1.11. Except as otherwise provided, Part I of this act becomes effective July 1, 2011.

PART II. TRANSFER STATE HEALTH PLAN TO DEPARTMENT OF STATE TREASURER

GRANT STATE TREASURER IMMEDIATE AUTHORITY TO APPOINT EXECUTIVE ADMINISTRATOR

SECTION 2.1.(a) G.S. 135-44.2(b) reads as rewritten:

"(b) The Executive Administrator shall be appointed by the ~~State Health Plan Administrative Commission.~~ State Treasurer. 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.~~ State Treasurer after consultation with the Board of Trustees.

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,~~ State Treasurer after consultation with the Board of Trustees, 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.~~ State Treasurer."

SECTION 2.1.(b) The State Treasurer shall have the power to designate an interim Executive Administrator prior to appointing an Executive Administrator under this section.

SECTION 2.1.(c) This section is effective when it becomes law.

TRANSFER OF STATE HEALTH PLAN WITHIN STATE GOVERNMENT

SECTION 2.2. The North Carolina State Health Plan for Teachers and State Employees is transferred to the Department of State Treasurer. This transfer shall have all the elements of a Type II transfer, as defined by G.S. 143A-6.

STATUTORY FRAMEWORK FOR AMENDED STATE HEALTH PLAN STATUTE

SECTION 2.3.(a) The title of Chapter 135 of the General Statutes reads as rewritten:

"Chapter 135.

Retirement System for Teachers and State Employees; Social Security; ~~Health Insurance Program for Children.~~ State Health Plan for Teachers and State Employees."

SECTION 2.3.(b) Chapter 135 of the General Statutes is amended by adding a new Article 3B to be entitled "State Health Plan for Teachers and State Employees; Long-term Care Benefits." That new Article shall be divided into five parts, as follows:

(1) "Part 1. General Provisions."
(2) "Part 2. Administrative Structure."
(3) "Part 3. Plan Operation."
(4) "Part 4. Eligibility and Enrollment."
(5) "Part 5. Coverage Mandates and Exclusions; Other Mandates."
(6) "Part 6. Long-Term Care Benefits."

RECODIFY PORTIONS OF PART 1 OF EXISTING STATE HEALTH PLAN ARTICLE

SECTION 2.4.(a) Subsections (a) and (b) of G.S. 135-43, as amended by Section 1.9 of this act, [confidentiality] are recodified as G.S. 135-48.10 under Part 1 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act. Subsection (c) of G.S. 135-43 is recodified as G.S. 135-48.57, to be entitled "Payments for county or city ambulance service.", under Part 5 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.4.(b) G.S. 135-43.4 [Committee on Actuarial Valuation] is recodified as G.S. 135-48.12 under Part 1 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.4.(c) G.S. 135-43.5 [auditing the Plan] is recodified as G.S. 135-48.28 under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.4.(d) G.S. 135-43.6 [reports to General Assembly] is recodified as G.S. 135-48.27 under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.4.(e) G.S. 135-43.7 [contract disputes] is recodified as G.S. 135-48.35 under Part 3 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

RECODIFY PORTIONS OF PART 2 OF EXISTING STATE HEALTH PLAN ARTICLE

SECTION 2.5.(a) G.S. 135-44 [Board of Trustees] is recodified as G.S. 135-48.20 under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.5.(b) G.S. 135-44.1 [officers, quorum, meetings] is recodified as G.S. 135-48.21 under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.5.(c) G.S. 135-44.2, as amended by Section 2.1 of this act, [Executive Administrator] is recodified as G.S. 135-48.23 under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.5.(d) Subdivision (26) of G.S. 135-44.4 [member education] is recodified as G.S. 135-48.56, to be entitled "Education of covered active and retired employees.", under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.5.(e) G.S. 135-44.5 [trust funds] is recodified as G.S. 135-48.5 under Part 1 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.5.(f) G.S. 135-44.6(d) [firefighter premiums] is recodified as G.S. 135-48.58, to be entitled "Premiums for firefighters, rescue squad workers, and members of National Guard.", under Part 5 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act. G.S. 135-44.6(e) [interest on late payments] is recodified as G.S. 135-48.55, to be entitled "Interest charged to charter schools on late premiums.", under Part 5 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.5.(g) G.S. 135-44.7 [administrative review] is recodified as G.S. 135-48.24 under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.5.(h) G.S. 135-44.8 [rules] is recodified as G.S. 135-48.25 under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

RECODIFY PORTIONS OF PART 3 OF EXISTING STATE HEALTH PLAN ARTICLE

SECTION 2.6.(a) Subsections (a) and (e) of G.S. 135-45 [undertaking] are recodified as subsections (a) and (b) of G.S. 135-48.2 under Part 1 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act. G.S. 135-45(c) [firefighter coverage in public interest] is recodified as G.S. 135-48.8, to be entitled "Statements of public interest.", under Part 1 of Article 3B of Chapter 135 of the General Statutes, as created by

Section 2.3 of this act. Subsection (d) of G.S. 135-45 [contracts with claim processors] is recodified as G.S. 135-48.32, to be entitled "Contracts to provide benefits.", under Part 3 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act. Subsection (d1) of G.S. 135-45 [contracting provisions] is recodified as G.S. 135-48.33, to be entitled "Contracting provisions; large contract review by Attorney General, auditing, no cost plus contracts.", under Part 3 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.6.(b) G.S. 135-45.1 [definitions] is recodified as G.S. 135-48.1 under Part 1 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.6.(c) Subsections (a), (a1), (b), and (c) of G.S. 135-45.2 [eligibility categories] are recodified as subsections (a), (b), (c), and (d) in G.S. 135-48.40, to be entitled "Categories of eligibility.", under Part 4 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act. Subsections (d), (e), (f), (g), (h), (i), (j), and (k) of G.S. 135-45.2 [other eligibility rules] are recodified as subsections (a), (c), (d), (e), (f), (g), (h), and (i) of G.S. 135-48.41, to be entitled "Additional eligibility provisions.", under Part 4 of Article 3B of Chapter 135 of the General Statues, as created by Section 2.3 of this act.

SECTION 2.6.(d) G.S. 135-45.3, as amended by Section 1.7 of this act, [enrollment] is recodified as G.S. 135-48.42 under Part 4 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.6.(e) G.S. 135-45.4, as amended by Section 1.7 of this act, [effective dates of coverage] is recodified as G.S. 135-48.43 under Part 4 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.6.(f) G.S. 135-45.5 [charter schools' participation] is recodified as G.S. 135-48.54 under Part 5 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.6.(g) G.S. 135-45.10 [Medicare] is recodified as G.S. 135-48.38 under Part 3 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.6.(h) G.S. 135-45.12 [cessation of coverage] is recodified as G.S. 135-48.44 under Part 4 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.6.(i) G.S. 135-45.13 [conversion] is recodified as G.S. 135-48.45 under Part 4 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.6.(j) G.S. 135-45.15 [subrogation] is recodified as G.S. 135-48.37 under Part 3 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

SECTION 2.6.(k) G.S. 135-45.16 [right to amend] is recodified as G.S. 135-48.3 under Part 1 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

RECODIFY PART 4 OF EXISTING STATE HEALTH PLAN ARTICLE

SECTION 2.7. G.S. 135-46 through G.S. 135-46.2 [long-term care] are recodified as G.S. 135-48.60 through G.S. 135-48.62 under Part 5 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

PLACE CHILD HEALTH INSURANCE FUND ESTABLISHMENT IN CHILD HEALTH INSURANCE PROGRAM STATUTES

SECTION 2.8. G.S. 135-47.2 [child health insurance fund] is recodified as G.S. 108A-70.20A.

REPEAL STATE HEALTH PLAN SECTIONS NOT RECODIFIED BY THIS PART

SECTION 2.9. Article 3A of Chapter 135 of the General Statutes is repealed.

REWRITE STATE HEALTH PLAN STATUTE

SECTION 2.10. Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act and as amended by Sections 1.6, 1.7, 2.1, 2.4, 2.5, 2.6, and 2.7 of this act, reads as rewritten:

"Article 3B.

"State Health Plan for Teachers and State Employees; Long-term Care Benefits.

"Part 1. General Provisions.

"**§ 135-48.1. General definitions.**

As used in this Article unless the context clearly requires otherwise, the following definitions apply:

~~(1) Allowed amount. – The charge that the Plan or its claims processors determines is reasonable for covered services provided to a Plan member. This amount may be established in accordance with an agreement between the provider and the Plan or its claims processor. In the case of providers that have not entered into an agreement with the Plan or its claims processor, the allowed amount will be the lesser of the provider's actual charge or a reasonable charge established by the Plan or its claims processor using a methodology that is applied to comparable providers for similar services under a similar health benefit plan.~~

~~(2)~~(1) Benefit period. – The period of time during which charges for covered services provided to a Plan member must be incurred in order to be eligible for payment by the Plan.

~~(3)~~(2) Chemical dependency. – The pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

~~(4)~~(3) Claims Processor. – One or more administrators, third-party administrators, or other parties contracting with the Plan to administer Plan benefits.

~~(5) Clinical trials. – Patient research studies designed to evaluate new treatments, including prescription drugs. Coverage for clinical trials shall be as provided in G.S. 135-45.8.~~

~~(6)~~(4) Comprehensive health benefit plan. – Health care coverage that consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies, and equipment that are generally available in the health insurance market.

(5) Comprehensive group health benefit plan. – A comprehensive health benefit plan offered to an individual because of an employment, organizational, or other group affiliation.

~~(7)~~(6) Covered service; benefit; allowable expense. – Any medically necessary, reasonable, and customary items of service, including prescription drugs, and medical supplies included in the Plan.

~~(8)~~(7) Deductible. – The dollar amount that must be incurred for certain covered services in a benefit period before benefits are payable by the Plan.

~~The deductible applies separately to each covered individual in each fiscal year, subject to an aggregate maximum per employee and child, employee and spouse, or employee and family coverage contract in any fiscal year.~~

~~If two or more family members are injured in the same accident, only one deductible is required for charges related to that accident during the benefit period.~~

~~(9)~~(8) Dependent. – An eligible Plan member other than the subscriber.

~~(10)~~(9) Dependent child. – Subject to the eligibility requirements of ~~G.S. 135-45.2(d),~~ subsections (a) and (b) of G.S. 135-48.41, any of the following:

a. A natural or legally adopted child or children of the employee up to the first of the month following the child's 26th birthday, whether or not the child is living with the employee.

b. A foster child or children of the employee up to the first month following the child's 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for the child's maintenance and support.

c. 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.

d. A stepchild who primarily resides with a member who is married to the stepchild's natural parent.

e. Any child under age 19 who has reached his or her 18th birthday, provided the subscriber was legally responsible for the 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.~~

~~(11)~~(10) Employee or State employee. – Any permanent full-time or permanent part-time regular employee (designated as half-time or more) of an employing unit.

~~(12)~~(11) Employing Unit. – A North Carolina School System; Community College; State Department, Agency, or Institution; Administrative Office of the Courts; or Association or Examining Board whose employees are eligible for membership in a State-Supported Retirement System. An employing unit also shall mean a charter school in accordance with Part 6A of Chapter 115C of the General Statutes whose board of directors elects to become a participating employer in the Plan under ~~G.S. 135-45.5.~~ G.S. 135-48.54. Bona fide fire departments, rescue or emergency medical service squads, and National Guard units are deemed to be employing units for the purpose of providing benefits under this Article.

~~(13) Experimental/Investigational. Experimental/Investigational Medical Procedures. The use of a service, supply, drug, or device not recognized as standard medical care for the condition, disease, illness, or injury being treated as determined by the Executive Administrator and Board of Trustees upon the advice of the Claims Processor.~~

~~(14)~~(12) Firefighter. – ~~Eligible firefighters as defined by G.S. 58-86-25 who belong to a bona fide fire department as defined by G.S. 58-86-25 and who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Firefighter shall also include members of the North Carolina Firemen and Rescue Squad Workers' Pension Fund who are in receipt of a monthly pension, who are not eligible~~

~~for any type of comprehensive group health insurance or other comprehensive group health benefit coverage, and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Comprehensive group health insurance and other benefit coverage consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies, and equipment that are generally available in the health insurance market. For purposes of this subdivision, comprehensive group health insurance and other benefit coverage includes Medicare benefits, CHAMPUS benefits, and other Uniformed Services benefits. North Carolina fire departments or their respective governing bodies shall certify the eligibility of their firefighters to the Plan for their participation in its benefits prior to enrollment.~~ A member of the group "eligible firemen" as defined in G.S. 58-86-25.

~~(15)~~(13) Health Benefits Representative or HBR. – The employee designated by the employing unit to administer the Plan for the unit and its employees. The HBR is responsible for enrolling new employees and dependents in accordance with the eligibility requirements under this Article, reporting changes, explaining benefits, reconciling group statements, and remitting group fees. The State Retirement System is the Health Benefits Representative for retired State employees.

~~(16) Medical necessity or medically necessary. Covered services or supplies that are:~~

~~a. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials covered under the Plan, not for experimental, investigational, or cosmetic purposes.~~

~~b. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.~~

~~c. Within generally accepted standards of medical care in the community.~~

~~d. Not solely for the convenience of the Plan member, the Plan member's family, or the provider.~~

~~For medically necessary services, the Plan or its representative may compare the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered and in what setting medically necessary services are eligible for coverage.~~

~~(17) National Guard members. Members of the North Carolina Army and Air National Guard who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Members of the North Carolina Army and Air National Guard include those who are actively serving in the National Guard as well as former members of the National Guard who have completed 20 or more years of service in the National Guard but have not attained the minimum age to begin receipt of a uniformed service military retirement benefit. Comprehensive group health insurance and other benefit coverage consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies, and equipment that are generally available in the health insurance market. Comprehensive group health~~

~~insurance and other benefit coverage includes Medicare benefits, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) benefits, and other Uniformed Services benefits. North Carolina National Guard units shall certify the eligibility of their members to the Plan for their participation in its benefits prior to enrollment.~~

~~(18) Optional alternative comprehensive benefit plans. – Comprehensive benefit plans administered by the Plan that differ in coverage, deductibles, coinsurance from the Standard Plan providing for 80/20 coinsurance, and that are alternative choices for coverage at the option of the Plan member.~~

~~(19)~~(14) Plan or State Health Plan. – The North Carolina State Health Plan for Teachers and State Employees. ~~Unless otherwise expressly provided,~~ Depending on the context, the term may refer to the entity created in G.S. 153-48.2 or to the health benefit plans offered by the entity, in which case "Plan" includes all comprehensive health benefit plans offered under the Plan.

~~(20)~~(15) Plan member. – A subscriber or dependent who is eligible and currently enrolled in the Plan and for whom a premium is paid.

~~(21) Plan year. – The period beginning July 1 and ending on June 30 of the succeeding calendar year.~~

~~(22)~~(16) Predecessor plan. – The Hospital and Medical Benefits for the Teachers' and State Employees' Retirement System of the State of North Carolina and the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan.

~~(23)~~(17) Rescue squad ~~workers.~~ worker. – ~~Eligible rescue squad workers as defined by the provisions of G.S. 58-86-30 who belong to a rescue or emergency medical services squad as defined by the same statute and who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Rescue squad workers shall also include members of the North Carolina Firemen and Rescue Squad Workers' Pension Fund who are in receipt of a monthly pension, who are not eligible for any type of comprehensive group health insurance or other comprehensive group health benefit coverage, and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six months. Comprehensive group health insurance and other benefit coverage consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies, and equipment that are generally available in the health insurance market. For purposes of this subdivision, comprehensive group health insurance and other benefit coverage includes Medicare benefits, CHAMPUS benefits, and other Uniformed Services benefits. North Carolina rescue or emergency medical services squads or their respective governing bodies shall certify the eligibility of their rescue squad workers to the Plan for their participation in its benefits prior to enrollment.~~ An "eligible rescue squad worker" as defined in G.S. 58-86-30.

~~(24)~~(18) Retired employee (retiree). – Retired teachers, State employees, and members of the General Assembly who are receiving monthly retirement benefits from any retirement system supported in whole or in part by contributions of the State of North Carolina, so long as the retiree is enrolled.

~~(25)~~(19) Subscriber. – A Plan member who is not a dependent.

"§ 135-48.2. Undertaking.

(a) The State of North Carolina undertakes to make available a State Health Plan (hereinafter called the "Plan") exclusively for the benefit of eligible employees, eligible retired employees, and certain of their eligible dependents, which will pay benefits in accordance with the terms of this Article. The Plan shall have all the powers and privileges of a corporation and shall be known as the State Health Plan for Teachers and State Employees. The State Treasurer, Executive ~~Administrator~~ Administrator, and Board of Trustees shall carry out their duties and responsibilities as fiduciaries for the Plan. The Plan shall administer one or more group health plans that are comprehensive in ~~coverage and shall provide eligible employees and retired employees coverage on a noncontributory basis under at least one of the group plans with benefits equal to that specified in subsection (g) of this section.~~ coverage. The ~~Executive Administrator and Board of Trustees~~ State Treasurer may operate group plans as a preferred provider option, or health maintenance, point-of-service, or other organizational ~~arrangement and may offer the plans to employees and retirees on a noncontributory or partially contributory basis. Plans offered on a partially contributory basis must provide benefits that are additional to that specified in subsection (g) of this section and may not be offered unless approved in an act of the General Assembly.~~ arrangement.

(b) Payroll deduction shall be available for coverage under ~~this Part~~ the Plan for subscribers able to meet the Plan's requirements for payroll deduction.

"§ 135-48.3. Right to amend.

The General Assembly reserves the right to alter, amend, or repeal this Article.

"§ 135-48.4: Reserved for future codification purposes.

"§ 135-48.5. Health benefit trust funds created.

(a) There are hereby established two health benefit trust funds, to be known as the Public Employee Health Benefit Fund and the Health Benefit Reserve Fund for the payment of hospital and medical benefits. As used in this section, the term "health benefit trust funds" refers to the fund type described under G.S. 143C-1-3(a)(10).

All premiums, fees, charges, rebates, refunds or any other receipts including, but not limited to, earnings on investments, occurring or arising in connection with health benefits programs established by this Article, shall be deposited into the Public Employee Health Benefit Fund. Disbursements from the Fund shall include any and all amounts required to pay the benefits and administrative costs of such programs as may be determined by the Executive Administrator and Board of Trustees.

Any unencumbered balance in excess of prepaid premiums or charges in the Public Employee Health Benefit Fund at the end of each fiscal year shall be used first, to provide an actuarially determined Health Benefit Reserve Fund for incurred but unpresented claims, second, to reduce the premiums required in providing the benefits of the health benefits programs, and third to improve the plan, as may be provided by the General Assembly. The balance in the Health Benefits Reserve Fund may be transferred from time to time to the Public Employee Health Benefit Fund to provide for any deficiency occurring therein.

The Public Employee Health Benefit Fund and the Health Benefit Reserve Fund shall be deposited with the State Treasurer and invested as provided in G.S. 147-69.2 and 147-69.3.

(b) Disbursement from the Public Employee Health Benefit Fund may be made by warrant drawn on the State Treasurer by the Executive Administrator, or the Executive Administrator and Board of Trustees may by contract authorize the Claims Processors to draw the warrant.

"§§ 135-48.6 through 135-48.7: Reserved for future codification purposes.

"§ 135-48.8. Statements of public interest.

The State of North Carolina deems it to be in the public interest for North Carolina firefighters, rescue squad workers, and members of the National Guard, and certain of their

dependents, who are not eligible for any other type of comprehensive group health insurance or other comprehensive group health benefits, and who have been without any form of group health insurance or other comprehensive group health benefit coverage for at least six consecutive months, to be given the opportunity to participate in the benefits provided by the State Health Plan for Teachers and State Employees. Coverage under the Plan shall be voluntary for eligible firefighters, rescue squad workers, and members of the National Guard who elect participation in the Plan for themselves and their eligible dependents.

"**§ 135-48.9: Reserved for future codification purposes.**

"**§ 135-48.10. Confidentiality of information and medical records; provider contracts.**

(a) Any information ~~as herein~~ described in this section ~~which~~ that 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~~ This information ~~may~~ may, however, be released to the State ~~Auditor,~~ Auditor or to the Attorney ~~General, or to the persons designated under G.S. 135-43.3~~ General 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~~ State Treasurer. 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.

(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~~ 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 under Chapter 132 of the General Statutes. No provision of law, however, shall be construed to prevent or restrict the release of any information in a Plan contract to the State Treasurer, 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. However, the Executive Administrator and Board of Trustees shall: (i) submit all proposed statewide and agency term contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subsection to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all proposed contracts to be awarded by the Executive Administrator and Board of Trustees under this section a standard clause which provides that the State Auditor and internal auditors of the Plan may audit the records of the contractor during the term of the contract to verify accounts and data affecting fees and performance. The Executive Administrator and Board of Trustees shall not award a cost plus percentage of cost~~

~~agreement or contract for any purpose. 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.~~ responsibilities.

"§ 135-48.11: **Reserved for future codification purposes.**

"**§ 135-48.12. Committee on Actuarial Valuation of Retired Employees' Health Benefits.**

(a) There is established the Committee on Actuarial Valuation of Retired Employees' Health Benefits. The Committee shall be responsible for collecting data and reviewing assumptions for the sole purpose of conducting required actuarial valuations of State supported retired employees' health benefits under other post-employment benefit accounting standards set forth by the Governmental Accounting Standards Board of the Financial Accounting Foundation.

(b) The Committee on Actuarial Valuation of Retired Employees' Health Benefits shall consist of five members serving ex officio, as follows:

(1) The State Budget Officer, who shall serve as the Chair;

(2) The State Auditor;

(3) The State Controller;

(4) The State Treasurer; and

(5) The Executive Administrator for the ~~Teachers' and the State Employees' Comprehensive Major Medical Plan [State Health Plan for Teachers and State Employees].~~ State Health Plan for Teachers and State Employees.

(c) A majority of the members of the Committee then serving shall constitute a quorum.

(d) Each member shall be entitled to one vote on the Committee. Three affirmative votes shall be necessary for a decision by the members at any meeting of the Committee.

(e) The Committee shall keep in convenient form such data as is necessary for actuarial valuation of retired employees' health benefits under accounting standards set forth by the Governmental Accounting Standards Board of the Financial Accounting Foundation. The Department of State Treasurer, Retirement Systems Division, the State Health Plan for Teachers and State Employees, and any other State agency, department, or university institution, local public school agency, or local community college institution shall provide any necessary data upon request of the Committee for the purpose of conducting its responsibilities.

(f) The Committee shall designate either the actuary under contract with the Department of State Treasurer, Retirement Systems Division, or the actuary under contract with the State Health Plan for Teachers and State Employees as the technical adviser to the Committee on matters regarding the actuarial valuation of retired employees' health benefits created by the provisions of this Chapter. The technical advisor shall perform such actuarial valuation and other duties as are required under this Chapter.

(g) The Committee shall secure an annual calendar-year actuarial valuation of retired employees' health benefits under accounting standards set forth by the Governmental Accounting Standards Board of the Financial Accounting Foundation.

(h) The Committee shall keep a record of all of its proceedings which shall be open to public inspection.

"Part 2. Administrative Structure.

"**§ 135-48.20. Board of Trustees established.**

(a) There is established the Board of Trustees of the State Health Plan for Teachers and State Employees.

(b) The Board of Trustees of the State Health Plan for Teachers and State Employees shall consist of ~~nine~~ 10 members.

(c) The State Treasurer shall be an ex officio member of the Board and shall serve as its Chair, but shall only vote in order to break a tie vote.

(d) The Director of the Office of State Budget and Management shall be an ex officio nonvoting member of the Board.

~~(e)~~(e) ~~Three~~ Two members shall be appointed by the Governor. Terms shall be for two years. Vacancies shall be filled by the Governor. ~~Of the members appointed by the Governor, one shall be either:~~

~~(1) An employee of a State department, agency, or institution;~~

~~(2) A teacher employed by a North Carolina public school system;~~

~~(3) A retired employee of a State department, agency, or institution; or~~

~~(4) A retired teacher from a North Carolina public school system.~~

(f) Two members shall be appointed by the State Treasurer. Terms shall be for two years. Vacancies shall be filled by the State Treasurer.

~~(d)~~(g) ~~Three~~ Two members shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives in accordance with G.S. 120-121. Terms shall be for two years. Vacancies shall be filled in accordance with G.S. 120-122.

~~(e)~~(h) ~~Three~~ Two members shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate in accordance with G.S. 120-121. Terms shall be for two years. Vacancies shall be filled in accordance with G.S. 120-122.

(i) In making appointments, the appointing authorities shall ensure that one of the appointees under subsection (e) of this section, one of the appointees under subsection (f) of this section, and one of the appointees under subsection (g) of this section, and one of the appointees under subsection (h) of this section are one of the following:

(1) An employee of a State department, agency, or institution;

(2) A teacher employed by a North Carolina public school system;

(3) A retired employee of a State department, agency, or institution; or

(4) A retired teacher from a North Carolina public school system.

Each appointing authority shall consult with all other appointing authorities to ensure that the Board's composition reflects a diversity of employees, teachers, retired employees, and retired teachers.

(j) In making appointments, except for the appointees under subsection (i) of this section, the appointing authorities shall appoint individuals from the following areas of expertise:

(1) Actuarial science.

(2) Health economics.

(3) Health benefits and administration.

(4) Health law and policy.

In making appointments to the Board under this section, each appointing authority shall consult with all other appointing authorities to ensure that each of the areas of expertise required by this subsection is represented by at least one member of the Board. Each appointing authority shall consider the expertise of the other members of the Board and make appointments so that the Board's composition reflects a diversity of expertise.

~~(f)~~(k) Each appointing authority may remove any member appointed by that appointing authority.

~~(g)~~(l) The members of the Board of Trustees shall receive one hundred dollars ($100.00) per day, except employees eligible to enroll in the Plan, whenever the full Board of Trustees holds a public session, and travel allowances under G.S. 138-6 when traveling to and from meetings of the Board of Trustees or hearings under ~~G.S. 135-44.7,~~ G.S. 135-48.24, but shall not receive any subsistence allowance or per diem under G.S. 138-5, except when holding a meeting or hearing where this section does not provide for payment of one hundred dollars ($100.00) per day.

~~(h)~~(m) No member of the Board of Trustees may serve more than three consecutive two-year terms.

~~(i) Meetings of the Board of Trustees may be called by the Executive Administrator, the Chair, or by any three members.~~

"**§ 135-48.21. ~~Officers,~~ Board officers, quorum, meetings.**

(a) ~~The~~ Besides the Chair, the Board of Trustees shall elect from its own membership such officers as it sees fit.

(b) A majority of the voting 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.~~ Article.

(c) The Board shall meet at least quarterly. Meetings may also be called by the Chair, or at the written request of three members.

"**§ 135-48.22. Board powers and duties.**

The Board of Trustees shall have the following powers and duties:

(1) Approve benefit programs, as provided in G.S. 135-48.30(2).

(2) Approve premium rates, co-pays, deductibles, and coinsurance maximums for the Plan, as provided in G.S. 135-48.30(2).

(3) Oversee administrative reviews and appeals, as provided in G.S. 135-48.24.

(4) Approve large contracts, as provided in G.S. 135-48.33(a).

(5) Consult with and advise the State Treasurer as required by this Article and as requested by the State Treasurer.

(6) Develop and maintain a strategic plan for the Plan.

"**§ 135-48.23. 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 Treasurer. The term of employment and salary of the Executive Administrator shall be set by the State Treasurer after consultation with the Board of Trustees.

The Executive Administrator may be removed from office by the State Treasurer after consultation with the Board of Trustees, and any vacancy in the office of Executive Administrator may be filled by the State Treasurer.

(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~~ Administrator, the Board of ~~Trustees~~ Trustees, and the State Treasurer 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,~~ G.S. 135-48.2, 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.~~ State Treasurer.

~~(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)~~(d) The Executive Administrator shall quarterly make reports and recommendations on the Plan to the President Pro Tempore of the ~~Senate,~~ Senate and the Speaker of the House of ~~Representatives and the Committee on Employee Hospital and Medical Benefits.~~ Representatives.

"§ 135-48.24. 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 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.

(b) The ~~Executive Administrator and Board of Trustees~~ State Treasurer, in consultation with the Board of Trustees, shall adopt and implement utilization review and internal grievance procedures that are substantially equivalent to those required under G.S. 58-50-61 and G.S. 58-50-62. External review of determinations shall be conducted in accordance with Part 4 of Article 50 of Chapter 58 of the General Statutes. As used in this section, "determination" is a decision by the ~~Executive Administrator and Board of Trustees,~~ State Treasurer, or the Plan's designated utilization review organization administrated by or under contract with the Plan that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness, and the requested service is therefore denied, reduced, or terminated.

(c) The Board of Trustees shall make the final agency decision in all cases contested pursuant to Chapter 150B of the General Statutes. The Executive Administrator shall execute the Board's final agency decisions. For purposes of G.S. 150B-44, the Board of Trustees is an agency that is a board or commission.

"§ 135-48.25. Rules.

The ~~Executive Administrator and Board of Trustees~~ State Treasurer, in consultation with the Board of Trustees, may adopt rules to implement ~~Parts 2, 3, 4, and 5 of~~ this Article. The

~~Executive Administrator and Board of Trustees~~ State Treasurer shall provide to all employing units, all health benefit representatives, ~~the oversight team 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~~ State Treasurer 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.~~ State Treasurer. The ~~Executive Administrator and Board of Trustees~~ State Treasurer shall provide a written description of the rules adopted under this section to all employing units, all health benefit representatives, ~~the oversight team 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~~ State Treasurer on a timely basis. Rules adopted by the ~~Executive Administrator and Board of Trustees~~ State Treasurer to implement this Article are not subject to Article 2A of Chapter 150B of the General Statutes.

"**§ 135-48.26: Reserved for future codification purposes.**

"**§ 135-48.27. Reports to the General ~~Assembly.~~Assembly; General Assembly access to information.**

~~The~~ In addition to the reports required by G.S. 135-48.22(d), the State Treasurer, the Executive ~~Administrator~~ 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 Pro Tempore of the Senate and the Speaker of the House of Representatives. Employees of the Legislative Services Commission designated by the Legislative Services Officer (i) shall have access to all records related to the Plan of the State Treasurer, the Board of Trustees, the Executive Administrator, the Claims Processor, and the Plan and (ii) shall be entitled to attend all meetings, including executive sessions, of the Board of Trustees.

"**§ 135-48.28. Auditing of the Plan.**

The ~~Board of Trustees and the Executive Administrator of the~~ State Health Plan for Teachers and State Employees and the Claims Processor shall be subject to the oversight of the State Auditor pursuant to Article 5A of Chapter 147 of the General Statutes.

"Part 3. Plan Operation.

"**§ 135-48.30. Powers and duties of the State Treasurer.**

The State Treasurer shall have the following powers and duties:

(1) Administer and operate the State Health Plan for Teachers and State Employees in accordance with G.S. 135-48.2 and the provisions of this Article.

(2) Set benefits, premium rates, co-pays, deductibles, and coinsurance maximums, subject to approval by the Board of Trustees. In setting premium rates, the Treasurer shall strive to maintain low premiums by finding savings in the operation of the Plan.

(3) Set the allowable charges for medical and prescription drug benefits, as necessary.

(4) Design and implement coordination of benefits policies.

(5) May offer wellness incentives.

(6) Set administrative and medical policies that are not in direct conflict with this Article.

(7) Adopt and implement, in consultation with the Board of Trustees, utilization review and internal grievance procedures that are substantially equivalent to those required under G.S. 58-50-61 and G.S. 58-50-62. External review of

determinations shall be conducted in accordance with Part 4 of Article 50 of Chapter 58 of the General Statutes.

(8) Implement and administer pharmacy and medical utilization management programs and programs to detect and address utilization abuse of benefits.

(9) Establish and operate fraud detection and audit programs.

(10) Expend funds for any independent audit.

(11) Establish procedures to require prior medical approval and implement the procedures after consultation with the Board of Trustees.

(12) Prepare and submit to the Governor and the General Assembly cost estimates for the Plan, including those required by Article 15 of Chapter 120 of the General Statutes.

(13) Disclose to the Governor 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.

(14) Secure and maintain tax qualification of the Plan under any applicable provisions of the Internal Revenue Code.

(15) Implement and administer a program of long-term care benefits pursuant to Part 6 of this Article.

(16) Establish separate premium rates for the long-term care benefits provided by Part 6 of this Article if the benefits are administered on a self-insured basis.

(17) Optionally offer Medicare-related options under G.S. 135-48.38.

(b) The State Treasurer may delegate his or her powers and duties under this section to the Executive Administrator, the Board of Trustees, and employees of the Plan. In delegating powers or duties, however, the State Treasurer maintains the responsibility for the performance of those powers or duties.

"**§ 135-48.31: Reserved for future codification purposes.**

"**§ 135-48.32. Contracts to provide benefits.**

The Plan benefits shall be provided under contracts between the Plan and the claims processors selected by the Plan. The ~~Executive Administrator~~ State Treasurer 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~~ this Article 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~~ this Article and the request for proposals must be modified for inclusion in the contract because of State law, such modification shall be made. The ~~Executive Administrator~~ State Treasurer shall ensure that the terms of the contract between the Plan and the Plan's Claims Processing Contractor, the Pharmacy Benefit Manager, and the Disease Management Contractor require the contractor to provide the following:

(1) Detailed billing by each entity showing itemized cost information, including individual administrative services provided;

(2) Transactional data; and

(3) The cost to the Plan for each administrative function performed by the contractor.

"**§ 135-48.33. Contracting provisions; large contract review by Board of Trustees and Attorney General, auditing, no cost plus contracts.**

(a) The Board of Trustees must approve all Plan contracts in excess of five hundred thousand dollars ($500,000), including contracts with an initial cost of less than five hundred

thousand dollars ($500,000), but that may exceed five hundred thousand dollars ($500,000) during the term of the contract.

(b) The ~~Executive Administrator and Board of Trustees~~ Plan shall: (i) submit all proposed statewide and agency term contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by ~~subsection (d) of this section~~ this Article to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all proposed contracts to be awarded by the ~~Executive Administrator and Board of Trustees~~ Plan under this section a standard clause which provides that the State Auditor and internal auditors of the Plan may audit the records of the contractor during the term of the contract to verify accounts and data affecting fees and performance. The ~~Executive Administrator and Board of Trustees~~ Plan shall not award a cost plus percentage of cost agreement or contract for any purpose.

"**§ 135-48.34. Contracts not subject to Article 3 of Chapter 143 of the General Statutes.**

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. 135-48.2, are not subject to the requirements of Article 3 of Chapter 143 of the General Statutes, but are subject to the requirements of G.S. 135-48.33.

"**§ 135-48.35. Contract disputes not contested case under the Administrative Procedure Act, Chapter 150B of the General Statutes.**

A dispute involving the performance, terms, or conditions of a contract between the Plan and an entity under contract with the Plan is not a contested case under Article 3 of Chapter 150B of the General Statutes.

"**§ 135.48.36: Reserved for future codification purposes.**

"**§ 135-48.37. Liability of third person; right of subrogation; right of first recovery.**

(a) The Plan shall have the right of subrogation upon all of the Plan member's right to recover from a liable third party for payment made under the Plan, for all medical expenses, including provider, hospital, surgical, or prescription drug expenses, to the extent those payments are related to an injury caused by a liable third party. The Plan member shall do nothing to prejudice these rights. The Plan has the right to first recovery on any amounts so recovered, whether by the Plan or the Plan member, and whether recovered by litigation, arbitration, mediation, settlement, or otherwise. Notwithstanding any other provision of law to the contrary, the recovery limitation set forth in G.S. 28A-18-2 shall not apply to the Plan's right of subrogation of Plan members.

(b) If the Plan is precluded from exercising its right of subrogation, it may exercise its rights of recovery ~~pursuant to G.S. 135-40.13(g).~~ against any third party who was overpaid. If the Plan recovers damages from a liable third party in excess of the claims paid, any excess will be paid to the member, less a proportionate share of the costs of collection.

(c) In the event a Plan member recovers any amounts from a liable third party to which the Plan is entitled under this section, the Plan may recover the amounts directly from the Plan member. The Plan has a lien, for not more than the value of claims paid related to the liability of the third party, on any damages subsequently recovered against the liable third party. If the Plan member fails to pursue the remedy against a liable third party, the Plan is subrogated to the rights of the Plan member and is entitled to enforce liability in the Plan's own name or in the name of the Plan member for the amount paid by the Plan.

(d) In no event shall the Plan's lien exceed fifty percent (50%) of the total damages recovered by the Plan member, exclusive of the Plan member's reasonable costs of collection as determined by the Plan in the Plan's sole discretion. The decision by the Plan as to the reasonable cost of collection is conclusive and is not a "final agency decision" for purposes of a contested case under Chapter 150B of the General Statutes. Notice of the Plan's lien or right to

recovery shall be presumed when a Plan member is represented by an attorney, and the attorney shall disburse proceeds pursuant to this section.

"**§ 135-48.38. Persons eligible for Medicare; optional participation in other Medicare products.**

(a) Benefits payable for covered expenses under this Plan ~~in G.S. 135-45.6 through G.S. 135-45.10~~ will be reduced by any benefits payable for the same covered expenses under Medicare, so that Medicare will be the primary carrier except where compliance with federal law specifies otherwise.

(b) For those participants eligible for Medicare, the Plan will be administered on a "carve out" basis. The provisions of the Plan are applied to the charges not paid by Medicare (Parts A & B). In other words, those charges not paid by Medicare would be subject to the deductible and coinsurance of the Plan just as if the charges not paid by Medicare were the total bill.

(c) For those individuals eligible for Part A (at no cost to them), benefits under this program will be reduced by the amounts to which the covered individuals would be entitled to under Parts A and B of Medicare, even if they choose not to enroll for Part B.

(d) Notwithstanding the foregoing provisions of this section or any other provisions of the Plan, the ~~Executive Administrator and Board of Trustees~~ State Treasurer may enter into negotiations with the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, in order to secure a more favorable coordination of the Plan's benefits with those provided by Medicare, including but not limited to, measures by which the Plan would provide Medicare benefits for all of its Medicare-eligible members in return for adequate payments from the federal government in providing such benefits. Should such negotiations result in an agreement favorable to the Plan and its Medicare-eligible members, the ~~Executive Administrator and Board of Trustees~~ State Treasurer may, after consultation with the ~~Committee on Employee Hospital and Medical Benefits,~~ Board of Trustees, implement such an agreement which shall supersede all other provisions of the Plan to the contrary related to its payment of claims for Medicare-eligible members.

(e) Notwithstanding subsections (a), (b), and (c) of this section, ~~the Plan may offer an optional Medicare Advantage plan to a Medicare eligible Plan member. A Medicare Advantage plan offered by the Plan shall be an insured product offered through a private insurance carrier authorized by the Centers for Medicare and Medicaid Services to offer Medicare Advantage plans. A Medicare Advantage plan offered by the Plan shall not be a self-funded benefit plan underwritten by the State of North Carolina. Prescription drug benefits shall not be included in the benefits offered under a Medicare Advantage insurance product but shall continue to be provided by the Plan as authorized under G.S. 135-45.6. An eligible Plan member may choose to enroll in a Medicare Advantage plan in lieu of any other benefit coverage plan offered under the Plan to Medicare eligible Plan members. A Medicare eligible Plan member must be enrolled in Medicare Part B to participate in an optional Medicare Advantage plan. A non-Medicare eligible dependent of a Medicare Advantage eligible Plan member may enroll on a fully contributory basis in benefit plans offered under the Plan to non-Medicare eligible Plan members. If an enrolled Plan member decides not to re-enroll in an optional Medicare Advantage plan during the Plan's annual enrollment period, the Plan member may at that time re-enroll in other benefit coverage offered by the Plan in accordance with the provisions of subsections (a), (b), and (c) of this section.~~ the State Treasurer may contract for coverage in lieu of current Plan medical and prescription drug benefits for Medicare retirees or to supplement Medicare benefits and may, after consultation with the Board of Trustees, implement such an agreement, which shall supersede all other provisions of the Plan to the contrary related to its payment of claims for Medicare-eligible members.

"Part 4. Eligibility and Enrollment.

"**§ 135-48.40. Categories of 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:~~ G.S. 135-48.43:

~~(3)~~(1) Retired teachers, State employees, members of the General Assembly, and retired State law enforcement officers who retired under the Law Enforcement Officers' Retirement System prior to January 1, 1985. Except as otherwise provided in this subdivision, on and after January 1, 1988, a retiring employee or retiree must have completed at least five years of contributory retirement service with an employing unit prior to retirement from any State-supported retirement system in order to be eligible for group benefits under this Part as a retired employee or retiree. For employees first hired on and after October 1, 2006, and members of the General Assembly first taking office on and after February 1, 2007, future coverage as retired employees and retired members of the General Assembly is subject to a requirement that the future retiree have 20 or more years of retirement service credit in order to be covered by the provisions of this subdivision.

~~(4)~~(2) Surviving spouses of:

a. Deceased retired employees, provided the death of the former plan member occurred prior to October 1, 1986; and

b. Deceased teachers, State employees, and members of the General Assembly who are receiving a survivor's alternate benefit under any of the State-supported retirement programs, provided the death of the former plan member occurred prior to October 1, 1986.

(b) Partially Contributory Coverage. – The following persons are eligible for coverage under the Plan, on a partially contributory basis, subject to the provisions of ~~G.S. 135-45.4:~~ G.S. 135-48.43:

(1) All permanent full-time employees of an employing unit who meet either of the following conditions:

a. Paid from general or special State funds.

b. Paid from non-State funds and in a group for which his or her employing unit has agreed to provide coverage.

Employees of State agencies, departments, institutions, boards, and commissions not otherwise covered by the Plan who are employed in permanent job positions on a recurring basis and who work 30 or more hours per week for nine or more months per calendar year are covered by the provisions of this subdivision.

(2) Permanent hourly employees who work at least one-half of the workdays of each pay period.

(3) Retired teachers, State employees, members of the General Assembly, and retired State law enforcement officers who retired under the Law Enforcement Officers' Retirement System prior to January 1, 1985. Except as otherwise provided in this subdivision, on and after January 1, 1988, a retiring employee or retiree must have completed at least five years of contributory retirement service with an employing unit prior to retirement from any State-supported retirement system in order to be eligible for group benefits under this Part as a retired employee or retiree. For employees first hired on and after October 1, 2006, and members of the General Assembly first taking office on and after February 1, 2007, future coverage as retired employees and retired members of the General Assembly is subject to a requirement that the future retiree have 20 or more years of retirement service credit in order to be covered by the provisions of this subdivision.

(4) Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except for legislative interns and pages.

(5) Members of the General Assembly.

(6) Notwithstanding the provisions of subsection (e) of this section, employees on official leave of absence while completing a full-time program in school administration in an approved program as a Principal Fellow in accordance with Article 5C of Chapter 116 of the General Statutes.

(7) Notwithstanding the provisions of ~~G.S. 135-45.12,~~ G.S. 135-48.44, 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, 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. An employee formerly covered by the provisions of this section shall not be eligible for coverage under this subdivision if the employee is provided health benefit coverage on a non-contributory basis by a subsequent employer.

(8) Any member enrolled pursuant to subdivision (1) or (2) of this subsection who is on approved leave of absence with pay or receiving workers' compensation.

(9) Employees on approved Family and Medical Leave.

(c) One-Half Contributory Coverage. – The following persons are eligible for coverage under the Plan, on a one-half contributory basis, subject to the provisions of ~~G.S. 135-45.4:~~ G.S. 135-48.43:

(1) A school employee in a job-sharing position as described in G.S. 115C-326.5. If these employees elect to participate in the Plan, the employing unit shall pay fifty percent (50%) of the Plan's total employer premiums. Individual employees shall pay the balance of the total premiums not paid by the employing unit.

(2) Employees and members of the General Assembly with 10 but less than 20 years of retirement service credit provided the employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007. For such future retirees, the State shall pay fifty percent (50%) of the Plan's total employer premiums. Individual retirees shall pay the balance of the total premiums not paid by the State.

(d) Fully Contributory Coverage. – The following persons shall be eligible for coverage under the Plan, on a fully contributory basis, subject to the provisions of ~~G.S. 135-45.4:~~ G.S. 135-48.43:

(1) Former members of the General Assembly who enroll before October 1, 1986.

(2) For enrollments after September 30, 1986, former members of the General Assembly if covered under the Plan at termination of membership in the General Assembly. To be eligible for coverage as a former member of the General Assembly, application must be made within 30 days of the end of the term of office. Only members of the General Assembly covered by the

Plan at the end of the term of office are eligible. If application is not made within the specified time period, the member forfeits eligibility.

(3) Surviving spouses of deceased former members of the General Assembly who enroll before October 1, 1986.

(4) Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except for legislative interns and pages.

(5) For enrollments after September 30, 1986, surviving spouses of deceased former members of the General Assembly, if covered under the Plan at the time of death of the former member of the General Assembly.

(6) All permanent part-time employees (designated as half-time or more) of an employing unit who meet the conditions outlined in sub-subdivision ~~(a1)(1)a.~~ (b)(1)a. of this section and who are not covered by the provisions of subdivision ~~(a1)(1)~~ (b)(1) of this section.

(7) The spouses and eligible dependent children of enrolled teachers, State employees, retirees, former members of the General Assembly, former employees covered by the provisions of ~~former subdivision (a)(8) or~~ subdivision ~~(a1)(7)~~ (b)(7) of this section, Disability Income Plan beneficiaries, enrolled continuation members, and members of the General Assembly. Spouses of surviving dependents are not eligible, nor are dependent children if they were not covered at the time of the member's death. Surviving spouses may cover their dependent children provided the children were enrolled at the time of the member's death or enroll within 90 days of the member's death.

(8) Blind persons licensed by the State to operate vending facilities under contract with the Department of Health and Human Services, Division of Services for the Blind and its successors, who are:

a. Operating such a vending facility;

b. Former operators of such a vending facility whose service as an operator would have made these operators eligible for an early or service retirement allowance under Article 1 of this Chapter had they been members of the Retirement System; and

c. Former operators of such a vending facility who attain five or more years of service as operators and who become eligible for and receive a disability benefit under the Social Security Act upon cessation of service as an operator.

Spouses, dependent children, surviving spouses, and surviving dependent children of such members are not eligible for coverage.

(9) Surviving spouses of deceased retirees and surviving spouses of deceased teachers, State employees, and members of the General Assembly provided the death of the former Plan member occurred after September 30, 1986, and the surviving spouse was covered under the Plan at the time of death.

(10) Any eligible dependent child of the deceased retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary, provided the child was covered at the time of death of the retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary, (or was in posse at the time and is covered at birth under this Part), or was covered under the Plan on September 30, 1986. An eligible surviving dependent child can remain

covered until age 26 or indefinitely if certified as incapacitated under ~~G.S. 135-45.2(d).~~ G.S. 135-44.41(b).

(11) Retired teachers, State employees, and members of the General Assembly with less than 10 years of retirement service credit, provided the teachers and State employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007.

(12) Notwithstanding the provisions of ~~G.S. 135-45.12~~ G.S. 135-48.44, former employees covered by the provisions of this section and their spouses and eligible dependent children who were covered by the Plan at the time of the former employees' separation from service pursuant to this section, following expiration of the former employees' coverage provided by this section. Election of coverage under this subdivision shall be made within 90 days after the termination of coverage provided under this section.

(13) ~~Firefighters, rescue squad workers, and members of the National Guard,~~ The following persons, their eligible spouses, and eligible dependent ~~children.~~ children, provided that the person seeking coverage as a subscriber (i) is not eligible for another comprehensive group health benefit plan and (ii) has been without coverage under a comprehensive group health benefit plan for at least six consecutive months:

a. Firefighters.

b. Rescue squad workers.

c. Persons receiving a pension from the North Carolina Firemen and Rescue Squad Workers' Pension Fund.

d. Members of the North Carolina National Guard.

e. Retirees of the North Carolina National Guard with 20 years of service.

For the purposes of this subdivision, Medicare benefits, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) benefits, and other Uniformed Services benefits shall be considered comprehensive group health benefit plans. The Plan may require certification of persons seeking coverage under this subdivision.

"**§ 135-48.41. Additional eligibility provisions.**

(a) 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.

(b) A dependent child shall not be eligible for coverage under the Plan if the dependent child is eligible for employer based health care outside of the State Health Plan for Teachers and State Employees. Coverage of a dependent child may be extended beyond the 26th birthday if 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(c)(7).~~ G.S. 135-48.40(d)(7).

(c) No person shall be eligible for coverage as a dependent if eligible as an employee or retired employee, except when a spouse is eligible on a fully contributory basis. In addition, no person shall be eligible for coverage as a dependent of more than one employee or retired employee at the same time.

(d) Former employees who are receiving disability retirement benefits or disability income benefits pursuant to Article 6 of Chapter 135 of the General Statutes or who are approved for those benefits but not in receipt of the benefits due to lump-sum payouts of vacation and bonus leave, provided the former employee has at least five years of contributory retirement service with an employing unit of a State-supported retirement system, shall be eligible for the benefit provisions of this Plan, as set forth in this Part, on a noncontributory basis. Such coverage shall terminate as of the end of the month in which such former employee is no longer eligible for disability retirement benefits or disability income benefits pursuant to Article 6 of this Chapter.

(e) Employees on official leave of absence without pay may elect to continue this group coverage at group cost provided that they pay the full employee and employer contribution through the employing unit during the leave period.

(f) For the support of the benefits made available to any member vested at the time of retirement, their spouses or surviving spouses, and the surviving spouses of employees who are receiving a survivor's alternate benefit under G.S. 135-5(m) of those associations listed in G.S. 135-27(a), licensing and examining boards under G.S. 135-1.1, the North Carolina State Art Society, Inc., and the North Carolina Symphony Society, Inc., each association, organization or board shall pay to the Plan the full cost of providing these benefits under this section as determined by ~~the Board of Trustees of~~ the State Health Plan for Teachers and State Employees. In addition, each association, organization or board shall pay to the Plan an amount equal to the cost of the benefits provided under this section to presently retired members of each association, organization or board since such benefits became available at no cost to the retired member. This subsection applies only to those individuals employed prior to July 1, 1983, as provided in G.S. 135-27(d).

(g) An eligible surviving spouse and any eligible surviving dependent child of a deceased retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary shall be eligible for group benefits under this section without waiting periods for preexisting conditions provided coverage is elected within 90 days after the death of the former plan member. Coverage may be elected at a later time, but will be subject to the 12-month waiting period for preexisting conditions and will be effective the first day of the month following receipt of the application.

(h) No person shall be eligible for coverage as an employee or retired employee or as a dependent of an employee or retired employee upon a finding by the ~~Executive Administrator or Board of Trustees~~ State Treasurer or by a court of competent jurisdiction that the employee or dependent knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan or in any representation or attestation to the Plan.

The ~~Executive Administrator and Board of Trustees~~ State Treasurer may make an exception to the provisions of this subsection when persons subject to this subsection have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subsection shall be construed to obligate the ~~Executive Administrator and Board of Trustees~~ State Treasurer to make an exception as allowed for under this subsection.

(i) Any employee receiving benefits pursuant to Article 6 of this Chapter when the employee has less than five years of retirement membership service, or an employee on leave without pay due to illness or injury for up to 12 months, is entitled to continued coverage under

the Plan for the employee and any eligible dependents by paying one hundred percent (100%) of the cost.

"§ 135-48.42. Enrollment.

(a) Except as otherwise required by applicable federal law, new employees must be given the opportunity to enroll or decline enrollment for themselves and their dependents within 30 days from the date of employment or from first becoming eligible on a partially contributory basis. Coverage may become effective on the first day of the month following date of entry on payroll or on the first day of the following month. New employees not enrolling themselves and their dependents age 19 and older within 30 days, or not adding dependents when first eligible as provided herein may enroll on the first day of any month but will be subject to a 12-month waiting period for preexisting health conditions, except for employees who elect to change their coverage in accordance with rules established by the ~~Executive Administrator and Board of Trustees~~ State Treasurer for optional or alternative plans available under the Plan. Children born to covered employees having coverage type (2) or (3), as outlined in ~~G.S. 135-45.4(d)~~ G.S. 135-48.43(d) shall be automatically covered at the time of birth without any waiting period for preexisting health conditions. Children born to covered employees having coverage type (1) shall be automatically covered at birth without any waiting period for preexisting health conditions so long as the claims processor receives notification within 30 days of the date of birth that the employee desires to change from coverage (1) to coverage type (2) or (3), provided that the employee pays any additional premium required by the coverage type selected retroactive to the first day of the month in which the child was born.

(b) Except as otherwise required by applicable federal law, newly acquired dependents (spouse/child) age 19 and older 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, 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.

(c) Eligible dependents younger than age 19 may be enrolled at any time and shall not be subject to any waiting period for a preexisting condition.

(d) 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.

"§ 135-48.43. Effective dates of coverage.

(a) Employees and Retired Employees. –

(1) Employees and retired employees covered under the Predecessor Plan will continue to be covered, subject to the terms hereof.

(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.

(3) Employees not enrolling or adding dependents age 19 and older when first eligible in accordance with ~~G.S. 135-45.3~~ G.S. 135-48.42 may enroll later on the first of any following month but will be subject to a 12-month waiting period for a preexisting health condition, except employees who elect to

change their coverage in accordance with rules adopted by the ~~Executive Administrator and Board of Trustees~~ State Treasurer for optional alternative plans offered under the Plan.

(4) Members of the General Assembly, beginning with the 1985 Session, shall become first eligible with the convening of each Session of the General Assembly, regardless of a Member's service during previous Sessions. Members and their dependents enrolled when first eligible after the convening of each Session of the General Assembly will not be subject to any waiting periods for preexisting health conditions. Members of the 1983 Session of the General Assembly, not already enrolled, shall be eligible to enroll themselves and their dependents on or before October 1, 1983, without being subject to any waiting periods for preexisting health conditions.

(b) Waiting Periods and Preexisting Conditions. –

(1) New employees and dependents age 19 and older enrolling when first eligible are subject to no waiting period for preexisting conditions under the Plan.

(2) Employees not enrolling or not adding dependents age 19 and older 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.

(3) Retiring employees and dependents enrolled when first eligible after an employee's retirement are subject to no waiting period for preexisting conditions under the Plan. Retiring employees not enrolled or not adding dependents age 19 and older when first eligible after an employee's retirement may enroll later on the first of any following month, but will be subject to a 12-month waiting period for preexisting conditions except as provided in subdivision (a)(3) of this section.

(4) Employees and dependents enrolling or reenrolling within 12 months after a termination of enrollment or employment that were not enrolled at the time of this previous termination, regardless of the employing units involved, shall not be considered as newly-eligible employees or dependents for the purposes of waiting periods and preexisting conditions. Employees and dependents transferring from optional prepaid alternative plans available under the Plan; employees and dependents immediately returning to service from an employing unit's approved periods of leave without pay for illness, injury, educational improvement, workers' compensation, parental duties, or for military reasons; employees and dependents immediately returning to service from a reduction in an employing unit's work force; retiring employees and dependents reenrolled in accordance with ~~G.S. 135-45.4(b)(3);~~ subdivision (3) of this subsection; formerly-enrolled dependents reenrolling as eligible employees; formerly-enrolled employees reenrolling as eligible dependents; and employees and dependents reenrolled without waiting periods and preexisting conditions under specific rules adopted by the ~~Executive Administrator and Board of Trustees~~ State Treasurer in the best interests of the Plan shall not be considered reenrollments for the purpose of this subdivision. Furthermore, employees accepting permanent, full-time appointments who had previously worked in a part-time or temporary position and their qualified dependents shall not be covered by waiting periods and preexisting conditions under this division

provided enrollment as a permanent, full-time employee is made when the employee and his dependents are first eligible to enroll.

(5) To administer the 12-month waiting period for preexisting conditions for employees and dependents age 19 and older under this 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.

(c) Dependents of Employees and Retired Employees. –

(1) Dependents of employees and retired employees who have family coverage under the Predecessor Plan will continue to be covered subject to the terms hereof.

(2) Employees who have dependents may apply for family coverage at the time they enroll as provided in subdivisions (a)(2) and (a)(3) of this section and such dependents will be covered under the Plan beginning the same date as such employees.

(3) Employees and retired employees may change from one category of coverage to a different category of coverage without a waiting period for preexisting conditions, and, as applicable, dependents will be covered under the Plan the first of the month or the first of the second month following the dependent's eligibility for coverage, provided written application is submitted to the Health Benefits Representative within 30 days of becoming eligible.

(4) Employees or retired employees who wish to change to employee only coverage shall give written notice to their Health Benefits Representative within 30 days after any change in the status of dependents, (resulting from death, divorce, etc.) that requires a change in contract category. The effective date will be the first of the month following the dependent's ineligibility event. If notification was not made within the 30 days following the dependent's ineligibility event, the dependent will be retroactively removed the first of the month following the dependent's ineligibility event, and the coverage category change will be the first of the month following written notification, except in cases of death, in which case the coverage category change will be made retroactive to the first of the month following the death.

(5) Employees not adding dependents age 19 and older when first eligible may enroll later on the first of any following month, but dependents will be subject to a 12-month waiting period for preexisting health conditions except as provided in subdivision (a)(3) of this section.

(6) Employees or retired employees who wish to change to employee only coverage even though their dependents continue to be eligible, shall give written notification to their Health Benefits Representative. Except as otherwise required by applicable federal law, the date of this category

change will be the first of the month following written notification or any first of the month thereafter as desired by the employee.

(7) The effective date for newborns or adopted children will be date of birth, date of adoption, or placement with adoptive parent provided member is currently covered under employee and family or employee and child coverage. If the member wishes to add a newborn or adopted child and is currently enrolled in employee only coverage, the member must submit application for coverage and a coverage type change within 30 days of the child's birth or date of adoption or placement. Effective date for the coverage category change is the first of the month in which the child is born, adopted, or placed. Adopted children may also be covered the first of the month following placement or adoption.

(d) Categories of Coverage Available. – There are four categories of coverage which an employee or retiree may elect.

(1) Employee Only. – Covers enrolled employees only. Maternity benefits are provided to employee only.

(2) Employee and Child. – Covers enrolled employee and all eligible dependent children. Maternity benefits are provided to the employee only.

(3) Employee and Family. – Covers employee and spouse, and all eligible dependent children. Maternity benefits are provided to employee or enrolled spouse.

(4) Employee and ~~spouse.~~ Spouse. – Covers employee and spouse only. Maternity benefits are provided to the employee or the employee's enrolled spouse.

~~(e) Notwithstanding any other provision of this section, no coverage under the Plan shall become effective prior to the payment of premiums required by the Plan.~~

~~(f)~~(d) Firefighters, rescue squad workers, and members of the National Guard are subject to the same terms and conditions of this section as are employees. Eligible dependents of firefighters, rescue squad workers, and members of the National Guard are subject to the same terms and conditions of this section as are dependents of employees.

~~(g) Different categories of coverage may be offered for optional alternative plans or programs.~~

~~(h)~~(e) If any provision of this section is in conflict with applicable federal law, federal law shall control to the extent of the conflict.

"§ 135-48.44. Cessation of coverage.

(a) Coverage under this Plan of an employee and his or her surviving spouse or eligible dependent children or of a retired employee and his or her surviving spouse or eligible dependent children shall cease on the earliest of the following dates:

(1) The last day of the month in which an employee or retired employee dies. Provided such surviving spouse or eligible dependent children were covered under the Plan at the time of death of the former employee or retired employee, or were covered on September 30, 1986, any such surviving spouse or eligible dependent children may then elect to continue coverage under the Plan by submitting written application to the Claims Processor and by paying the cost for such coverage when due at the applicable fees. Such coverage shall cease on the last day of the month in which such surviving spouse or eligible dependent children die, except as provided by this Article.

(2) The last day of the month in which an employee's employment with the State is terminated as provided in subsection (c) of this section.

(3) The last day of the month in which a divorce becomes final.

(4) The last day of the month in which an employee or retired employee requests cancellation of coverage.

(5) The last day of the month in which a covered individual enters active military service.

(6) The last day of the month in which a covered individual is found to have knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan. The ~~Executive Administrator and Board of Trustees~~ State Treasurer may make an exception to the provisions of this subdivision when persons subject to this subdivision have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subdivision shall be construed to obligate the ~~Executive Administrator and Board of Trustees~~ State Treasurer to make an exception as allowed for under this subdivision.

(7) The last day of the month in which an employee who is Medicare-eligible selects Medicare to be the primary payer of medical benefits. Coverage for a Medicare-eligible spouse of an employee shall also cease the last day of the month in which Medicare is selected to be the primary payer of medical benefits for the Medicare-eligible spouse. Such members are eligible to apply for conversion coverage.

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

(b) Coverage under this Plan as a dependent child ceases when the child ceases to be a dependent child as defined by ~~G.S. 135-45.1~~ G.S. 135-48.1 except, coverage may continue under this Plan for a period of not more than 36 months after loss of dependent status on a fully contributory basis provided the dependent child was covered under the Plan at the time of loss of dependent status.

(c) Coverage under the Plan as a surviving dependent child whether covered as a dependent of a surviving spouse, or as an individual member (no living parent), ceases when the child ceases to be a dependent child as defined by ~~G.S. 135-45.1,~~ G.S. 135-48.1, except coverage may continue under the Plan on a fully contributory basis for a period of not more than 36 months after loss of dependent status.

(d) Termination of employment shall mean termination for any reason, including layoff and leave of absence, except as provided in subdivisions (a)(1) and (2) of this section, but shall not, for purposes of this Plan, include retirement upon which the employee is granted an immediate service or disability pension under and pursuant to a State-supported Retirement System.

(1) In the event of termination for any reason other than death, coverage under the Plan for an employee and his or her eligible spouse or dependent children, provided the eligible spouse or dependent children were covered under the Plan at termination of employment may be continued for a period of not more than 18 months following termination of employment on a fully contributory basis. Employees who were covered under the Plan at termination of employment may be continued for a period of not more than 18 months or 29 months if determined to be disabled under the Social Security Act, Title II, OASDI or Title XVI, SSI.

(2) In the event of approved leave of absence without pay, other than for active duty in the armed forces of the United States, coverage under this Plan for an employee and his or her dependents may be continued during the period of

such leave of absence by the employee's paying one hundred percent (100%) of the cost.

(3) If employment is terminated in the second half of a calendar month and the covered individual has made the required contribution for any coverage in the following month, that coverage will be continued to the end of the calendar month following the month in which employment was terminated.

(4) Employees paid for less than 12 months in a year, who are terminated at the end of the work year and who have made contributions for the non-work months, will continue to be covered to the end of the period for which they have made contributions, with the understanding that if they are not employed by another State-covered employer under this Plan at the beginning of the next work year, the employee will refund to the ex-employer the amount of the employer's cost paid for them during the non-paycheck months.

(5) Any employee receiving benefits pursuant to Article 6 of this Chapter when the employee has less than five years of retirement membership service, or an employee on leave of absence without pay due to illness or injury for up to 12 months, is entitled to continued coverage under the Plan for the employee and any eligible dependents by the employee's paying one hundred percent (100%) of the cost.

(e) A legally divorced spouse and any eligible dependent children of a covered employee or retired employee may continue coverage under this Plan for a period of not more than 36 months following the first of the month after a divorce becomes final on a fully contributory basis, provided the former spouse and any eligible dependent children were covered under the Plan at the time a divorce became final.

(f) A legally separated spouse of a covered employee or retired employee may continue coverage under this Plan for a period not to exceed 36 months from the separation date on a fully contributory basis, provided the separated spouse was covered under the Plan at the time of separation and provided the covered employee's or retired employee's actions result in the loss of coverage for the separated spouse. Eligible dependent children may also continue coverage if covered under the Plan at time of separation, provided the employee's or retired employee's actions result in the loss of coverage for the dependent children.

(g) Whenever this section gives a right to continuation coverage, such coverage must be elected within the time allowed by applicable federal law.

(h) Continuation coverage under this Plan shall not be continued past the occurrence of any one of the following events:

(1) The termination of the Plan.

(2) Failure of a Plan member to pay monthly in advance any required premiums.

(3) A person becomes a covered employee or a dependent of a covered employee under any group health plan and that group health plan has no restrictions or limitations on benefits.

(4) A person becomes eligible for Medicare benefits on or after the effective date of the continuation coverage.

(5) The person was determined to be no longer disabled, provided the 18-month coverage was extended to 29 months due to having been determined to be disabled under the Social Security Act, Title II, OASDI or Title XVI, SSI.

(6) The person reaches the maximum applicable continuation period of 18, 29, or 36 months.

(i) Notice requirements concerning continuation coverage shall be developed by the ~~Executive Administrator and Board of Trustees.~~ Plan.

(j) The spouse and any eligible dependent children of a covered employee may continue coverage under the Plan on a fully contributory basis for a period not to exceed 36 months from the date the employee becomes eligible for Medicare benefits which results in a loss of coverage under the Plan, provided that the spouse and eligible dependent children were covered under the Plan at the time the employee became eligible for Medicare benefits which results in a loss of coverage under the Plan.

"**§ 135-48.45. Conversion.**

(a) Upon a cessation of group coverage under the Plan and/or eligibility for group coverage under the Plan, an employee or dependent shall be entitled to a conversion to nongroup coverage without the necessity of a physical examination. Such conversion coverage shall include hospitalization, surgical, and medical benefits as contained in the major medical and alternative plan conversion provisions of Article 53 of Chapter 58 of the General Statutes. The ~~Executive Administrator and Board of Trustees~~ State Treasurer in ~~their~~ his or her sole discretion shall approve the conversion coverage, which shall be administered by the Claims Processor through an insurance contract arranged by the Claims Processor, or administered as otherwise directed by the ~~Executive Administrator and Board of Trustees.~~ State Treasurer. An eligible employee or dependent must apply for conversion coverage within 30 days after termination of group eligibility.

(b) The ~~Executive Administrator and Board of Trustees~~ State Treasurer shall provide for the continuation of conversion privilege exercised under the predecessor plan, on a fully contributory basis. The ~~Executive Administrator and Board of Trustees~~ State Treasurer shall consult with the ~~Committee on Employee Hospital and Medical Benefits~~ Board of Trustees before taking action under this subsection.

"Part 5. Coverage Mandates and Exclusions; Other Mandates

"**§ 135-48.50. Coverage mandates.**

The Plan shall provide coverage subject to the following coverage mandates:

(1) Reserved.

(2) Immunizations. – The Plan shall pay one hundred percent (100%) of allowable medical charges for immunizations for the prevention of contagious diseases as generally accepted medical practices would dictate when directed by a credentialed provider as determined by the claims processor.

(3) Insulin. – Prescription benefits shall be provided for insulin even though a prescription is not required.

(4) Mental health parity. – Benefits for the treatment of mental illness and chemical dependency are covered by the Plan and shall be subject to the same deductibles, durational limits, and coinsurance factors as are benefits for physical illness generally. Nothing in this subdivision, however, shall prohibit the Plan from requiring the most cost-effective treatment setting to be utilized by a person undergoing necessary care and treatment for chemical dependency.

(5) Reserved.

(6) Permissive coverage extension. – If a covered service becomes excluded from coverage under the Plan, the Executive Administrator and Claims Processor may, in the event of exceptional situations creating undue hardships or adverse medical conditions, allow persons enrolled in the Plan to remain covered by the Plan's previous coverage for up to three months after the effective date of the change in coverage, provided the persons so enrolled had been undergoing a continuous plan of specific treatment initiated within three months prior to the effective date of the change in coverage.

(7) Reconstructive surgery. – Charges for cosmetic surgery or treatment required for correction of damage caused by accidental injury sustained by the covered individual while coverage under this plan is in force on his or her account or to correct congenital deformities or anomalies shall not be excluded if they otherwise qualify as covered medical expenses. Reconstructive breast surgery following mastectomy, as those terms are defined in G.S. 58-51-62, shall be covered.

"**§ 135-48.51. Coverage and operational mandates related to Chapter 58 of the General Statutes.**

The following provisions of Chapter 58 of the General Statutes apply to the State Health Plan:

(1) G.S. 58-3-191, Managed care reporting and disclosure requirements.
(2) G.S. 58-3-221, Access to nonformulary and restricted access prescription drugs.
(3) G.S. 58-3-223, Managed care access to specialist care.
(4) G.S. 58-3-225, Prompt claim payments under health benefit plans.
(5) G.S. 58-3-235, Selection of specialist as primary care provider.
(6) G.S. 58-3-240, Direct access to pediatrician for minors.
(7) G.S. 58-3-245, Provider directories.
(8) G.S. 58-3-250, Payment obligations for covered services.
(9) G.S. 58-3-265, Payment obligations for covered services.
(10) G.S. 58-3-280, Coverage for the diagnosis and treatment of lymphedema.
(11) G.S. 58-3-285, Coverage for hearing aids.
(12) G.S. 58-50-30, Right to choose services of optometrist, podiatrist, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, licensed marriage and family therapist, or physician assistant.
(13) G.S. 58-67-88, Continuity of care.

"**§ 135-48.52. General limitations and exclusions.**

The Plan shall not provide coverage for or pay any benefits for any of the following:

(1) Charges to the extent paid, or which the individual is entitled to have paid, or to obtain without cost, in accordance with any government laws or regulations except Medicare. If a charge is made to any such person which he or she is legally required to pay, any benefits under this Plan will be computed in accordance with its provisions, taking into account only such charge. "Any government" includes the federal, State, provincial, or local government, or any political subdivision thereof, of the United States, Canada, or any other country.
(2) Charges for services rendered in connection with any occupational injury or disease arising out of and in the course of employment with any employer, if (i) the employer furnishes, pays for or provides reimbursement for such charges, or (ii) the employer makes a settlement payment for such charges, or (iii) the person incurring such charges waives or fails to assert his or her rights respecting such charges.
(3) Charges for any services rendered as a result of injury or sickness due to an act of war, declared or undeclared, which act shall have occurred after the effective date of a person's coverage under the Plan.
(4) Charges for any services with respect to which there is no legal obligation to pay. For the purposes of this item, any charge which exceeds the charge that would have been made if a person were not covered under this Plan shall, to

the extent of such excess, be treated as a charge for which there is no legal obligation to pay; and any charge made by any person for anything which is normally or customarily furnished by such person without payment from the recipient or user thereof shall also be treated as a charge for which there is no legal obligation to pay.

(5) Charges during a continuous hospital confinement which commenced prior to the effective date of the person's coverage under this Plan.

(6) Charges for services unless a claim is filed within 18 months from the date of service.

(7) Charges for sexual dysfunction or hair growth drugs or for nonmedically necessary drugs used for cosmetic purposes.

"§ 135-48.53. **Reserved for future codification purposes.**

"§ 135-48.54. **Optional participation for charter schools operated by private nonprofit corporations.**

(a) The board of directors of each charter school operated by a private nonprofit corporation shall elect whether to become a participating employer in the Plan in accordance with this Article. This election shall be in writing, shall be made no later than 30 days after ~~this section becomes law,~~ October 28, 1998, and shall be filed with the ~~Executive Administrator and Board of Trustees~~ Plan and with the State Board of Education. For each charter school employee who is employed on or before the date the board makes the election, membership in the Plan is effective as of the date the board makes the election. For each charter school employee who is employed after the date the board makes the election, membership in the Plan is effective as of the date of that employee's entry into eligible service. This subsection applies only to charter schools that received State Board of Education approval under G.S. 115C-238.29D in 1997 or 1998.

(b) No later than 30 days after both parties have signed the written charter under G.S. 115C-238.29E, the board of directors of a charter school operated by a private nonprofit corporation shall elect whether to become a participating employer in the Plan in accordance with this Article. This election shall be in writing and filed with the ~~Executive Administrator, the Board of Trustees,~~ Plan and the State Board of Education. This election is effective for each charter school employee as of the date of that employee's entry into eligible service. This subsection applies to charter schools that receive State Board of Education approval under G.S. 115C-238.29D after 1998.

(c) A board's election to become a participating employer in the Plan under this section is irrevocable and shall require all eligible employees of the charter school to participate.

(d) If a charter school's board of directors does not elect to become a participating employer in the Plan under this section, that school's employees and the dependents of those employees are not eligible for any benefits under the Plan on account of employment with a charter school.

(e) The board of directors of each charter school shall notify each of its employees as to whether the board elected to become a participating employer in the Plan under this section. This notification shall be in writing and shall be provided within 30 days of the board's election or at the time an initial offer for employment is made, whichever occurs last. If the board did not elect to become a participating employer in the Plan, the notice shall include a statement that the employee shall have no legal recourse against the board or the State for any possible benefit under the Plan. The employee shall provide written acknowledgment of the employee's receipt of the notification under this subsection.

"§ 135-48.55. **Interest charged to charter schools on late premiums.**

The total amount of premiums due the Plan from charter schools as employing units, including amounts withheld from the compensation of Plan members, that is not remitted to the Plan by the fifteenth day of the month following the due date of remittance shall be assessed

interest of one and one-half percent (1 1/2%) of the amount due the Plan, per month or fraction thereof, beginning with the sixteenth day of the month following the due date of the remittance. The interest authorized by this section shall be assessed until the premium payment plus the accrued interest amount is remitted to the Plan. The remittance of premium payments under this section shall be presumed to have been made if the remittance is postmarked in the United States mail on a date not later than the fifteenth day of the month following the due date of the remittance.

"§ 135-48.56. Education of covered active and retired employees.

It is the intent of the General Assembly that active employees and retired employees covered under the Plan and its successor Plan shall have several opportunities in each fiscal year to attend presentations conducted by Plan management staff providing detailed information about benefits, limitations, premiums, co-payments, and other pertinent Plan matters. To this end, the Plan's management staff shall conduct multiple presentations each year to Plan members and association groups representing active and retired employees across all geographic regions of the State. Regional meetings shall be held in locations that afford reasonably convenient access to Plan members. The presentations shall be designed not only to present information about the Plan but also to hear and respond to Plan members' questions and concerns.

"§ 135-48.57. Payments for county or city ambulance service.

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.

"§ 135-48.58. Premiums for firefighters, rescue squad workers, and members of National Guard.

In setting premiums for firefighters, rescue squad workers, and members of the National Guard, and their eligible dependents, the ~~Executive Administrator and Board of Trustees~~ Plan shall establish rates separate from those affecting other members of the Plan. These separate premium rates shall include rate factors for incurred but unreported claim costs, for the effects of adverse selection from voluntary participation in the Plan, and for any other actuarially determined measures needed to protect the financial integrity of the Plan for the benefit of its served employees, retired employees, and their eligible dependents.

"Part 6. Long-term Care Benefits.

"§ 135-48.60. Undertaking.

(a) The State of North Carolina undertakes to make available an optional program of long-term care benefits for the benefit of its qualified employees, retired employees and their dependents which will pay benefits in accordance with the terms hereof. Retired employees of the Local Governmental Employees' Retirement System pursuant to Article 3 of Chapter 128 of the General Statutes and their dependents are also eligible to be qualified for the benefits provided by this Part.

(b) The long-term care benefits provided by this Part shall be made available through the State Health Plan for Teachers and State Employees pursuant to ~~Article~~ Articles 2 and ~~3A~~ 3B of this Chapter (hereinafter called the "Plan") and administered by the ~~Plan's Executive Administrator and Board of Trustees.~~ State Treasurer. In administering the benefits provided by this Part, the ~~Executive Administrator and Board of Trustees~~ State Treasurer shall have the same type of powers and duties that are provided under ~~Part 3~~ the other Parts of this Article for hospital and medical benefits. The benefits provided by this Part may be offered by the Plan on a self-insured basis, in which case a third-party claims processor shall be chosen through competitive bids, or through a contract of insurance, in which case a carrier licensed to do

business in North Carolina shall be selected on a competitive bid basis in accordance with State law.

(c) The benefits authorized by this Part are available only to qualified employees and retired employees who voluntarily elect to provide such benefits for themselves and their qualified dependents. Payroll deductions shall be available from employee salary and disability benefit payments and from retired employee retirement benefit payments for fully contributory premium amounts.

(d) The ~~Executive Administrator and Board of Trustees of the Plan~~ State Treasurer shall insure insofar as possible that the long-term care benefits provided by this Part shall be tax-qualified under federal law.

"**§ 135-48.61. Long-term care benefits.**

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

(1) Adult care facility. – A facility which (i) is operated under State law to provide group care for the aged and disabled in a setting away from their residence on a less than 24-hour basis when such aged or disabled would otherwise be in need of full-time personal care away from their residence; or (ii) meets the requirements for certification under Chapter 131D of the General Statutes.

(2) Assisted living facility. – A facility which (i) is operated under State law to provide residential care for the aged or disabled whose principal need is a home which provides personal care appropriate to their age or disability; or (ii) meets the requirements for licensure under Chapter 131D of the General Statutes.

(3) Home care agency. – A residential care agency which is (i) operated under State law and which is qualified as a home health care agency under Medicare; or (ii) an agency meeting the requirements for licensure as a home care agency under Chapter 131E of the General Statutes.

(4) Nursing home. – A facility or a part of a facility which is (i) operated under State law and which is qualified as a skilled nursing or intermediate nursing facility under Medicare; or is (ii) a facility meeting the requirements for licensure under Chapter 131E of the General Statutes.

(b) Long-term care benefits provided by this Part are subject to elimination periods, coinsurance provisions, and other limitations separate and apart from those provided for in ~~Part 3~~ the other Parts of this Article. No limitation on out-of-pocket expenses are provided for the benefits covered by this section. Long-term care benefits are as follows:

(1) Nursing Home Benefits. – The Plan will pay a fixed amount of the reasonable and customary daily charges allowed for nursing facilities providing skilled nursing care and intermediate nursing care up to a maximum amount per day for each day after a fixed number of consecutive days for each nursing home stay. Such daily charges shall be inclusive of semiprivate room and board; skilled and semiskilled nursing services; routine laboratory tests and examinations; physical, occupational, and speech therapy; respiratory and other gas therapy; and drugs, injections, biologicals, fluids, solutions, dietary aids and supplements, and other routine medical supplies and equipment. Readmission to a nursing home within 180 days, exclusive of hospital stays, for the same or related cause or causes shall be considered a single nursing home stay for the purposes of this section. Benefits payable under this subdivision are contingent upon compliance with the following conditions and will, in no instance, be paid under this section without compliance with each of the following conditions:

a. Confinement to a nursing home is medically appropriate due to an illness, disease, or injury upon recommendation of an admitting physician other than a proprietor, employee, or agent of the nursing home;
b. Confinement to a nursing home is for any overnight stay for which a charge for a day's stay is due and payable; and
c. Prior to confinement, the admitting physician secures approval certification from the Plan for confinement.

~~As used in this section, a nursing home is a facility or a part of a facility which is (i) operated under State law and which is qualified as a skilled nursing or intermediate nursing facility under Medicare; or is (ii) a facility meeting the requirements for licensure under Chapter 131E of the General Statutes.~~

(2) Custodial Benefits. – The Plan will pay a fixed percentage of the fixed amount of reasonable and customary daily charges allowed by the Plan in subdivision (1) of this section for assisted living facilities, for adult day care facilities, and for home care agencies up to a maximum amount per day for each day after a fixed number of consecutive days that such custodial care is provided. Benefits payable under this subdivision are contingent upon compliance with the following conditions and will, in no instance, be paid under this subdivision without compliance with each of the following conditions:
a. Use of such custodial benefits is medically appropriate in a treatment plan established and certified initially and at least once every six months by an attending physician or other allied health professionals other than a proprietor, employee, or agent of one or more of the aforementioned facilities and agencies;
b. Confinement to a nursing home would be medically appropriate without custodial care proposed to be rendered by one or more of the aforementioned facilities or agencies; and
c. Prior to use of such custodial benefits, an attending physician or other allied health professional secures approval from the Plan for the use of the benefits.

~~As used in this section, an assisted living facility is a facility which (i) is operated under State law to provide residential care for the aged or disabled whose principal need is a home which provides personal care appropriate to their age or disability; or (ii) meets the requirements for licensure under Chapter 131D of the General Statutes. As used in this section, an adult care facility is a facility which (i) is operated under State law to provide group care for the aged and disabled in a setting away from their residence on a less than 24 hour basis when such aged or disabled would otherwise be in need of full-time personal care away from their residence; or (ii) meets the requirements for certification under Chapter 131D of the General Statutes. As used in this section, a home care agency is a residential care agency which is (i) operated under State law and which is qualified as a home health care agency under Medicare; or (ii) an agency meeting the requirements for licensure as a home care agency under Chapter 131E of the General Statutes.~~

(3) Other Benefits. – Upon prior approval of the Plan, other care, services, supplies, and equipment may be used as more cost-effective alternatives to the benefits provided by this section when directed by an attending physician.

(4) The Executive Administrator and Board of Trustees of the Plan shall establish the payment percentages, maximum daily payment rates, benefit periods, elimination periods, and maximum lifetime benefits payable for

each covered individual for the nursing home and custodial benefits provided by this section. The Executive Administrator and Board of Trustees shall provide for inflationary increases in the maximum daily payment rates and the maximum lifetime benefits payable for each covered individual.

(5) The ~~Executive Administrator and Board of Trustees of the~~ Plan shall provide a bed reservation benefit whenever Plan members are hospitalized during a stay in a nursing home or an assisted living facility.

(6) The ~~Executive Administrator and Board of Trustees of the~~ Plan shall provide for a waiver of premiums involving minimum lengths of stay in a nursing home or an assisted living facility. In addition, the Executive Administrator and Board of Trustees shall allow coverage to be reinstated upon failure to pay premiums, provided certain grace periods are not exceeded and retroactive premium payments are made.

(7) Limitations and Exclusions to Long-Term Care Benefits. – The benefits provided by this section are for the purpose of meeting the requirements for assistance from the loss of functional capacity associated with a chronic illness, disease, or disabling injury for extended periods of time; and are, in no way, intended to duplicate the benefits provided for acute and other medical care provided by Medicare or Part 3 of this Article. A loss of functional capacity can occur from: (i) an illness, disease, or disabling injury resulting in a physical incapacity to perform the activities of daily living; or (ii) an irreversible organic mental impairment resulting in a mental incapacity. Activities of daily living consist of routine functions involving personal care and mobility.

"**§ 135-48.62. Conversion.**

Upon cessation of group coverage under this Part, an employee, retired employee, or dependent shall be entitled to a conversion to a nongroup plan of long-term care benefits. The Executive Administrator and Board of Trustees of the Plan shall determine how the conversion rights authorized by this Part shall be administered."

MISCELLANEOUS CHANGES

SECTION 2.11.(a) G.S. 150B-1(d)(7) reads as rewritten:

"(7) The State Health Plan for Teachers and State Employees in administering the provisions of ~~Article 3A~~ Article 3B of Chapter 135 of the General Statutes."

SECTION 2.11.(b) Sections 1.2 and 1.3(a) of this act are repealed.

STATEMENT OF LEGISLATIVE INTENT REGARDING REPEAL OF LANGUAGE

SECTION 2.12. In repealing a specific, detailed provision of Article 3A of Chapter 135 of the General Statutes and not placing that detailed provision into Article 3B of Chapter 135 of the General Statutes, it is not necessarily the intent of the General Assembly to prohibit the State Treasurer or the State Health Plan from having that authority.

CARRYOVER OF RULES AND POLICIES

SECTION 2.13. Rules and policies adopted by the Executive Administrator and the Board of Trustees prior to the effective date of this section shall continue to be in effect unless the rule or policy directly conflicts with a provision of Article 3B of Chapter 135 of the General Statutes or until the State Treasurer changes the rule or policy.

EFFECTIVE DATE FOR PART II

SECTION 2.14. Except as otherwise provided, Part II of this act becomes effective January 1, 2012.

PART III. MISCELLANEOUS PROVISIONS

EFFECT OF HEADINGS

SECTION 3.1. The headings to the parts and sections of this act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of this act, except for effective dates referring to a part.

EFFECTIVE DATE

SECTION 3.2. Except as otherwise provided, the remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: Proposed Committee Substitute to Senate Bill 323 [S323-PCS85171-ME-14]

SHORT TITLE: State Health Plan/Appropriations & Transfer II

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: House Proposed Committee Substitute 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 proposed bill also moves the Plan under the Department of State Treasurer via a Type II transfer, provides the State Treasurer with the power to appoint or remove the Plan's Executive Administrator, and generally gives the State Treasurer broad authority over the operation of the Plan.

EFFECTIVE DATE: Section 1.9 becomes effective when it becomes law. Section 1.10(a) becomes effective July 1, 2010. All other sections of Part I become effective July 1, 2011. Section 2.1 becomes effective when it becomes law. All other sections of Part II become effective January 1, 2012.

ESTIMATED IMPACT ON STATE:

2011-13 Biennium

Increased Premium Contributions

Appropriated Funds

Sections 1.1(a), (b), and (c) appropriate the estimated required funds to support increased employer contributions to the Plan for the 2011-13 biennium. These appropriations are based on increased employer contribution rates derived from an annual 5.2 % premium increase in total premium rates for the fiscal year beginning July 1, 2011, and an additional annual premium increase of 5.2% for the fiscal year beginning July 1, 2012. The table below reflects the allocation of appropriated funds by fund source:

Additional Employer Contributions Appropriated Funds			
Fund Source	**FY 2011-12**	**FY 2012-13**	**Biennium**
General Fund	$8,061,798	$101,782,670	$109,844,468
Highway Fund	$376,217	$4,749,858	$5,126,075
Other Funds	$1,663,159	$20,997,887	$22,661,046
Total	$10,101,174	$127,530,415	$137,631,589

Employee Funds

Section 1.2(a) of the bill establishes new monthly contribution rates for active employees in the Basic 70/30 plan and the Standard 80/20 plan options, and for retired employees enrolled in the Standard 80/20 plan. There is no monthly contribution required for retired employees enrolled in the Basic 70/30 plan option. A summary of the most common estimated monthly contribution rates are reflected below:

Employee & Retired Employee Contribution Rates for Own Coverage				
	FY 2011-12		FY 2012-13	
	Basic 70/30	Standard 80/20	Basic 70/30	Standard 80/20
Employeee Contribution				
Non-Medicare Eligible Medicare Secondary	$10.86	$21.72	$11.43	$22.85
Medicare Primary	$8.27	$16.54	$8.70	$17.40
Retiree Contribution				
Non-Medicare Eligible	$0.00	$21.72	$0.00	$22.85
Medicare Eligible	$0.00	$16.54	$0.00	$17.40

Section 1.2(b) of the bill authorizes an annual 5.2% premium increase in contributory premium rates for dependent coverage for the fiscal year beginning July 1, 2011, and an additional annual premium increase of 5.2% for the fiscal year beginning July 1, 2012.

The estimated additional premium contributions from these collective changes in Section 1.2 are listed below:

Additional Member Contributions			
Coverage Category	**FY 2011-12**	**FY 2012-13**	**Biennium**
Contributions for Employee Coverage	$79,744,912	$83,086,125	$162,831,036
Contributions for Retiree Coverage	$27,598,650	$29,324,999	$56,923,650
Contributions for Dependent Coverage	$22,035,960	$44,933,201	$66,969,161
Total	$129,379,522	$157,344,325	$286,723,847

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 2011-13 biennium as a result of the authorized premium rate increase:

Total Additonal Premium Contributions From Appropriated and Employee/Retiree Paid Funds			
Fund Source	**FY 2011-12**	**FY 2012-13**	**Biennium**
Appropriated			
General Fund	$8,061,798	$101,782,670	$109,844,468
Highway Fund	$376,217	$4,749,858	$5,126,075
Other Funds	$1,663,159	$20,997,887	$22,661,046
Sub-total	$10,101,174	$127,530,415	$137,631,589
Member Contributions			
Contributions for Employee Coverage	$79,744,912	$83,086,125	$162,831,036
Contributions for Retiree Coverage	$27,598,650	$29,324,999	$56,923,650
Contributions for Dependent Coverage	$22,035,960	$44,933,201	$66,969,161
Sub-total	$129,379,522	$157,344,325	$286,723,847
Total	$139,480,696	$284,874,740	$424,355,436

Financial Savings for the 2011-13 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 authorized increases in plan member out-of-pocket requirements and other changes that are estimated to affect the financial condition of the Plan. A summary of the authorized changes are described below including the estimated actuarial impact of these changes.

Sections 1.3(a)(1), (a)(2) and (b) of the bill authorize various increases in plan member out-of-pocket requirements to include increased annual deductibles and annual co-insurance maximums, increased office visit co-pays and increased outpatient prescription drug co-pays.

The in-network out-of-pocket changes for medical and pharmacy benefit related services are summarized in the table below:

	Basic 70/30		Standard 80/20	
	Current	New	Current	New
Medical Benefits				
Plan Member Co-pays (per visit)				
Primary Care	$30	$35	$25	$30
Mid-Tier	$55	$64	$45	$52
Specialty Care	$70	$81	$60	$70
Urgent Care	$75	$87	$75	$87
Inpatient Hospital	$250	$291	$200	$233
Emergency Room	$250	$291	$200	$233
Annual Deductible (Individual)				
In-network	$800	$933	$600	$700
Out-of-network	$1,600	$1,866	$1,200	$1,400
Coinsurance Maximum (Individual)				
In-network	$3,250	$3,793	$2,750	$3,210
Out-of-network	$6,500	$7,586	$5,500	$6,420
Pharmacy Benefits				
Generic (copay)	$10	No change	$10	No change
Preferred Brand (copay)	$35	$40	$35	$40
Non-preferred Brand (copay)	$55	$64	$55	$64

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

Aon Consulting
Projected Financial Savings
Increasing Out-of-Pocket Limits

Category	FY 2011-12	FY 2012-13	Biennium
Medical Benefits	$43,657,837	$48,670,256	$92,328,093
Pharmacy Benefits	$17,302,875	$19,998,817	$37,301,692
Total	$60,960,712	$68,669,073	$129,629,785

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

Hartman & Associates
Projected Financial Savings
Increasing Out-of-Pocket Limits

Category	FY 2011-12	FY 2012-13	Biennium
Medical Benefits	$44,506,165	$53,115,895	$97,622,060
Pharmacy Benefits	$14,829,123	$14,651,174	$29,480,297
Total	$59,335,288	$67,767,069	$127,102,357

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

Total Projected Financial Savings From Increasing Out-of-Pocket Limits (By Type)

	Aon Consulting (Plan)			Hartman & Assoc. (General Assembly)		
Category	FY 2011-12	FY 2012-13	Biennium	FY 2011-12	FY 2012-13	Biennium
Medical Benefits						
Primary Care Co-pay (Increase)	$6,650,120	$7,454,181	$14,104,301	$7,036,512	$8,026,021	$15,062,533
Mid-tier Specialty Co-pay (Increase)	$2,869,525	$3,216,476	$6,086,001	$2,989,322	$3,409,696	$6,399,018
Specialist Co-pay (Increase)	$7,903,492	$8,859,097	$16,762,589	$8,099,385	$9,440,846	$17,540,231
Urgent Care Co-pay (Increase)	$452,746	$507,488	$960,234	$496,656	$571,464	$1,068,120
Inpatient Co-pay (Increase)	$1,321,982	$1,481,822	$2,803,804	$1,391,786	$1,587,505	$2,979,291
Emergency Room Co-pay (Increase)	$2,203,033	$2,469,400	$4,672,433	$2,326,070	$2,653,172	$4,979,242
Deductible and Coinsurance Max (Increase)	$22,256,937	$24,681,793	$46,938,730	$22,166,434	$27,427,191	$49,593,625
Sub-total	$43,657,835	$48,670,257	$92,328,092	$44,506,165	$53,115,895	$97,622,060
Outpatient Prescription Drugs (acute drugs)						
Brand Drug Co-pay (Increase)	$10,921,107	$12,523,397	$23,444,504	$8,358,944	$8,258,637	$16,617,581
Non-Preferred Brand Drug Co-pay (Increase)	$6,381,768	$7,475,419	$13,857,187	$6,470,179	$6,392,537	$12,862,716
Sub-total	$17,302,875	$19,998,816	$37,301,691	$14,829,123	$14,651,174	$29,480,297
Grand Total	$60,960,710	$68,669,073	$129,629,783	$59,335,288	$67,767,069	$127,102,357

Other Changes Affecting the Plan

Section 1.5 repeals the "Comprehensive Wellness Initiative" authorized originally under Session Law 2009-16. The Plan's consulting actuary has incorporated the increased financial cost of the program's repeal into the overall actuarial cost projection for the changes proposed in the bill, by assuming approximately 95% of employee or retiree contracts, that involve a plan member who is a tobacco-user and currently enrolled in the Basic 70/30 plan per the requirement of the Comprehensive Wellness Initiative, will migrate back to the Standard 80/20 plan in the absence of the requirement. The Plan's consulting actuary estimates by fiscal year the increased financial impact to the Plan for the 2011-13 biennium:

	FY 2011-12	FY 2012-13	Biennium
Repeal Comprehensive Wellness Initiative	$18.4M	$26.0M	$44.4M

Since the weight management component of the Comprehensive Wellness Initiative would not be implemented prior to the repeal date of the program, no actuarial cost impact was expected.

Section 1.6 amends current statutory language under G.S. 135-45 to allow implementation of monthly premium contribution rates to be paid by employees and certain retired employees for their own coverage under the Plan.

Section 1.7 amends G.S. 135-45.1 to conform to requirements under the federal Affordable Care Act requiring coverage to be offered to dependent children to age 26 without requiring the dependent to be a full-time student.

Section 1.8 is a boilerplate provision used to set specific employer contribution amounts paid by State agencies and departments, universities, local public schools, and local community colleges to fund health benefit coverage for employees, and percentage-based payroll contributions paid to the Retiree Health Benefit Fund to finance premiums paid by the Retirement Systems Division of the Department of State Treasurer on behalf of retired employees.

Annual Employer Contributions

	Basic 70/30		Standard 80/20	
I. Employees & Retirees	FY 2011-12	FY 2012-13	FY 2011-12	FY 2012-13
Employees	$4,952	$5,211	$4,952	$5,211
Non-Medicare Retiree	$4,952	$5,211	$4,952	$5,211
Medicare Retiree	$3,768	$3,965	$3,768	$3,965
II. Retiree Health Benefit Fund	FY 2011-12	FY 2012-13		
Payroll Contribution Rate	5.0%	5.3%		

Section 1.9 amends G.S. 135-45(b) to make the protection of trade secrets in State Health Plan contracts consistent with the general trade secret protection for all public agency contracts.

Section 1.10(a) amends G.S. 135-44.4(18) to allow the Plan to authorize benefit coverage or payment of claims on behalf of a plan member that have been denied as a result of administrative errors or system issues. Section 1.10(b) makes the amended change effective July 1, 2010.

Section 1.10(c) amends G.S. 135-45.1(15) to require Health Benefits Representatives to enroll employees and dependents in accordance with the Plan's eligibility requirements.

Section 2 of the bill (Part II), which transfers the Plan to the Department of State Treasurer, and provides the State Treasurer with broad authority over the Plan, is not estimated to have any financial impact on the Plan.

Reconciliation of Plan's Projected Financial Requirements for the 2011-13 Biennium

For the new biennium beginning July 1, 2011 the Plan is estimated to require over $515.5 million in additional financial support to remain solvent and maintain current benefit levels and minimum claim stabilization reserves. This estimate assumes the Plan will experience a 9.5% per capita claims trend, continued implementation of the Comprehensive Wellness Initiative, extending coverage to dependent children to age 26 per the requirements of the federal Affordable Care Act, receiving $25.6 million in Early Retiree Reinsurance Program as authorized by the federal Affordable Care Act, maintaining "grandfather" status per the federal Affordable Care Act, achieving an additional $151 million in pharmacy cost savings over the biennium through a new pharmacy benefit management contract effective October 1, 2011, and implementing an estimated 6.3% premium increase on July 1, 2011 and again on July 1, 2012.

The bill addresses the projected shortfall described above by authorizing the following changes:

1. Authorizing a 5.2% annual premium increase on July 1 of each fiscal year of the biennium for total premium rates;

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

3. Establishing new monthly contribution rates for active employees in the Basic 70/30 plan and the Standard 80/20 plan options and for retired employees enrolled in the Standard 80/20 plan. There is no monthly contribution required for retired employees enrolled in the Basic 70/30 plan option.

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 2011-13 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[1,2]

Senate Bill 323 (Proposed House Committee Substitute)

($ Million)

	FY 2011-12	FY 2012-13	Biennium
1) Projected Financial Support Required	$168.8	$346.7	$515.5
2) Benefit Reductions (Changes in Out-of-Pocket Amounts) Effective July 1, 2011			
Medical			
Primary Care Co-pay (Increase)	($6.7)	($7.5)	($14.1)
Mid-tier Specialist Co-pay (Increase)	($2.9)	($3.2)	($6.1)
Specialist Co-pay (Increase)	($7.9)	($8.9)	($16.8)
Urgent Care Co-pay (Increase)	($0.5)	($0.5)	($1.0)
Inpatient Co-pay (Increase)	($1.3)	($1.5)	($2.8)
Emergency Room Co-pay (Increase)	($2.2)	($2.5)	($4.7)
Deductible and Coinsurance Maximum (Increase)	($22.3)	($24.7)	($46.9)
Sub-total	($43.7)	($48.7)	($92.3)
Outpatient Acute and Specialty Prescription Drugs			
Brand Drug Co-pay (Increase)	($10.9)	($12.5)	($23.4)
Non-Preferred Brand Drug Co-pay (Increase)	($6.4)	($7.5)	($13.9)
Sub-total	($17.3)	($20.0)	($37.3)
Total -- Benefit Reductions	($61.0)	($68.7)	($129.6)
3) Appropriations by the General Assembly			
Premium increase for Employing Agencies			
General Fund	($8.1)	($101.8)	($109.8)
Highway Fund	($0.4)	($4.7)	($5.1)
Other Employer Funds	($1.7)	($21.0)	($22.7)
Total Additional Employer Funds	($10.1)	($127.5)	($137.6)
4) Premium increases paid by Employees and Retirees			
Paid for Employee's Own Coverage	($79.7)	($83.1)	($162.8)
Paid for Retiree's Own Coverage	($27.6)	($29.3)	($56.9)
Paid for Spouses and Dependent Children	($22.0)	($44.9)	($67.0)
Total Employee Additional Funds	($129.4)	($157.3)	($286.7)
5) Net Financial Effect of Member Migration Between Plan Options	$17.0	$25.2	$42.2
6) Balance	($14.6)	$18.4	$3.7

Notes:

[1] The $3.7 million balance remaining at the end of the biennium (see Item 6) is a product of rounding error and a difference in projected ending cash balances between baseline financial projections and final projections after the authorized premium increases, benefit changes, and other program changes. This difference is not expected to have an adverse effect on the Plan's finances.

[2]The $42.2 million in financial costs to the Plan (see Item 5) reflects mostly the predicted effect of certain plan members currently enrolled in the Basic 70/30 plan migrating back to the Standard 80/20 plan to receive lower out-of-pocket requirements. This assumption is due to the repeal of the requirement under the current Comprehensive

Wellness Initiative for a plan member to enroll in the Basic 70/30 plan if that plan member is a tobacco-user who declines to participate in tobacco use cessation programs to maintain eligibility for the Standard 80/20 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.

Premium contributions rates and estimates of aggregate collections, projected claims expenditures, estimated administrative expenditures, projections of enrollment migration between the Basic 70/30 plan and the Standard 80/20 plan, effects due to the repeal of the Comprehensive Wellness initiative, and other financial impacts on the Plan were estimated by the Plan's consulting actuary for the purposes of this Legislative Actuarial Note.

General Assumption Highlights

The following items represent key assumptions used with respect to predicting the Plan's financial requirements for the 2011-13 biennium:

1. The Plan will maintain "grandfather' status under the federal Affordable Care Act. To maintain grandfather status under the federal guidelines, premium contributions for an employee or retired employee's own coverage cannot exceed 5% of the premium cost. In addition, the out-of-pocket limits cannot increase by more than 15% plus the rate of medical inflation in FY 2011-12, and by the rate of medical inflation in FY 2012-13. For the purposes increasing out-of-pocket limits in the bill, FY 2011-12, the rate of increase was 16.7% which is calculated by using a medical inflation rate of 1.7% plus the aforementioned 15% one-time adjustment. There was no adjustment made for the FY 2012-13.
2. The Plan will achieve $151 million in additional savings over the 2011-13 biennium on pharmacy related claims and administrative costs over current costs. These savings are estimated due to the implementation of a new pharmacy benefit management contract effective October 1, 2011.
3. The Plan will incur projected additional costs of $15.6 million in FY 2011-12 and $17.0 million in FY 2012-13 to provide dependent coverage to age 26 per the requirements of the federal Affordable Care Act.
4. The Plan will collect $45.1 million in FY 2010-11, and $25.6 million in FY 2011-12 in Early Retiree Reinsurance Program funds authorized under the federal Affordable Care Act.
5. Approximately 95% of employee or retiree contracts, that involve a plan member who is a tobacco-user and currently enrolled in the Basic 70/30 plan per the requirement of the Comprehensive Wellness Initiative, will migrate back to the Standard 80/20 plan in the absence of the requirement. An estimated 25% of retiree only contracts in the Standard 80/20 plan are expected to migrate to the Basic 70/30 plan to avoid paying a monthly premium contribution charged to retired employees in the Standard 80/20 plan. It is estimated that 5% of employee only contracts and contracts covering dependents in the Standard 80/20 plan will migrate to the Basic 70/30 plan to reduce their amount of monthly premium contribution paid. It is generally assumed that plan members will migrate to the plan option that will most benefit them economically based on their relative need for medical services.

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.

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 $2.90 billion for FY 2011-12 and $3.08 billion for FY 2012-13. 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.

The following table provides a summary of most monthly premium rates for the Plan in FY 2010-11:

	Basic 70/30		Standard 80/20	
Coverage Type	Employee/ Retiree	Employer	Employee/ Retiree	Employer
Non-Medicare Active Employee/Retiree				
Employee	$0.00	$410.80	$0.00	$410.80
Employee + Child(ren)	$178.68	$410.80	$237.62	$410.80
Employee + Spouse	$460.36	$410.80	$547.48	$410.80
Employee + Family	$490.34	$410.80	$580.44	$410.80
Medicare Primary for Only Employee/Retiree				
Employee	$0.00	$312.76	$0.00	$312.76
Employee + Child(ren)	$187.60	$312.76	$237.62	$312.76
Employee + Spouse	$469.28	$312.76	$547.48	$312.76
Employee + Family	$499.26	$312.76	$580.44	$312.76

The employer share of premiums for retirees is paid from the Retiree Health Benefit Fund. During FY 2010-11, employers contribute 4.9% of active employee payroll into the Fund. Total contributions for the year are projected to be approximately $721 million.

Financial Condition

Current and Projected Results for 2009-11 Biennium – The following summarizes actual financial results for FY 2009-10 and projected financial results for FY 2010-11, based on financial experience through December, 2010.

	($ millions) Actual FY 2009-10	Projected FY 2010-11
Beginning Cash Balance	$189.9	$121.5
Receipts:		
Net Premium Collections	$2,412.6	$2,677.4
Early Retirement Reinsurance Program	$0.0	$45.0
Medicare Part D Subsidies	$74.4	$60.5
Investment Earnings	$3.5	$2.4
Total	$2,490.5	$2,785.3
Disbursements:		
Net Medical Claim Payment Expenses	$1,797.5	$1,860.5
Net Pharmacy Claim Payment Expenses	$596.7	$647.7
Administration and Claims-Processing Expenses	$164.6	$171.7
Total	$2,558.9	$2,679.9
Net Operating Income (Loss)	($68.4)	$105.4

Financial Projection 2011-13 Biennium – The following summarizes a financial projection conducted by the Plan's consulting actuary, Aon Consulting, for the 2011-13 biennium. The information is provided by fiscal year based on year-to-date financial experience (through December 2010) and other updated factors. The projection assumes a 9.5% annual claims growth trend, that benefit provisions remain the same, and that both employer and member-paid premiums are increased by 6.3% effective July 1, 2011 and July 1, 2012.

	($ millions) Projected FY 2011-12	Projected FY 2012-13
Beginning Cash Balance	$226.8	$239.0
Receipts:		
Net Premium Collections	$2,829.0	$2,995.2
Early Retirement Reinsurance Program	$25.6	$0.0
Medicare Part D Subsidies	$60.1	$62.6
Investment Earnings	$2.3	$2.5
Total	$2,917.0	$3,060.3
Disbursements:		
Net Medical Claim Payment Expenses	$2,065.1	$2,199.0
Net Pharmacy Claim Payment Expenses	$659.2	$699.4
Administration and Claims-Processing Expenses	$180.5	$183.6
Total	$2,904.8	$3,082.0
Net Operating Income (Loss)	$12.2	($21.7)

This projection incorporates $151 million in projected savings over the biennium from a new Pharmacy Benefit Manager (PBM) contract to be effective October 1, 2011. It assumes that the Plan maintains "grandfathered" status under the federal Affordable Care Act (ACA). It assumes the Plan experiences an increase of $33 million in claims over the biennium due to requirements in the ACA to cover additional dependents.

Other Information

In the 2009-11 biennium, the annual premium increases were applied at the beginning of each fiscal year of the biennium. Historically, the Plan had applied a premium increase in October of the first fiscal year of a 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 9.5% annually according to the Plan's consulting actuary. Investment earnings are based upon a 1.0% return on available cash balances. The active population is projected to decline by 1% per year, the COBRA population is projected to remain constant, and the retired population is projected to increase by 1% per year.

Enrollment by Category Type

State Health Plan Enrollment as of December 31, 2010

I. No. of Participants	Basic	Standard	Total	Percent of Total
Actives				
Employees	65,849	256,468	322,317	48.6%
Dependents	50,588	105,759	156,347	23.6%
Sub-total	116,437	362,227	478,664	72.2%
Retired				
Employees	16,429	143,764	160,193	24.2%
Dependents	4,352	14,173	18,525	2.8%
Sub-total	20,781	157,937	178,718	26.9%
Former Employees with Continuation Coverage				
Employees	1,014	1,237	2,251	0.3%
Dependents	403	347	750	0.1%
Sub-total	1,417	1,584	3,001	0.5%
Firefighters, Rescue Squad & National Guard				
Employees	2	3	5	0.0%
Dependents	1	2	3	0.0%
Sub-total	3	5	8	0.0%
Local Governments				
Employees	486	1,429	1,915	0.3%
Dependents	303	629	932	0.1%
Sub-total	789	2,058	2,847	0.4%
Total				
Employees	83,780	402,901	486,681	73.4%
Dependents	55,647	120,910	176,557	26.6%
Grand Total	**139,427**	**523,811**	**663,238**	**100%**
Percent of Total	**21.0%**	**79.0%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Total
Employee Only	55,472	335,154	390,626
Employee Child(ren)	13,817	36,176	49,993
Employee Spouse	5,719	17,462	23,181
Employee Family	8,772	14,109	22,881
Total	**83,780**	**402,901**	**486,681**

Percent Enrollment by Contract	Basic	Standard	Total
Employee Only	66.2%	83.2%	80.3%
Employee Child(ren)	16.5%	9.0%	10.3%
Employee Spouse	6.8%	4.3%	4.8%
Employee Family	10.5%	3.5%	4.7%
Total	**100.0%**	**100.0%**	**100.0%**

III. Enrollment by Sex	Basic	Standard	Total
Female	75,627	338,703	414,330
Male	63,800	185,108	248,908
Total	**139,427**	**523,811**	**663,238**

Percent Enrollment by Sex	Basic	Standard	Total
Female	54.2%	64.7%	62.5%
Male	45.8%	35.3%	37.5%
Total	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Total
19 & Under	35,455	74,859	110,314
20 to 29	12,915	46,222	59,137
30 to 44	31,582	98,133	129,715
45 to 54	27,089	85,600	112,689
55 to 64	29,854	106,470	136,324
65 & Over	2,532	112,527	115,059
Total	**139,427**	**523,811**	**663,238**

Percent Enrollment by Age	Basic	Standard	Total
19 & Under	25.4%	14.3%	16.6%
20 to 29	9.3%	8.8%	8.9%
30 to 44	22.7%	18.7%	19.6%
45 to 54	19.4%	16.3%	17.0%
55 to 64	21.4%	20.3%	20.6%
65 & Over	1.8%	21.5%	17.3%
Total	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	53,034	11,292	64,326
Medicare Eligible	107,159	7,233	114,392
Total	**160,193**	**18,525**	178,718

Percent Enrollment by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.1%	61.0%	36.0%
Medicare Eligible	66.9%	39.0%	64.0%
Total	**100.0%**	**100.0%**	100.0%

VI. Enrollment By Major Employer Groups	Employees	Dependents	Total
State Agencies	75,779	33,151	108,930
UNC System	50,357	29,457	79,814
Local Public Schools	180,864	86,046	266,910
Local Community Colleges	15,317	7,693	23,010
Other			
Local Governments	1,915	932	2,847
COBRA	2,251	750	3,001
Nat. Guard, Fire & Rescue	5	3	8
Sub-total	326,488	158,032	484,520
Retirement System	160,193	18,525	178,718
Total	**486,681**	**176,557**	**663,238**

Percent Enrollment by Major Employer Groups	Employees	Dependents	Total
State Agencies	15.6%	18.8%	16.4%
UNC System	10.3%	16.7%	12.0%
Local Public Schools	37.2%	48.7%	40.2%
Local Community Colleges	3.1%	4.4%	3.5%
Other			
Local Governments	0.4%	0.5%	0.4%
COBRA	0.5%	0.4%	0.5%
Nat. Guard, Fire & Rescue	0.0%	0.0%	0.0%
Sub-total	67.1%	89.5%	73.1%
Retirement System	32.9%	10.5%	26.9%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

Aon Consulting, North Carolina State Health Plan, Financial Projections – January 2011, Total for All Plans – 9.5% Trend with Risk Adjustment, with PBM Contract Savings, February 4, 2011.

Aon Consulting, North Carolina State Health Plan, Financial Projections – January 2011 – 14b ($10 Generic), Total for All Plans – 9.5% Trend with Risk Adjustment, with Max GF Benefits except $10 Generic, with PBM Contract Savings, Additional Premium Charged to All Tiers – Active 5% Standard, 2.5% Basic; Retiree 5% Standard, 0% Basic ($5 less for Medicare) Non-Smoker Movement: Active 5% single, 5% dependents; Retiree: 25%, 5% dependents, March 14, 2011.

Aon Consulting, North Carolina State Health Plan, Financial Projections – January 2011 – 14b ($10 Generic), Total for All Plans – 9.5% Trend with Risk Adjustment, with Max GF Benefits except $10 Generic, with PBM Contract Savings, Additional Premium Charged to All Tiers – Active 5% Standard, 2.5% Basic; Retiree 5% Standard, 0% Basic ($5 less for Medicare) Non-Smoker Movement: Active 5% single, 5% dependents; Retiree: 25%, 5% dependents, March 24, 2011. [For setting Monthly Employee Premium Contribution Rates].

Medco Health Solutions, various outpatient acute, specialty, and maintenance drug data and discount assumptions, December 2010.

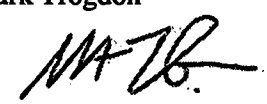
State Health Plan, various summarized claims reports for medical claims by category and purpose and time period, December 2010.

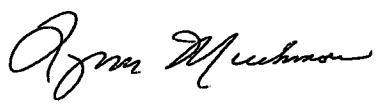
-Actuarial Note, Hartman & Associates, Senate Bill 323 PCS, "Senate Bill 323 Proposed Committee Substitute S323-PCS85171-ME-14: An Act to Make Appropriations and Adjustments for the 2011-13 Biennium to the state Health Plan and to Transfer the Plan to the Office of State Treasurer", April 19, 2011, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, Senate Bill 323 PCS, "Senate Bill 323 Proposed Committee Substitute S323-PCS85171-ME-14 State Health Plan/Appropriations and Transfer", April 19, 2011, 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:

Lynn Muchmore, Director
Fiscal Research Division

DATE: April 19, 2011

SENATE BILL 323:
State Hlth Plan/ Appropriations and Transfer II

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	April 18, 2011
Introduced by:	Sen. Apodaca	**Prepared by:**	Ryan Blackledge
Analysis of:	S323-PCS85171-ME-14		Staff Attorney

SUMMARY: ***The PCS for Senate Bill 323 contains the text of ratified Senate Bill 265, short title "State Health Plan/ Appropriations and Transfer," with an additional sentence in the powers and duties of the State Treasurer. The PCS also makes a technical change related to long-term care benefits.***

[As introduced, this bill was identical to H298, as introduced by Rep. Dockham, which is currently in House Insurance, if favorable, Finance.]

ANALYSIS OF CHANGE: G.S. 135-48.30(2), as it appeared in Senate Bill 265 and which would become effective January 1, 2012, if this PCS were to become law, grants the State Treasurer the power to "Set benefits, premium rates, co-pays, deductibles, and coinsurance maximums, subject to approval by the Board of Trustees." The PCS for Senate Bill 323 adds the following language after that sentence:

> "In setting premium rates, the Treasurer shall strive to maintain low premiums by finding savings in the operation of the Plan."

The PCS also makes technical changes related to long-term care benefits. The PCS for Senate Bill 265 that came out of House Insurance on March 28, 2011, contained the words "Long-term Care Benefits" in the title of the new Article 3B as well as two enumerated powers of the Treasurer to facilitate the provision of long-term care benefits. The PCS in House Appropriations on March 29, 2011, inadvertently did not include these changes, although it contained the Part on (and other references to) the provision of long-term care.

Summary of Senate Bill 265

(This summary was presented to House Appropriations on March 29, 2011, and is reproduced here for reference.)

SUMMARY: ***Senate Bill 265 provides funding for the State Health Plan for Teachers and State Employees for the 2011-2013 fiscal biennium; adjusts contributory coverage, deductibles, coinsurance, and co-payments; and transfers control and operation of the State Health Plan to the State Treasurer effective January 1, 2012.***

BACKGROUND: The State Health Plan for Teachers and State Employees (State Health 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.

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 $2.90 billion for FY 2011-12 and $3.08 billion for FY 2012-13. Enrollment in the State Health Plan as of December 31, 2010 was 663,238.

EFFECTIVE DATES: The PCS for SB 265 contains three Parts and the following effective dates: Sections 1-8 of Part I become effective July 1, 2011, Section 9 of Part I becomes effective when it becomes law; Section 2.1 of Part II becomes effective when it becomes law, the remainder of Part II becomes effective January 1, 2012; Part III provides that the remainder of the act is effective when it becomes law.

BILL ANALYSIS:

Part I. Appropriations and Contributions for 2011-2013 Fiscal Biennium

Section 1.1 appropriates funds for health benefit coverage for eligible employees and retirees notwithstanding the appropriations bill order process outlined by law (G.S. 143C-5-2). The appropriations are made to the Reserve for the State Health Plan in the Office of State Budget and Management for the 2011-2013 biennium and are allocated to employing units to pay the increase cost of coverage for the employer's share of the premium contribution charged by the State Health Plan for employee or retiree coverage:

Fund	FY 2011-12	FY 2012-13
General Fund Appropriation	$8,061,798	$101,782,670
Highway Fund Appropriation	$376,217	$4,749,858

Other agency funds to provide health benefit coverage, but not specifically listed, are also appropriated for the 2011-13 fiscal biennium.

Section 1.2 specifies monthly premium contribution rates. Section 1.2(a) provides the rates for the partially contributory coverage established in Section 1.6. The rates are provided in the chart below. Current rates have also been provided in the shaded portion.

	Current Basic (70/30) Plan	*FY 2011-12 Proposed* Basic (70/30) Plan	*FY 2012-13 Proposed* Basic (70/30) Plan	Current Standard (80/20) Plan	*FY 2011-12 Proposed* Standard (80/20) Plan	*FY 2012-13 Proposed* Standard (80/20) Plan
Employee Contribution	$0	$10.86	$11.43	$0	$21.72	$22.85
Retiree (Non-Medicare) Contribution	$0	$0	$0	$0	$21.72	$22.85
Retiree (Medicare) Contribution	$0	$0	$0	$0	$16.72	$17.59

Section 1.2(b) establishes an increase in the premium rates for contributory coverage. G.S. 135-44.6 requires the Executive Administrator and Board of Trustees to recommend premium rate adjustments to the General Assembly. This section of the bill establishes a 5.2% premium rate increase for contributory coverage for FY 2011-12, and an additional 5.2% premium rate increase for contributory coverage for FY 2012-13.

Estimates of Select Rate Increases: The following information provides estimates of premium rate increases for an employee or retiree to provide family coverage or coverage for children under the Basic and Standard Plans. *The chart does not represent estimated rate increases in all categories of coverage, it only provides for illustration purposes the current rates and estimated increased rates of two categories of coverage.*

Basic 70/30 Plan Illustration of Select Rates	Current 2010-11	Estimate of 2011-12 w/ 5.2% Increase	Estimate of 2012-13 w/ 5.2% Increase
Cost for Employee/Retiree to Cover Children*	$178.68	$187.97	$197.75
Cost for Employee/Retiree to Cover Family*	$490.34	$515.84	$542.66

Standard 80/20 Plan Illustration of Select Rates	Current 2010-11	Estimate of 2011-12 w/ 5.2% Increase	Estimate of 2012-13 w/ 5.2% Increase
Cost for Employee/Retiree to Cover Children*	$237.62	$249.98	$262.98
Cost for Employee/Retiree to Cover Family*	$580.44	$610.62	$642.38

*The chart does not include the cost of employee/retiree premium contribution increases if applicable.

Section 1.3 requires the Executive Administrator to make changes to deductibles, coinsurance, and co-payments effective July 1, 2011 for the Basic and Standard PPO Plans. The charts below provide those deductible, coinsurance and co-payment amounts. (For information purposes, current rates (effective on July 1, 2009) have been provided in the shaded portion of the chart.)

Basic 70/30	Current In-Network	2011-12 In-Network	Current Out-of-Network	2011-12 Out-of-Network
Annual Deductible	$800 Member Only $2,400 Family	$933 Member Only $2,799 Family	$1,600 Member Only $4,800 Family	$1,866 Member Only $5,598 Family
Coinsurance	$3,250 Member Only $9,750 Family	$3,793 Member Only $11,379 Family	$6,500 Member Only $19,500 Family	$7,586 Member Only $22,758 Family
Urgent Care Co-Payment	$75/Individual	$87/Individual	Same as in-network	Same as in-network
Primary Care Co-Payment	$30/Individual	$35/Individual	50% coinsurance after deductible	50% coinsurance after deductible
Specialist Co-Payment	$70/Individual	$81/Individual	50% coinsurance after deductible	50% coinsurance after deductible
Other Specialist Co-Payment [1]	$55/Individual	$64/Individual	50% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Co-Payment	$250/Individual	$291/Individual	$250/Individual	$291/Individual
Emergency Room Co-Payment	$250/Individual	$291/Individual	$250/Individual	$291/ Individual

Standard 80/20	Current In-Network	2011-12 In-Network	Current Out-of-Network	2011-12 Out-of-Network
Annual Deductible	$600 Member Only $1,800 Family	$700 Member Only $2,100 Family	$1,200 Member Only $3,600 Family	$1,400 Member Only $4,200 Family
Coinsurance	$2,750 Member Only $8,250 Family	$3,210 Member Only $9,630 Family	$5,500 Member Only $16,500 Family	$6,420 Member Only $19260 Family
Urgent Care Co-Payment	$75/Individual	$87/Individual	Same as in-network	Same as in-network
Primary Care Co-Payment	$25/Individual	$30/Individual	40% coinsurance after deductible	40% coinsurance after deductible
Specialist Co-Payment	$60/Individual	$70/Individual	40% coinsurance after deductible	40% coinsurance after deductible
Other Specialist Co-Payment [2]	$45/Individual	$52/Individual	40% Coinsurance after deductible	40% Coinsurance after deductible
Inpatient Co-Payment	$200/Individual	$233/Individual	$200/Individual	$233/Individual
Emergency Room Co-Payment	$200/Individual	$233/Individual	$200/Individual	$233/Individual

[1] Other Specialist Co-Payment Services Include: Mental Health, Substance Abuse, Chiropractic, Physical Therapy, Occupational Therapy, and Speech Therapy.

[2] Other Specialist Co-Payment Services Include: Mental Health, Substance Abuse, Chiropractic, Physical Therapy, Occupational Therapy, and Speech Therapy.

Section 1.3(b) amends G.S. 135-45.6(b)(1) to provide that the Plan will pay the allowable charges for each outpatient prescription drug minus the following copayments:

- $40 (currently $35) for each preferred branded prescription without a generic equivalent
- $64 (currently $55) for each nonpreferred branded prescription.

The $10 charge for generic prescriptions remains unchanged. Also unchanged is the requirement that for a branded prescription with a generic equivalent drug, the member 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.

Section 1.4 amends G.S. 135-45(g) to limit the authority of the Executive Administrator and Board of Trustees to change benefits in effect on July 1, 2011 unless directed by the General Assembly.

Section 1.5 repeals the Comprehensive Wellness Initiative for individuals covered by the State Health Plan which focused on smoking cessation (effective July 1, 2010) and weight management (July 1, 2011 effective date).

Section 1.6(a) authorizes individuals eligible for coverage to participate on a contributory (partially, one-half, or fully) basis in authorized plans. **Section 1.6(b)** amends G.S. 135-45.2 to eliminate noncontributory and authorize partially contributory coverage for permanent employees, employees of the General Assembly as determined by the Legislative Services Commission and not otherwise covered, Members of the General Assembly, employees on a leave of absence, and employees whose positions were eliminated. (The new contribution rates are outlined in Section 1.2 of the bill.) For a school employee in a job-sharing position that elects to participate in the Plan, the bill provides that an employing unit will pay 50% of the Plan's total employer premiums and the employee will pay the balance of the total premiums not paid by the State. Upon retirement, the State will pay 50% of the total employer premiums for employees and members of the General Assembly with 10 but less than 20 years of retirement service credit if the employees were first hired on or after October 1, 2006 and members took office on or after February 1, 2007, these future retirees will be responsible for the balance of the premium. The section also makes technical and conforming changes.

Section 1.7 pertains to eligibility requirements for coverage of a dependent child and complies with provisions of the federal Affordable Care Act. (Coverage for children up to age 26 under the Act was effective for plan or policy years beginning on September 23, 2010.) Section 1.7(a) conforms the definition of "dependent child" contained in G.S. 135-45.1(10) with the federal law to allow coverage for a natural or legally adopted child up to the first of the month following the child's 26th (currently 19th) birthday and makes additional technical and organizational changes to the statute . Eligibility requirements for coverage of a dependent child are currently provided in G.S. 135-45.2(d). Section 1.7(b) amends G.S. 135-45.2(d) to conform with the federal law to allow coverage of a dependent child beyond the 26th (currently 19th) birthday if 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 the provisions for contributory coverage of dependents and surviving dependents (contained in G.S. 135-45.2(c)(7)).

Section 1.8(a-e) contains standard language that is typically found in the Appropriations bill outlining employer salary-related contribution rates.

Section 1.9 amends G.S. 135-45(b) to make the protection of trade secrets in State Health Plan contracts consistent with the general trade secret protection for all public agency contracts.

Part II. Transfer State Health Plan to Department of State Treasurer

Section 2.1 amends G.S. 135-2(b) to grant the State Treasurer the authority, after consultation with the Board of Trustees, to hire, fire and set the terms of employment for the State Health Plan's Executive Administrator. It also allows the Treasurer to appoint an interim Executive Administrator.

Section 2.2 transfers the State Health Plan to the Department of State Treasurer as a Type II transfer. A Type II transfer means the transferring intact of an existing agency to a principal department established by Chapter 143A.

Section 2.3 amends the title of Chapter 135 to reference the State Health Plan and to add a new Article 3B to the Chapter. Article 3B will be organized into 6 Parts: General Provisions, Administrative Structure, Plan Operation, Eligibility and Enrollment, Coverage Mandates and Exclusions/Other Mandates, and Long-Term Care Benefits.

Sections 2.4 through 2.8 recodify portions of Article 3A to create the new Article 3B of Chapter 135. A very brief description of the recodified provision appears in brackets after each specific citation. The Child Health Insurance Fund is recodified as G.S. 108A-70.20A. Although recodified, the provisions related to eligibility, enrollment, effective date of coverage and cessation of coverage are retained.

Section 2.9 repeals any portion of Article 3A of Chapter 135 that was not recodified. Some of the provisions that are repealed include: G.S. 135-43.1 (Committee on Employee Hospital and Medical Benefits), G.S. 135-43.2 (State Health Plan Administrative Commission), G.S. 135-43.3 (Oversight team), and G.S. 135-44.4 (Powers and duties of the Executive Administrator and Board of Trustees). Other provisions that essentially set the terms and conditions of the Plan [G.S. 135-45.6 (Benefits not subject to deductible or coinsurance), G.S. 135-45.7 (Prior approval procedures), G.S. 135-45.8 (General limitations and exclusions), G.S. 135-45.9 (Special provisions for chemical dependency and mental health benefits)] are repealed, but are re-enacted as duties of the Treasurer [G.S. 135-48.30(a)]. The Coverage Mandates (Part 5 of Article 3B) are consolidated, but include the same coverage mandates as under current law.

Section 2.10 amends the newly created Article 3B to provide the State Treasurer the necessary authority to operate the State Health Plan, to further reorganize the remaining provisions, and to conform internal and external citations. Some of the changes include:

- Repealing the definition of "plan year".
- Adding the Treasurer to the State Health Plan Board of Trustee as an ex officio member as well as the Director of the Office of State Budget and Management. The Treasurer could vote in the event of a tie, but the Director would be a nonvoting member. The remaining 8 members of the Board would be appointed 2 each by the Treasurer, the Governor, and the General Assembly (2 upon the recommendation of the President Pro Tempore of the Senate and 2 upon the recommendation of the Speaker of the House). A current and a retired teacher and a current and a retired State employee must be included among the members of the Board.
- Specifying the Treasurer's Powers and Duties (G.S. 135-48.30). These include: setting benefits, premium rates, and out-of-pocket expenses; setting allowable charges for medical and prescription drug benefits; adopting and implementing utilization review and internal grievance procedures; establishing fraud detection and audit programs; preparing and submitting cost estimates to the Governor and General Assembly; establishing, administering and setting premium rates for long-term care benefits.

- Requiring quarterly reports by the Executive Administrator to the President Pro Tempore of the Senate and the Speaker of the House. The Treasurer must also submit reports upon the request of either office.

Section 2.11 provides that by repealing a specific provision in Article 3A, the General Assembly did not necessarily intend to prevent the Treasurer or the State Health Plan from having that authority.

Section 2.12 provides that existing rules and policies continue to be effective unless they directly conflict with new Article 3B or until changed by the Treasurer.

Section 2.13 provides that Part II becomes effective January 1, 2012.

Part III. Miscellaneous Provisions

Section 3.1 provides that headings are for the convenience of the reader and are for reference only.

Section 3.1 provides that, except as otherwise provided, the remainder of the act is effective when it becomes law.

S323-SMME-2(e2) v2

Theresa Matula, Legislative Analyst, and Kory Goldsmith, Insurance Committee Counsel, substantially contributed to this summary.

SENATE BILL 323
Insurance Committee Substitute Adopted 3/24/11

Short Title: Insurance Amendments.-AB (Public)

Sponsors:

Referred to:

March 14, 2011

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES IN THE INSURANCE LAWS TO PRIVATIZE ONLINE AND ADMINISTRATIVE PROCESSES FOR LICENSE APPLICANTS, CODIFY THE EXISTING SENIORS' HEALTH INSURANCE INFORMATION PROGRAM, ENSURE ACCURACY IN CERTIFICATES OF INSURANCE, REQUIRE PRIOR APPROVAL OF SMALL GROUP HEALTH INSURANCE RATES AND ENCOURAGE THE SALE OF CHILD-ONLY HEALTH INSURANCE POLICIES, AMEND THE RISK-BASED CAPITAL LAW TO MAINTAIN NAIC ACCREDITATION, PROVIDE AN EXEMPTION FOR LICENSING OF CLAIMS INPUT EMPLOYEES FOR PORTABLE ELECTRONIC DEVICES, PROHIBIT FEDERAL PREEMPTION OF CROP ADJUSTERS' REGULATION, AND EASE THE REGULATORY BURDEN ON THE NORTH CAROLINA SELF-INSURANCE SECURITY ASSOCIATION AND THE ASSOCIATION AGGREGATE SECURITY SYSTEM.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-2-69(g) reads as rewritten:

"(g) The Commissioner may contract with the NAIC or other persons for the provision of online services to applicants and licensees, for the provision of administrative ~~services to licensees, or~~ services, for the provision of license processing and support services, and for the provision of regulatory data systems to the Commissioner. The NAIC or other person with whom the Commissioner contracts may charge applicants and licensees a reasonable fee for ~~the costs associated with the licensees' use~~ the provision of online ~~services and~~services, the provision of administrative ~~services.~~ services, the provision of license processing and support services, and the provision of regulatory data systems to the Commissioner. The fee shall be agreed to by the Commissioner and the other contracting party and shall be stated in the contract. The fee is in addition to any applicable license application and renewal fees. Contracts for the provision of online services, contracts for the provision of administrative services, and contracts for the provision of regulatory data systems shall not be subject to Article 3, 3C, or 8 of Chapter 143 of the General Statutes or to Article 3D of Chapter 147 of the General Statutes. However, the Commissioner shall: (i) submit all proposed statewide and agency term contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subsection to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all contracts to be awarded by the Commissioner under this subsection a standard clause which provides that the State Auditor and internal auditors of the Commissioner may audit the records of the contractor during the term of the agreement or contract to verify accounts and data affecting fees and performance. The Commissioner shall not award a cost plus percentage of cost agreement or contract for any purpose."

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

"**§ 58-2-31. Seniors' Health Insurance Information Program.**

The Seniors' Health Insurance Information Program is established within the Department as a statewide health benefits counseling program to provide the State's Medicare beneficiaries with counseling in Medicare, Medicare supplement insurance, long-term care insurance, and related health care coverage plans."

SECTION 3. G.S. 58-3-150 reads as rewritten:

"**§ 58-3-150. Forms to be approved by Commissioner.**

(a) It is unlawful for any insurance company licensed and admitted to do business in this State to issue, sell, or dispose of any policy, contract, ~~or~~ certificate, or certificate of insurance, or use applications in connection therewith, until the forms of the same have been submitted to and approved by the Commissioner, and copies filed in the Department. If a policy form filing is disapproved by the Commissioner, the Commissioner may return the filing to the filer. As used in this section, "policy form" includes endorsements, riders, or amendments to policies that have already been approved by the Commissioner.

(b) With respect to group and blanket accident and health insurance, group life insurance, and group annuity policies issued and delivered to a trust or to an association outside of this State and covering persons resident in this State, the group certificates to be delivered or issued for delivery in this State shall be filed with and approved by the Commissioner pursuant to subsection (a) of this section.

(c) If not submitted electronically, all contracts, literature, advertising materials, letters, and other documents submitted to the Department to comply with the filing requirements of this Chapter or an administrative rule adopted pursuant to this Chapter shall be submitted on paper eight and one-half inches by eleven inches. Brochures and pamphlets shall not be stapled or bound.

(d) As used in this section, "certificate of insurance" means a document prepared or issued by an insurance company or producer that is used to verify or evidence the existence of property or casualty insurance coverage. "Certificate of insurance" shall not include a policy of insurance or insurance binder.

(e) A certificate of insurance is not a policy of insurance and does not amend, extend, or alter the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to a certificate of insurance holder new or additional rights beyond what the referenced policy of insurance expressly provides.

(f) It is unlawful for any person to knowingly prepare, issue, request, or require a certificate of insurance that meets any of the following criteria:

(1) Has not been filed with and approved by the Commissioner.

(2) Contains any false or misleading information concerning the policy of insurance to which the certificate of insurance makes reference.

(3) Purports to alter, amend, or extend the coverage provided by the policy of insurance to which the certificate of insurance makes reference.

(g) A holder of a certificate of insurance shall only have a legal right to notice of cancellation, nonrenewal, or any material change, or any similar notice concerning a policy of insurance if the holder is named within the policy or any endorsement and the policy or endorsement requires notice to be provided to the holder. The terms and conditions of the notice, including the required timing of the notice, are governed by the policy of insurance and cannot be altered by a certificate of insurance."

SECTION 4. Article 50 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-50-131. Premium rates for health benefit plans; approval authority; hearing.**

(a) No schedule of premium rates for coverage for a health benefit plan subject to this act, or any amendment to the schedule, shall be used in conjunction with any such health benefit plan until a copy of the schedule of premium rates or premium rate amendment has been filed with and approved by the Commissioner. Any schedule of premium rates or premium rate amendment filed under this section shall be established in accordance with G.S. 58-50-130(b). The schedule of premium rates shall not be excessive, inadequate, or unfairly discriminatory and shall exhibit a reasonable relationship to the benefits provided by the contract of insurance. Each filing shall include a certification by an individual who is a member in good standing with the Society of Actuaries.

(b) The Commissioner shall approve or disapprove a schedule of premium rates within 60 days of receipt of a complete filing. It shall be unlawful to use a schedule of premium rates until approved. If the Commissioner disapproves the filing, the Commissioner shall notify the filer, shall specify the reasons for disapproval, and shall provide an opportunity for refiling.

(c) The Commissioner shall adopt rules as necessary or proper (i) to prevent the federal preemption of health insurance regulation in the State, (ii) to implement the provisions of this section, and (iii) to establish minimum standards for loss ratios of policies subject to this section on the basis of incurred claims experience and earned premium in accordance with accepted actuarial principles and practices to assure that the benefits are reasonable in relation to the premium charged. The Commissioner shall adopt rules to require the submission of supporting data and any information that the Commissioner considers necessary or proper to determine whether the filed schedule of premium rates meets the standards set forth in this section."

SECTION 5. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-285. Nondependent child coverage defined; open enrollment.**

(a) As used in this section, the following definitions apply:

(1) "Nondependent child coverage" or "nondependent child policy" means an individual health benefit plan which provides coverage to an individual under age 19. This shall not include health benefit plans that cover children under age 19 as a dependent.

(2) "Health benefit plan" has the same meaning as G.S. 58-3-167(a)(1).

(3) "Individual market" has the same meaning as G.S. 58-68-25(a)(9).

(4) "Insurer" has the same meaning as G.S. 58-3-167(a)(2).

(5) "Open enrollment" means, with respect to "nondependent child coverage," the period of time during which any individual under age 19 has the opportunity to apply for coverage under a health benefit plan offered by an insurer and shall not be denied eligibility for coverage under the plan due to factors relating to the individual's health status.

(b) An insurer who offers nondependent child coverage shall offer open enrollment either continuously throughout the year or for the months of January and July of each year. Coverage issued under this section shall be issued without any riders based on the health status of the child. Nothing in this section shall require an insurer to offer nondependent child coverage.

(c) The Commissioner shall adopt rules as necessary or proper to implement the provisions of this section.

(d) Nothing in this section shall prohibit an insurer from adjusting the initial premium charged an individual afforded coverage under this section based upon medical underwriting to the extent that such an adjustment is in compliance with the applicable product's current rate filing approved by the Commissioner."

SECTION 6. G.S. 58-12-2 reads as rewritten:

"**§ 58-12-2. Definitions.**

As used in this Article, the following terms have the following meanings:

(1) Adjusted risk-based capital report. – A risk-based capital report that has been adjusted by the Commissioner under G.S. 58-12-6.

(2) Corrective order. – An order issued by the Commissioner specifying corrective actions that the Commissioner has determined are required.

(3) Domestic insurer. – Any insurance company or health organization organized in this State under ~~Article 7,~~ Article 7 of this Chapter as specified in subdivisions (4b) and (5a) of this section, or under Article 15, 65, or 67 of this Chapter.

(4) Foreign insurer. – Any insurance company or health organization that is admitted to do business in this State under Article 16 or 67 of this Chapter but is not domiciled in this State.

(4a) Health organization. – Any insurer which is required by the Commissioner to use the NAIC Health Annual Statement Blank when filing the annual statement prescribed by G.S. 58-2-165 or any health maintenance organization, limited health service organization, dental or vision plan, hospital, medical, or dental indemnity or service corporation, or other organization licensed under Article 65 or 67 of this Chapter. "Health organization" does not include an insurer that is licensed as either a life or health insurer or a property or casualty insurer under this Chapter and that is otherwise subject to either the life or property and casualty risk-based capital requirements.

(4b) Life or health insurer. – Any insurance company licensed to write the kinds of insurance specified in G.S. 58-7-15(1), (2), or (3); or a licensed property and casualty insurer writing only the kinds of insurance specified in G.S. 58-7-15(3). "Life or health insurer" does not mean any insurer that is required by the Commissioner to use the NAIC Health Annual Statement Blank when it files the annual statement prescribed by G.S. 58-2-165.

(5) Negative trend. – A negative trend, with respect to a life or health insurer, over a period of time, as determined in accordance with the "trend test calculation" included in the risk-based capital instructions.

(5a) Property or casualty insurer. – Any insurance company licensed to write the kinds of insurance specified in G.S. 58-7-15(4) through (22); but not monoline mortgage guaranty insurers, financial guaranty insurers, or title ~~insurers.~~insurers; nor any insurer that is required by the Commissioner to use the NAIC Health Annual Statement Blank when filing the annual statement prescribed by G.S. 58-2-165.

(6) Risk-based capital instructions. – The risk-based capital report including risk-based capital instructions adopted by the NAIC, as those risk-based capital instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(7) Risk-based capital level. – An insurer's company action level risk-based capital, regulatory action level risk-based capital, authorized control level risk-based capital, or mandatory control level risk-based capital where:

a. "Company action level risk-based capital" means, with respect to any insurer, the product of 2.0 and its authorized control level risk-based capital.

b. "Regulatory action level risk-based capital" means the product of 1.5 and its authorized control level risk-based capital.

c. "Authorized control level risk-based capital" means the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

d. "Mandatory control level risk-based capital" means the product of .70 and the authorized control level risk-based capital.

(8) Risk-based capital plan. – A comprehensive financial plan containing the elements specified in G.S. 58-12-11(b). If the Commissioner rejects the risk-based capital plan, and it is revised by the insurer, with or without the Commissioner's recommendation, the plan shall be called the "revised risk-based capital plan".

(9) Risk-based capital report. – The report required in G.S. 58-12-6.

(10) Total adjusted capital. – The sum of:

a. An insurer's statutory capital and surplus, as determined in accordance with the statutory accounting applicable to the annual financial statements required under G.S. 58-2-165; and

b. Such other items, if any, as the risk-based capital instructions may provide."

SECTION 7. G.S. 58-12-11(a) reads as rewritten:

"(a) "Company action level event" means any of the following events:

(1) The filing of a risk-based capital report by an insurer that indicates that:

a. The insurer's total adjusted capital is greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based ~~capital, if the insurer is a property or casualty insurer or a health organization;~~ capital; or

b. ~~The~~ In the case of a life or health insurer, the insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and 2.5 and has a negative ~~trend, if the insurer is a life or health insurer.~~trend; or

c. In the case of a property or casualty insurer or a health organization, the insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty or health organization risk-based capital instructions.

(2) The notification by the Commissioner to the insurer of an adjusted ~~risk-bases~~ risk-based capital report that indicates the event in sub-subdivision ~~(1)a. or b.~~(1)a., (1)b., or (1)c. of this subsection if the insurer does not challenge the adjusted risk-based capital report under G.S. 58-12-30.

(3) If the insurer challenges an adjusted risk-based capital report that indicates the event in sub-subdivision ~~(1)a. or b.~~ (1)a., (1)b., or (1)c. of this subsection under G.S. 58-12-30, the notification by the Commissioner to the insurer that the Commissioner has rejected the insurer's challenge."

SECTION 8. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-27. Claims handling for portable consumer electronic devices.**

(a) As used in this section, the following definitions apply:

(1) "Automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation, and system generated final resolution of claims on insurance policies that provide

coverage only on the repair and replacement of portable consumer electronic devices, which system shall meet the following criteria:

a. Be utilized only by a licensed adjuster or supervised individuals operating pursuant to this section.

b. Comply with all claims payment requirements of this Chapter.

c. Be certified as compliant with this section by a licensed adjuster who is an officer of a licensed business entity under this Chapter.

(2) "Portable consumer electronic devices" include the following, which must be easily carried or conveyed by hand: smartphones, navigation devices, cellular phones, personal digital assistants, iPads, iPhones, Androids, video games, wireless reading devices, laptops, tablets, netbooks, MP3 players, digital cameras, and other electronic devices that are portable in nature, their accessories, and services related to the use of the device.

(b) No adjuster license is required for an individual who, in connection solely with coverage on the repair and replacement of portable consumer electronic devices as defined in subdivision (a)(2) of this section, collects claim information from or furnishes claim information to insureds, who conducts data entry, including entering data into an automated claims adjudication system, and who does not exercise any discretion in the disposition of the claim; provided that the individual is supervised by a licensed adjuster under this Chapter and there are no more than 25 individuals who may adjust claims under the supervision of the licensed adjuster.

(c) If other property losses occur in conjunction with the loss associated with the portable consumer electronic device, the individual who performs duties as described in G.S. 58-33-10(2) on the total loss, including the loss associated with the portable consumer electronic device, must hold an adjuster license."

SECTION 9. G.S. 58-33-30(e) reads as rewritten:

"(e) Examination.

(1) After completion and filing of the application with the Commissioner, the Commissioner shall require each applicant for license as an agent or an adjuster to take an examination as to the applicant's competence to be licensed. The applicant must take and pass the examination according to requirements prescribed by the Commissioner. This subsection shall not apply to adjusters who adjust only federal crop insurance claims and are certified in accordance with subsection (2a) of this section.

(2) The Commissioner may require any licensed agent, adjuster, or motor vehicle damage appraiser to take and successfully pass an examination in writing, testing his competence and qualifications as a condition to the continuance or renewal of his license, if the licensee has been found guilty of any violation of any provision of this Chapter. If an individual fails to pass such an examination, the Commissioner shall revoke all licenses issued in his name and no license shall be issued until such individual has passed an examination as provided in this Article.

(2a) Adjusters who adjust federal crop insurance claims shall be certified as having passed a proficiency examination approved by the federal Risk Management Agency (RMA) as a condition of obtaining an adjuster's license under this Chapter, or another proficiency examination approved by the Commissioner. An adjuster who intends to adjust crop insurance claims shall furnish the Commissioner proof that the adjuster is certified as having passed the required examination pursuant to this section.

(3) Each examination shall be as the Commissioner prescribes and shall be of sufficient scope to test the applicant's knowledge of:

a. The terms and provisions of the policies or contracts of insurance the applicant proposes to effect; or
b. The types of claims or losses the applicant proposes to adjust; and
c. The duties and responsibilities of the license; and
d. The current laws of this State applicable to the license.

(4) The answers of the applicant to the examination shall be provided by the applicant under the Commissioner's supervision. The Commissioner shall give examinations at such times and places within this State as the Commissioner considers necessary reasonably to serve the convenience of both the Commissioner and applicants: Provided that the Commissioner may contract directly with persons for the processing of examination application forms and for the administration and grading of the examinations required by this section; the Commissioner may charge a reasonable fee in addition to the registration fee charged under G.S. 58-33-125, to offset the cost of the examination contract authorized by this subsection; and such contracts shall not be subject to Article 3 of Chapter 143 of the General Statutes. However, the Commissioner shall: (i) submit all proposed statewide and agency term agreements or contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subdivision to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all contracts to be awarded by the Commissioner under this subdivision a standard clause which provides that the State Auditor and internal auditors of the Commissioner may audit the records of the contractor during the term of the contract to verify accounts and data affecting fees and performance. The Commissioner shall not award a cost plus percentage of cost contract for any purpose.

(5) The Commissioner shall collect in advance the examination and registration fees provided in G.S. 58-33-125 and in subsection (4) of this section. The Commissioner shall make or cause to be made available to all applicants, for a reasonable fee to offset the costs of production, materials that he considers necessary for the applicants' proper preparation for examinations. The Commissioner may contract directly with publishers and other suppliers for the production of the preparatory materials, and contracts so let by the Commissioner shall not be subject to Article 3 of Chapter 143 of the General Statutes. However, the Commissioner shall: (i) submit all proposed statewide and agency term contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subdivision to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all contracts to be awarded by the Commissioner under this subdivision a standard clause which provides that the State Auditor and internal auditors of the Commissioner may audit the records of the contractor during the term of the contract to verify accounts and data affecting fees and performance. The Commissioner shall not award a cost plus percentage of cost contract for any purpose.

(6) In addition to the examinations for the kinds of insurance specified in G.S. 58-33-25(c)(1) and (2), before any resident may sell Medicare supplement or long-term care insurance policies defined respectively in Articles 54 and 55 of this Chapter, the resident must take and pass a

supplemental written examination according to requirements prescribed by the Commissioner.

(7) 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."

SECTION 10. Article 4 of Chapter 97 of the General Statutes reads as rewritten:

"Article 4.

North Carolina Self-Insurance Security Association.

"§ 97-130. Definitions.

As used in this Article:

(1) "Association" means the North Carolina Self-Insurance Security Association established by G.S. 97-131.

(1a) "Association Aggregate Security System" means the security system established by the Association under G.S. 97-133 whereby individual self-insurers collectively secure their aggregate self-insured workers' compensation liabilities through the North Carolina Self-Insurance Security Association.

(2) "Board" means the Board of Directors of the Association established by G.S. 97-132.

(3) "Commissioner" means the North Carolina Commissioner of Insurance.

(4) "Covered claim" means an unpaid claim against an insolvent individual self-insurer or group self-insurer that relates to an injury that occurs while the individual self-insurer or group self-insurer is a member of the Association and that is compensable under this Chapter.

(5) "Fund" means the North Carolina Self-Insurance Security Fund established by G.S. 97-133.

(5a) "Group" or "Group self-insurer" means a group self-insurer licensed by the Commissioner under Part 1, Article 47 of Chapter 58 of the General Statutes.

(5b) "Individual self-insurer" means an individual employer licensed by the Commissioner under Article 5 of this Chapter.

(6) "Member self-insurer" or "member" means an individual self-insurer or group self-insurer that is required to be a member of the Association under this Article or Part 1, Article 47 of Chapter 58 of the General Statutes.

(7) "Plan" means the Plan of Operation authorized by G.S. 97-134.

(8) Repealed by Session Laws 2005-400, s. 1.2, effective January 1, 2006.

(9) "Servicing facility" means those persons delegated by the Board ~~and approved by the Commissioner~~ to settle or compromise claims and to expend Fund assets to pay claims.

"§ 97-131. Creation.

...

(b) All individual self-insurers and group self-insurers shall be and remain members of the Association as a condition of being licensed to self-insure in this State. The Association shall perform its functions under a Plan of Operation established or amended, or both, by the ~~Board and approved by the Commissioner,~~ Board and shall exercise its powers through the Board.

(1) An individual self-insurer or a group self-insurer shall be deemed to be a member of the Association for purposes of another member's insolvency, as defined in G.S. 97-135, when:

a. The individual self-insurer or group self-insurer is a member of the Association when an insolvency occurs, or

b. The individual self-insurer or group self-insurer has been a member of the Association at some point in time during the 12-month period immediately preceding the insolvency in question.

(2) An individual self-insurer or a group self-insurer shall be deemed to be a member of the Association for purposes of its own insolvency if it is a member when the compensable injury occurs.

(3) In determining the membership of the Association for the purposes of subdivisions (1) and (2) of this subsection for any date after the effective date of this Article, no individual self-insurer or group self-insurer may be deemed to be a member of the Association on any date after the effective date of this Article, unless that employer is on that date licensed as an individual self-insurer by the Commissioner under Article 5 of this Chapter or a group of employers is at that time licensed as a group self-insurer by the Commissioner under Article 47 of Chapter 58 of the General Statutes.

"§ 97-132. Board of directors.

The Board shall consist of not less than nine directors serving terms as established in the Plan. The directors shall be selected by the members of the ~~Association, subject to the approval of the Commissioner,~~ Association and shall serve for three-year terms and until a successor is elected and qualified. There is no limitation on the number of terms a director may serve. ~~In approving selections to the Board, the Commissioner shall consider, among other things, whether individual self-insurers and group self-insurers are fairly represented.~~ Directors may be reimbursed from the assets of the Association for expenses incurred by them as directors.

"§ 97-133. Powers and duties of the Association.

(a) The Association shall:

(1) Repealed by Session Laws 1999-219, s. 7.2, effective June 25, 1999.

(1a) Administer a fund, to be known as the North Carolina Self-Insurance Security Fund, which shall receive the assets of the North Carolina Self-Insurance Guaranty Fund previously established under subdivision (2) of this subsection, the assessments required by subdivisions (2a) and (3a) of this subsection and any other sums received by the Association. ~~In its discretion, the Board may determine that the assets of the Fund should be segregated or that a separate accounting shall be made in order to identify that portion of the Fund which represents assessments paid by individual self-insurers and that portion of the Fund which represents assessments paid by group self-insurers. If the Board segregates the Fund in this manner, the Association shall thereafter pay covered claims against individual member self-insurers from that portion of the Fund that represents assessments against individual self-insurers and shall thereafter pay covered claims against group member self-insurers from that portion of the Fund that represents assessments against group self-insurers.~~ The costs of administering the Association shall be borne by the Fund. The Association is authorized to secure insurance, primary excess insurance, reinsurance, bonds, other insurance, financial guarantees and related financial instruments to effectuate the purposes of the Association. The Board will invest the Fund assets pursuant to an investment policy adopted by the Board and reviewed and approved annually by the Department of the State Treasurer. The earnings from investment of Fund assets shall be placed in or credited to the Fund.

(2) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

(2a) ~~Establish, operate, and maintain~~ Establish and operate the Association Aggregate Security System as defined in G.S. 97-130 and G.S. 97-165 as follows:

a. The Association shall ~~annually prepare and submit to the Commissioner a written plan to~~ provide an Association Aggregate Security System through a combination of cash on deposit in the Fund, securities, surety bonds, irrevocable letters of credit, ~~insurance~~ insurance, reinsurance, or other financial instruments or guarantees owned or entered into by the ~~Association and acceptable to the Commissioner.~~ Association. ~~The written plan shall include, but not be limited to, (i) a description of the institutions that will issue or guarantee the securities, surety bonds, irrevocable letters of credit, insurance or other financial instruments or guarantees, including, but not limited to, the credit rating, financial strength, and AM best rating, if applicable to the institutions (ii) applicable cash flow information and financial assumptions (iii) a description of the methodology to be used by the Association to assess and collect the Association Aggregate Security System assessments to be made pursuant to subdivision (3a) of this subsection and (iv) a proposed timetable for the release of existing individual company deposits posted pursuant to G.S. 97-185(c), provided, however, that no individual company deposits posted pursuant to G.S. 97-185(c) shall be released without the written consent of the Commissioner. The noncash elements of the composite security may be one-year or multiple-year instruments.~~

~~b. Within 90 days following the submission of the initial plan under sub-subdivision a. of this subdivision, the Commissioner shall either approve or disapprove the initial plan and shall notify the Association in writing. If the Commissioner does not approve or disapprove the initial plan within 90 days following submission, then the initial plan shall be deemed to be approved by the Commissioner. All subsequent plans shall be either approved or disapproved within 60 days following submission.~~

~~c. The Commissioner shall also determine the total undiscounted claims liability of each individual self-insurer that will participate in the Association Aggregate Security System as well as the aggregate total undiscounted outstanding claims liabilities of all the individual self-insurers that are to participate in the Association Aggregate Security System and shall notify the Association of this determination.~~

~~d. Upon approval by the Commissioner of the Association's plan for the Association Aggregate Security System, the~~ The Association shall assess the individual self-insurers that participate in the Association Aggregate Security System pursuant to subdivision (3a) of this subsection.

e. ~~If the Commissioner disapproves the plan for any year,~~ If the Association determines it is not feasible or practical to continue the Association Aggregate Security System, it shall notify the Commissioner at least 90 days prior to the termination of the Association Aggregate Security System. ~~every~~ Every self-insurer shall deposit with the Commissioner, or continue to deposit, the

amount required by G.S. 97-185(b3) in the manner prescribed by G.S. 97-185(c).

f. Group self-insurers shall not participate in the Association Aggregate Security System.

(3) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

(3a) Assess members of the Association as follows:

a. Association Aggregate Security System assessments. – The Association shall assess each individual self-insurer participating in the Association Aggregate Security System a security system assessment. The amount of the security system assessment charged to each individual self-insurer participating in the Association Aggregate Security System shall be based on the Association's reasonable consideration of all of the following factors:

1. The total amount of assessments necessary to provide aggregate security for all participating individual self-insurers.
2. The individual self-insurer's total workers' compensation liabilities under the Act.
3. The financial strength and creditworthiness of the participating individual self-insurer.
4. Any other relevant factors.

b. Special assessment. – In the event that there are covered claims against an insolvent member or members and the assets of the Fund are not sufficient to pay the obligations of the Association, then the Association may collect a special assessment from the members in an amount sufficient to pay the aggregate value of such covered claims. Each member's special assessment shall be determined by the Board and shall be based on the proportion of the member's total obligations under the Act to the aggregate total of all members' obligations under the Act.

c. Initial assessments. – An individual self-insurer that becomes a member and does not initially participate in the Association Aggregate Security System shall pay an initial assessment to the Association in an amount determined by the Board. A group self-insurer, upon receiving its initial license from the Commissioner, shall pay an initial assessment to the Association in an amount determined by the Board.

d. Each member shall be notified of assessments no later than 30 days before the assessment is due.

e. Delinquent assessments, except as otherwise provided, shall bear interest at a rate to be established by the Board.

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).

(4) Be obligated to pay covered claims.

(5) After paying any covered claim, be subrogated to the rights of the injured employee and dependents and be entitled to enforce liability against the self-insurer or any third party by any appropriate action brought in its own name or in the name of the injured employee and dependents.

(6) Expend Fund assets in amounts necessary to pay all of the following:
a. The obligations of the Association under this Article subsequent to an insolvency.
b. The expenses of handling covered claims subsequent to an insolvency.
c. The cost of examinations under G.S. 97-137.
d. The costs of implementing and operating the Association Aggregate Security System.
e. All other expenses authorized by this Article.
(7) Investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation; and deny all other claims. The Association may review settlements to which the insolvent member was a party to determine the extent to which such settlements may be properly contested.
(8) Notify such persons as the Commissioner directs under G.S. 97-136.
(9) Handle claims through its directors, its employees, or through one or more members or other persons designated as servicing facilities. Designation ~~of a servicing facility is subject to the approval of the Commissioner, but designation~~ of a member as a servicing facility may be declined by such member.
(10) Reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association.
(11) Pay any other expenses of the Association authorized by this section.
(12) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.
(13) Require each member to determine annually its total undiscounted claims liability and shall require each member to notify the Association of this determination.

(b) The Association may:
(1) Employ or retain such persons, including, but not limited to, adjustors, brokers, accountants, attorneys, financial advisors, investment bankers, placement agents, and consultants, as the Board may determine are necessary to handle claims, perform other duties of, provide services to, and consult with the Association.
(2) Borrow funds necessary to effect the purposes of this Article in accord with the Plan, including entering into standby lines of credit.
(3) Sue or be sued.
(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this section.
(5) Perform such other acts as are necessary or proper to effectuate the purpose of this section.
~~(6) Reimburse the Department of Insurance up to twenty thousand dollars ($20,000) for consultants retained by the Department to review the initial plan submitted pursuant to G.S. 97-133(a)(2a).~~

(c) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

(c1) The Association shall provide in its Plan that the functions of administration and adjusting claims shall not be performed by the same entity that provides legal representation to the Association for claims.

(d) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

"**§ 97-134. Plan of Operation.**

The Plan is as follows:

(1) The ~~Association~~ Board shall ~~submit to the Commissioner~~ adopt a Plan of Operation and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. ~~The Plan and any amendments become effective upon approval in writing by the Commissioner. If the Association at any time fails to submit a suitable Plan or suitable amendment to the Plan the Commissioner shall, after notice and hearing, adopt such reasonable rules as are necessary or advisable to effectuate this Article. The rules shall continue in force until modified by the Commissioner or superseded by a Plan submitted by the Association and approved by the Commissioner.~~

(2) All member self-insurers shall comply with the Plan.

(3) The Plan shall:

a. Establish the procedures whereby all the powers and duties of the Association under G.S. 97-133 will be performed.

b. Establish procedures for investing and managing Fund assets.

c. Adopt a reasonable mechanism and procedure to achieve equity in assessing members under G.S. 97-133.

d. Establish the amount and method of reimbursing members of the Board under G.S. 97-132.

e. Establish procedures by which claims may be filed with the Association and establish acceptable forms of proof of covered claims.

f. Establish regular places and times for meetings of the Board.

g. Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the Board.

h. Provide that any member self-insurer aggrieved by any final action or decision of the Association may appeal to the Commissioner within 30 days after the action or decision.

~~i. Establish the procedures whereby selections for the Board shall be submitted to the Commissioner.~~

j. Contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

...

"§ 97-136. Powers and duties of the Commissioner.

(a) The Commissioner shall:

(1) Notify the Association of the existence of an insolvent member self-insurer not later than 30 days after he receives notice of an insolvency pursuant to the standards set forth in G.S. 97-135.

~~(2) Approve or disapprove the plan for an Association Aggregate Security System as required under G.S. 97-133(a)(2a)b. and notify the Association of the information required under G.S. 97-133(a)(2a)c.~~

"§ 97-137. Examination of the Association.

The Association shall be subject to examination and regulation by the Commissioner. The Board shall submit, not later than ~~March 30~~ June 1 of each year, a financial report for the preceding calendar year in a form approved by the Commissioner.

...."

SECTION 11. G.S. 97-185(a1) reads as rewritten:

"(a1) All individual self-insurers as defined in G.S. 97-130(5b) shall participate in the Association Aggregate Security System established under G.S. 97-131 unless excluded by the Board of Directors of the North Carolina Self-Insurance Security Association. The Board of

Directors of the North Carolina Self-Insurance Security Association shall exclude all of the following from the Association Aggregate Security System:

(1) Individual self-insurers whose licenses have previously been revoked by the Commissioner.

(2) Individual self-insurers with a debt rating as established by Standard & Poor's Rating Service or by Moody's Investor Service, below the minimum Standard & Poor's ~~and~~ or Moody's ratings if a minimum debt rating has been established ~~in the written plan~~ by the Board of Directors of the North Carolina Self-Insurance Security Association for the Association Aggregate Security ~~System submitted by the Association and approved by the Commissioner under G.S. 97-133(a)(2a).~~ System.

(3) Individual self-insurers that have defaulted on the payment of their self-insured workers' compensation liabilities.

(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.

The Board of Directors of the North Carolina Self-Insurance Security Association shall notify the Commissioner of the individual self-insurers that are excluded from participating in the Association Aggregate Security System."

SECTION 12. Sections 1, 4, 10, and 11 of this act become effective July 1, 2011. Sections 3, 5, 6, and 7 of this act become effective October 1, 2011. Section 8 of this act becomes effective July 1, 2012, and applies to licenses issued on or after that date. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 115
Committee Substitute Favorable 3/30/11
PROPOSED COMMITTEE SUBSTITUTE H115-CSTK-8 [v.9]

4/18/2011 4:37:32 PM

Short Title: North Carolina Health Benefit Exchange. (Public)

Sponsors:

Referred to:

February 17, 2011

A BILL TO BE ENTITLED

AN ACT TO PRESERVE STATE-BASED AUTHORITY TO REGULATE THE NORTH CAROLINA HEALTH INSURANCE MARKET AND TO PREVENT FEDERAL ENCROACHMENT ON STATE AUTHORITY BY ESTABLISHING THE NORTH CAROLINA BENEFIT EXCHANGE.

The General Assembly of North Carolina enacts:

SECTION 1. The purpose of this act is to provide for the establishment of the North Carolina Health Benefits Exchange Authority (Exchange Authority). The purpose of the Exchange Authority is to facilitate the purchase and sale of qualified health plans in the individual and small employer market by providing education, outreach, and technical assistance. The General Assembly believes it is in the best interest of the State, and thus the purpose of the Exchange Authority, to promote competition and choice in the health care marketplace and to facilitate innovation by offering products with variation in price and design. The Exchange Authority shall accomplish its purpose through a robust portal that provides meaningful guidance to health benefit plans that meet the needs of the health care marketplace of this State and not through the limitations of health benefit plan options to qualified individuals or qualified employers or by excluding health benefit plans who meet the premium and solvency requirements approved by the North Carolina Department of Insurance. In establishing the Exchange Authority, it is the intent of the General Assembly to reduce the number of uninsured individuals in this State, promote improved competition in the health care marketplace, reduce health care costs by, among other things, improving reimbursements to health care providers for uncompensated care, increasing consumer education, increasing transparency, and assisting individuals and employers in accessing health coverage, premium tax credits, and cost-sharing reductions.

SECTION 2. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 8. North Carolina Health Benefit Exchange Act.

"**§ 58-50-300. Definitions.**

The following definitions apply to this Part:

(1) Agent. – Defined in G.S. 58-33-10(1).

(2) Board. – The Board of Directors of the North Carolina Health Benefit Exchange Authority.

(3) Broker. – Defined in G.S. 58-33-10(3).

(4) Commissioner. – The Commissioner of Insurance of North Carolina or the Commissioner's authorized designee.

(5) Educated Health Care Consumer. – An individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical, and scientific matters.

(6) Essential Health Benefits. – Defined under section 1302(b) of the Federal Act.

(7) Exchange Authority. – The North Carolina Health Benefit Exchange Authority established pursuant to G.S. 58-50-310 and includes the Individual Exchange and the SHOP Exchange, unless otherwise specified.

(8) Executive Director. – The individual selected by a majority vote of the Board members and hired to serve as the Executive Director of the Exchange Authority.

(9) Federal Act. – The federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as further amended, as well as any regulations or guidance issued under those acts.

(10) Grandfathered Health Plan Coverage or Grandfathered Health Plan. – Defined in 45 C.F.R. Part 147.140(a).

(11) Health Benefit Plan. – Defined in G.S. 58-3-167(a)(1).

(12) Health Care Provider. – Defined in G.S. 58-50-270(3a).

(13) Health Insurer or Insurer. – Defined in G.S. 58-68-25(a)(6) and, for the purposes of this act, the terms also include qualified nonprofit health insurance issuers (CO-OP Insurers) as provided in section 1322 of the Federal Act, and multistate Qualified Health Plans as provided in section 1334 of the Federal Act.

(14) Individual Exchange. – The Exchange through which Qualified Individuals may purchase coverage established pursuant to this Part.

(15) Navigator. – An individual who is either an employee of or has been licensed by the North Carolina Department of Insurance Consumer Assistance Program in accordance with the standards set forth by the Secretary, as provided in section 1311(i) of the Federal Act; and G.S. 58-50-340(18).

(16) Plan of Operation. – The articles, bylaws, and operating rules and procedures adopted by the Board in accordance with this Part.

(17) Qualified Dental Plan. – A limited scope dental plan that has been certified in accordance with G.S. 58-50-350.

(18) Qualified Employer. – A Small Employer that elects to make its full-time employees eligible for one or more Qualified Health Plans offered through the SHOP Exchange, and at the option of the employer, some or all of its part-time employees.

(19) Qualified Health Plan. – A Health Benefit Plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and G.S. 58-50-350.

(20) Qualified Individual. – An individual, including a minor, who meets all of the following requirements:

a. Is seeking to enroll in a Qualified Health Plan offered to individuals through the Individual Exchange.

b. Resides in this State pursuant to G.S. 58-50-175(18).

c. At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges.

d. Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

(21) Secretary. – The Secretary of the federal Department of Health and Human Services.

(22) SHOP Exchange. – The Small Business Health Options Program established in G.S. 58-50-34(13) that is designed to assist Qualified Employers in the State who are Small Employers in facilitating the enrollment of their employees in Qualified Health Plans offered in the small group market in the State.

(23) Small Employer. – An employer as such term is defined in G.S. 58-50-110(22), subject to the requirements of the Federal Act and the Public Health Service Act (PHSA).

"**§ 58-50-310. Exchange established; Board of Directors; Plan of Operation.**

(a) There is hereby created a nonprofit entity to be known as the North Carolina Health Benefit Exchange Authority, which is subject to the supervision of the Commissioner. Notwithstanding that the Exchange Authority may be supported in whole or in part from State or federal funds, the Exchange Authority is not an instrumentality of the State or federal government and shall be operated by the Board. The purpose of the Exchange Authority is to do the following:

(1) Create and administer an Individual Exchange and a SHOP Exchange which shall be operated as two separate health benefit exchanges and shall not be operated as one health benefit exchange.

(2) Facilitate the purchase and sale of Qualified Health Plans to Qualified Individuals and Qualified Employers.

(3) Assist Qualified Individuals in enrollment in Qualified Health Plans and assist Qualified Employers in facilitating the enrollment of their employees in Qualified Health Plans.

(b) There is established the North Carolina Health Benefit Exchange Authority Board. The Board shall have the duties and powers as established by this section.

(1) The North Carolina Health Benefit Exchange Authority Board shall consist of the Commissioner of Insurance, the Director of the Division of Medical Assistance, who shall both serve as ex officio nonvoting members of the Board, and 11 additional members appointed as follows:

a. Four members appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, as follows:

1. One member who represents the medical provider community, as recommended by the North Carolina Medical Society.

2. One member who represents an insurer, and is not a licensed health insurance agent, as recommended by the North Carolina Association of Health Plans.

3. One member who represents business, who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider, as recommended by the North Carolina Chamber.

4. One member who represents the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider and shall reasonably be expected to qualify for coverage in the

Individual Exchange or SHOP Exchange. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member.

b. Four members appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, as follows:

1. One member who represents the medical provider community, as recommended by the North Carolina Hospital Association.
2. One member who represents the insurance industry and is not a licensed health insurance agent.
3. One member who represents small business, who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider, as recommended by the National Federation of Independent Business.
4. One member who represents the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider and shall reasonably be expected to qualify for coverage in the Individual Exchange or SHOP Exchange. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member.

c. Three members appointed by the Governor, who do not represent the categories listed in sub-subdivision a. and sub-subdivision b. of this subdivision, as follows:

1. One member, who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider, who has expertise and experience in the development and operation of State-scale information technology systems capable of conducting electronic funds transfers, secure data transfers, and other electronic functions relating to the creation and ongoing operations of the Exchange Authority.
2. One member, who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider, who has expertise and experience in rural health policy, rural health economics, or rural health care finance as recommended by the North Carolina Rural Economic Development Center.
3. One member who has experience and expertise as a licensed health insurance agent in the State of North Carolina, as recommended by the North Carolina Association of Health Underwriters, the National Association of Insurance and Financial Advisors – North Carolina, and the Independent Insurance Agents of North Carolina.

(2) The initial appointments by the General Assembly upon the recommendation of the Speaker of the House of Representatives and the President Pro Tempore of the Senate shall be made no later than 30 days after enactment

of this Part and shall serve a term of three years. The initial appointments by the Governor shall be made no later than 30 days after enactment of this Part and shall be for a term of two years. All succeeding appointments shall be for terms of three years. Members shall not serve for more than two successive terms. A Board member's term shall continue until the member's successor is appointed by the original appointing authority. Vacancies shall be filled by the appointing authority for the unexpired portion of the term in which they occur. A Board member may be removed by the member's appointing authority or by the Commissioner for cause. The Board shall meet at least quarterly upon the call of the chair. A majority of the total membership of the Commission shall constitute a quorum. The Commissioner shall appoint a chair to serve for the initial two years of the Exchange Authority's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms. Board members shall receive travel allowances under G.S. 138-5 when traveling to and from meetings of the Board but shall not receive any subsistence allowance or per diem under subdivision (a)(1) of that section.

(3) The Board shall employ or fix compensation of the Executive Director.

(4) The Board shall appoint appropriate legal, actuarial, and other persons, entities, or committees as necessary to provide technical assistance in the operation, policy, contractual design, and other functions of the Exchange Authority.

(5) The Board shall adopt bylaws, policies, and procedures as may be necessary or convenient.

(6) Each member of the Board shall comply with the conflict of interest rules and recusal procedures set forth in the Plan of Operation.

(7) No member of the Board or staff shall make, participate in making, or in any way attempt to use his or her official position to influence the making of any decision that he or she knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally or on all members of a profession, occupation, industry, or general class, on him or her or a member of his or her immediate family, or which will have reasonably foreseeable material effect on any business entity in which the member or his or her immediate family is director, officer, partner, trustee, employee, or holds any position of management.

(8) Each member of the Board shall have the responsibility and duty to meet the requirements of this Part, the Federal Act, and all applicable State and federal laws, rules, and regulations to serve the public interest of the individuals and employers seeking health care coverage through the Exchange Authority, and to ensure the operational well-being and fiscal solvency of the Exchange Authority.

(c) The Board shall submit to the Commissioner a Plan of Operation for the Exchange Authority and any amendments.

(1) The Commissioner shall review and approve or disapprove the Plan of Operation within 90 days after its submission or resubmission. If the Commissioner fails to act within 90 days of submission, the Plan of Operation shall be deemed approved. If the Commissioner disapproves any part of the Plan of Operation, the Commissioner shall provide specific reasons for the disapproval and provide the Board an opportunity to revise and resubmit the Plan of Operation. The Plan of Operation shall become effective upon approval in writing by the Commissioner. If the Board fails to

submit a Plan of Operation within 180 days after the appointment of the Board that is approved by the Commissioner, or at any time thereafter fails to submit amendments as required by statute or federal law to the Plan of Operation, the Commissioner shall adopt temporary rules necessary to effectuate the provisions of this section. The rules shall continue in force until modified by the Commissioner or superseded by a Plan of Operation submitted by the Board and approved by the Commissioner.

(2) The Plan of Operation shall establish policies and procedures for operation of the Exchange Authority, including, but not limited to, the following:

a. Process by which the Board sets policies and conducts business, including bylaws.

b. Process for certifying Qualified Health Plans.

c. Plans for determining the need for and selection of eligible entities with whom to contract for performance of Exchange Authority functions or operations.

d. Fiscal operations of the Exchange Authority, addressing the collection, handling, disbursing, accounting, and auditing of assets and monies of the Exchange Authority and any eligible entity with whom the Exchange Authority contracts.

e. Statement acknowledging the fiduciary duty owed by the Exchange Authority to persons receiving Qualified Health Plan coverage through the Exchange Authority.

f. Process for evaluating the effectiveness of the Executive Director and the overall operations of the Exchange Authority.

g. Provide for conflict of interest rules and recusal procedures that require a Board member to recuse himself or herself from an official matter whenever that matter will have a reasonably foreseeable material effect, distinguishable from its effect on the public generally or on all members of a profession, occupation, industry, or general class, on any Board member, or his or her immediate family member or on any business entity in which the member or his or her immediate family is a direct, officer, partner, trustee, employee, or holds any position of management.

h. Identify an approach for coordinating efforts with the Department of Health and Human Services to fairly allocate administrative costs for eligibility determinations in the Exchange Authority and Medicaid.

i. Provide for other matters as may be necessary or proper for the execution of the Executive Director's powers, duties, and obligations under this act.

j. Appeals processes authorized by this Part, including appeals of tax credit eligibility, cost-sharing subsidy, mandate waiver determination, affordability determinations pursuant to G.S. 58-50-340 and appeals of Insurer noncertification or decertification pursuant to G.S. 58-50-350.

"**§ 58-50-320. Exchange Authority general powers.**

(a) The Exchange Authority shall have the general powers and authority granted under the laws of this State and the specific authority to do all of the following:

(1) Contract with an eligible entity for any of its functions described in this act. For the purposes of this act, an eligible entity has the same meaning as section 1311(f)(3)(B) of the Federal Act.

(2) Take legal action as necessary.

(3) Enter into information-sharing agreements with federal and State agencies and other state exchanges to carry out its responsibilities under this act provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all State and federal laws and regulations.

"**§ 58-50-330. General requirements.**

(a) The Exchange Authority shall make Qualified Health Plans available to Qualified Individuals and Qualified Employers beginning with effective dates on or after January 1, 2014.

(b) The Exchange Authority shall not make available any Health Benefit Plan that is not a Qualified Health Plan. The Exchange Authority shall allow a Health Insurer to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange Authority, either separately or in conjunction with a Qualified Health Plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

(c) The Exchange Authority, or any Insurer offering Qualified Health Plans through the Exchange Authority, shall not impose any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986 without regard to paragraph (1)(C) or (D) thereof) or such coverage has become affordable within the meaning of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

(d) The Exchange Authority may make a Qualified Health Plan available notwithstanding any provision of law that may require benefits other than the Essential Health Benefits specified under section 1302(b) of the Federal Act.

(1) Nothing in this section shall preclude a Qualified Health Plan from including benefits in addition to Essential Health Benefits, including wellness programs.

(2) To the extent that State law or regulation requires that a Qualified Health Plan include benefits in addition to the Essential Health Benefits, the State shall make payments to defray the cost of any additional benefits directly to an individual enrolled in a Qualified Health Plan or on behalf of an individual directly to the Health Insurer in whose Qualified Health Plan such individual is enrolled.

(3) To the extent that funding to defray the cost for such additional benefits is not provided, notwithstanding any requirements in Chapter 58 of the General Statutes, a Health Insurer is not required to include such additional benefits in a Qualified Health Plan, may discontinue such benefits at the time such funding is no longer available, and shall provide written or electronic notice of discontinuation of such benefits to insureds and contracted Health Care Providers as soon as is reasonably practicable. The Exchange Authority shall not require that a Qualified Health Plan provide such additional benefits when funding to defray the cost for such additional benefits is not provided.

(e) Nothing in this Part, and no action taken by the Exchange Authority pursuant to the Part, shall be construed to conflict with, preempt, limit, or supersede any applicable health insurance laws of this State or regulations adopted and orders issued by the Commissioner. Nothing in this Part shall be construed to conflict with, limit, or supersede the statutory or regulatory authority vested with the North Carolina Department of Insurance. Except as expressly provided to the contrary by federal law, Insurers and any other entities or persons participating in the Exchange Authority in this State shall comply fully with all applicable provisions of Chapter 58 of the General Statutes and all related regulations adopted and orders issued by the Commissioner. Participation in the Exchange Authority in any way, including

payment or receipt of payment in relation to a Qualified Health Benefits Plan, does not exempt any Insurer, entity, or person from complying fully with Chapter 58 of the General Statutes and all related regulations adopted and orders issued by the Commissioner.

(f) The Executive Director shall make an annual report to the Governor, Speaker of the House of Representatives, the President Pro Tempore of the Senate, and the Commissioner by March 1 of each year. The report shall summarize the activities of the Exchange Authority in the preceding calendar year, including information about the number and types of plans offered; number of Insurers; summary information about premiums, enrollment levels and enrollment/disenrollment activity, duration of coverage; and cost of operating the Exchange Authority.

(g) Neither the Board nor the employees of the Exchange Authority are liable for any obligations of the Exchange Authority. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the Exchange Authority or its agents or employees, the Board, the Executive Director, or the Commissioner or the Commissioner's representatives for any action taken by them in good faith in the performance of their powers and duties under this Part.

(h) The Exchange Authority, including the Board and its employees, is subject to the provisions of Article 33C of Chapter 143 of the General Statutes.

(i) The Executive Director, with the approval of the Board, shall operate the Exchange Authority in a manner so that the estimated cost of operating the Exchange Authority during any calendar year is not anticipated to exceed the total income the Exchange Authority expects to receive from any revenue available to the Exchange Authority.

(j) The Board shall provide for other matters as may be necessary and proper for the execution of the Executive Director's powers, duties, and obligations under this Part.

(k) All documents, papers, letters, maps, books, photographs, films, sound recordings, magnetic or other tapes, electronic data-processing records, artifacts, or other documentary material, regardless of physical form or characteristics within the possession of the Exchange Authority, including its employees and the Board, are subject to the provisions of Chapter 132 of the General Statutes except to the extent that these public records are protected under State or federal law, or are confidential or proprietary property of a person as defined in G.S. 66-152.

(l) The members of the Board and the Executive Director are public servants under G.S. 138A-3(30) and are subject to the provisions of Chapter 138A of the General Statutes.

"**§ 58-50-340. General duties.**

The Exchange Authority shall do the following:

(1) Facilitate the purchase and sale of Qualified Health Plans.

(2) Assist qualified individuals in this State with enrollment in Qualified Health Plans.

(3) Assist qualified employers in this State with enrollment of their employees in Qualified Health Plans.

(4) Implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and this Part, of health benefit plans as Qualified Health Plans.

(5) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance in a manner that is accessible to individuals with different communication needs and that effectively communicates information in a manner that is appropriate to the needs of the population being served by the Exchange Authority.

(6) Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act.

(7) Maintain an Internet Web site through which enrollees and prospective enrollees of Qualified Health Plans and individuals eligible for Medicaid or North Carolina Health Choice may obtain standardized comparative information on such plans.

(8) Assign a rating to each Qualified Health Plan offered through the Exchange Authority in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act, and determine each Qualified Health Plan's level of coverage in accordance with regulations issued by the Secretary under section 1302(d)(2)(A) of the Federal Act.

(9) Use a standardized format for presenting health benefit options in the Exchange Authority, including the use of the uniform outline of coverage established under section 2715 of the PHSA that supports consumer choice by making comprehensive information about health plans available in an objective, easy-to-understand format.

(10) In accordance with section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act, or any applicable State or local public program and if, through screening of the application by the Exchange Authority, the Exchange Authority determines that any individual is eligible for any such program, enroll that individual in that program.

(11) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act.

(12) Establish an Individual Exchange, through which Qualified Individuals may enroll in any qualified plan offered through the Individual Exchange for which they are eligible.

(13) Establish a SHOP Exchange through which Qualified Employers may make its employees eligible for one or more Qualified Health Plans offered through the SHOP Exchange or through which Qualified Employers may specify a level of coverage so that any of its employees may enroll in any Qualified Health Plan offered through the SHOP Exchange at the specified level of coverage.

(14) Subject to section 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because of either of the following:

a. There is no affordable Qualified Health Plan available through the Exchange Authority, or the individual's employer, covering the individual.

b. The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty.

(15) Transfer to the federal Secretary of the Treasury the following:

a. A list of the individuals who are issued a certification under subdivision (14) of this subsection, including the name and taxpayer identification number of each individual.

b. The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be

eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because of either of the following:

1. The employer did not provide minimum essential coverage.
2. The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code of 1986 to either be unaffordable to the employee or not provide the required minimum actuarial value.

c. The name and taxpayer identification number of the following:

1. Each individual who notifies the Exchange Authority under section 1411(b)(4) of the Federal Act that he or she has changed employers.
2. Each individual who ceases coverage under a Qualified Health Plan during a plan year and the effective date of that cessation.

(16) Provide to each employer the name of each employee of the employer described in sub-sub-subdivision b.2. of subdivision (15) of this subsection who ceases coverage under a Qualified Health Plan during a plan year and the effective date of the cessation.

(17) Perform duties required of the Exchange Authority by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions.

(18) Select Navigators and award grants to enable Navigators to do the following:

a. Conduct public education activities to raise awareness of the availability of Qualified Health Plans.
b. Distribute fair and impartial information concerning enrollment in Qualified Health Plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act.
c. Facilitate enrollment in Qualified Health Plans.
d. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHSA, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their Health Benefit Plan, coverage, or a determination under that plan or coverage.
e. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange Authority.

(19) Take into account any excess of premium growth outside of the Exchange Authority as compared to the rate of such growth inside the Exchange Authority when determining under section 1302(f)(2)(B) of the Federal Act whether to recommend to the General Assembly that Qualified Health Plans be offered in the large group market through the SHOP Exchange.

(20) Consult with stakeholders relevant to carrying out the activities required under this act, including, but not limited to, the following:

a. Educated health care consumers who are enrollees in Qualified Health Plans.
b. Individuals and entities with experience in facilitating enrollment in Qualified Health Plans.

c. Representatives of small businesses and self-employed individuals.
d. Representatives of Health Insurers that offer Qualified Health Plans through the Exchange Authority.
e. Representatives of Health Insurers that are not offering qualified plans through the Exchange Authority.
f. Representatives of Health Care Providers.
g. The Division of Medical Assistance.
h. The North Carolina Department of Insurance.
i. Advocates for enrolling hard to reach populations.

(21) Meet all of the following financial integrity requirements:
a. Keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the Secretary, the Governor, the Commissioner, and the General Assembly a report concerning such accountings.
b. Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Federal Act and allow the Secretary, in coordination with the Inspector General of the U.S. Department of Health and Human Services, to do all of the following:
1. Investigate the affairs of the Exchange Authority.
2. Examine the properties and records of the Exchange Authority.
3. Require periodic reports in relation to the activities undertaken by the Exchange Authority.
c. In carrying out its activities under this act, not use any funds intended for the administrative and operational expenses of the Exchange Authority for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or State legislative and regulatory modifications.

(22) Meet the following fiduciary duties and liability:
a. Any person who acts on behalf of an Exchange Authority shall act as a fiduciary. Such person shall ensure that the Exchange Authority is operated (i) solely in the interests of individuals participating in qualified health plans offered through the Exchange Authority and (ii) for the exclusive purpose of facilitating the purchase of Qualified Health Plans.
b. Any person who acts as a fiduciary on behalf of the Exchange Authority who breaches any of their responsibilities, obligations, or duties imposed by this section shall be liable to make good to the Exchange Authority, the Qualified Health Plans offered through the Exchange Authority, or participants of Qualified Health Plans offered through the Exchange Authority any losses resulting from each breach and shall be subject to such other legal or equitable relief as the court may deem appropriate, including removal of such fiduciary.

(23) With respect to eligibility determinations, provide for (i) review of enrollee appeals of Exchange Authority premium tax credit and cost-sharing reductions and mandate exemption determinations and establish procedures for identifying and confirming income levels of applicants for Exchange Authority coverage and eligibility for receipt of premiums and tax credits

and (ii) employer appeals of employer-sponsored plan availability or affordability determinations.

(24) Conduct a review of the costs and benefits of collecting and distributing premiums for small businesses. No later than January 1, 2015, the Exchange Authority shall report the results of the review, including analysis of the financial impact of such collection and distribution, and its recommendations to the North Carolina General Assembly. The Exchange Authority may implement and carry out a process for collecting and distributing premiums if it has sufficient funding to implement the initiative and upon approval by vote by both chambers of the North Carolina General Assembly.

(25) In conjunction with North Carolina Department of Health and Human Services, study the feasibility of offering a Basic Health Plan pursuant to section 1331 of the Federal Act and make a recommendation to the 2013 Regular Session of the 2013 General Assembly.

(26) Provide for publicity and outreach campaigns to raise awareness of the existence of the Exchange Authority and disseminate information regarding eligibility criteria, enrollment procedures, availability of premium tax credits and cost-sharing reductions, small employer tax credits, and other relevant information.

(27) Consider the extent to and the circumstances under which benefits for spiritual care services that are deductible under Section 213(d) of the Internal Revenue Code of 1986 as of January 1, 2011, will be made available under the Exchange Authority in accordance with Section 1311(d)(3)(B) of the Affordable Care Act.

"**§ 58-50-350. Health Benefit Plan certification.**

(a) The Exchange Authority shall certify a Health Benefit Plan as a Qualified Health Plan if the Department of Insurance determines that it satisfies the requirements set forth in subdivisions (1) through (6) of this subsection unless the Exchange Authority determines that making the plan available through the Exchange Authority is not in the interest of Qualified Individuals and Qualified Employers in this State.

(1) The plan provides the Essential Health Benefits package described in section 1302(a) of the Federal Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of Qualified Dental Plans, as provided in subsection (e) of this section, if both of the following occur:

a. The Exchange Authority has determined that at least one Qualified Dental Plan is available to supplement the plan's coverage.

b. The Insurer makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange Authority, that the plan does not provide the full range of essential pediatric benefits, and that Qualified Dental Plans providing those benefits and other dental benefits not covered by the plan are offered through the Exchange Authority.

(2) The premium rates and insurance policy forms, certifications, applications and riders have been approved by the Commissioner.

(3) The plan provides at least a bronze level of coverage, unless the plan is certified as a qualified catastrophic plan, meets the requirements of section 1302(e) of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage.

(4) The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the Federal Act, and if the plan is offered

through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act.

(5) The Health Insurer offering the plan meets the following requirements:

a. Is licensed and in good standing to offer health insurance coverage in this State.

b. Offers at least one Qualified Health Plan in the silver level and at least one plan in the gold level through each component of the Exchange Authority in which the Insurer participates, where "component" refers to the SHOP Exchange and the Individual Exchange.

c. Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange Authority and without regard to whether the plan is offered directly from the Insurer or through an insurance producer.

d. Does not charge any cancellation fees or penalties in violation of G.S. 58-50-330(c).

e. Complies with the regulations developed by the Secretary under section 1311(d) of the Federal Act and such other requirements as the Exchange Authority may establish.

(6) The plan meets the requirements of certification as promulgated by regulation pursuant to this section and by the Secretary under section 1311(c) of the Federal Act.

(b) The Exchange Authority shall not exclude a health plan through the imposition of premium price controls nor shall it exclude a health plan based on the following:

(1) That the plan is a fee-for-service plan.

(2) That the Health Benefit Plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange Authority determines are inappropriate or too costly.

(c) The Exchange Authority shall require each Health Insurer seeking certification of a plan as a Qualified Health Plan to do the following:

(1) Submit a justification for any premium increase before implementation of that increase. The Insurer shall prominently post such information on its Internet Web site. The Exchange Authority shall take this information, along with the information and the recommendations provided to the Exchange Authority by the Commissioner under section 2794(b) of the PHSA, relating to patterns or practices of excessive or unjustified premium increases, into consideration when determining whether to continue to allow the Insurer to make plans available through the Exchange Authority. In no case shall an Exchange Authority impose any premium price controls or restrict premiums that otherwise meet the requirements of State law.

(2) Make available to the public and submit to the Exchange Authority, the Secretary, and the Commissioner, accurate and timely disclosure of the following:

a. Claims payment policies and practices.

b. Periodic financial disclosures.

c. Data on enrollment.

d. Data on disenrollment.

e. Data on the number of claims that are denied.

f. Data on rating practices.

g. Information on cost-sharing and payments with respect to any out-of-network coverage.

h. Information on enrollee and participant rights under title I of the Federal Act.

i. Other information as determined appropriate by the Secretary.

The information shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act.

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, co-payments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet Web site and through other means for individuals without access to the Internet.

(d) The Exchange Authority shall establish and publish a transparent, objective process for denying certification or decertifying Qualified Health Plans.

(1) The Exchange Authority shall give each Health Insurer the opportunity to appeal a decertification decision or the denial of certification as a Qualified Health Plan.

(2) The Exchange Authority shall give each Health Insurer that appeals a decertification decision or the denial of certification the opportunity for the following:

a. The submission and consideration of facts, arguments, or proposals of adjustment of the health plan or plans at issue.

b. A hearing and a decision on the record, to the extent that the Exchange Authority and the Health Insurer are unable to reach agreement following the submission of the information in sub-subdivision a. of this subdivision.

(3) Any hearing held pursuant to subdivision (2) of this subsection shall be conducted by an impartial party agreed to by the Exchange Authority and the Health Insurer. If the Exchange Authority and the Health Insurer cannot agree on an impartial party, then the hearing must be held by an administrative law judge.

(4) The hearing decision may be appealed to the North Carolina Court of Appeals by the aggrieved party.

(e) The Exchange Authority shall not exempt any Health Insurer seeking certification of a Qualified Health Plan, regardless of the type or size of the Insurer, from State licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among Health Insurers participating in the Exchange Authority.

(1) The provisions of this act that are applicable to Qualified Health Plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of subdivisions (2), (3), and (4) of this subsection or by regulations adopted by the Commissioner.

(2) The Insurer shall be licensed to offer dental coverage but need not be licensed to offer other health benefits.

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by Health Benefit Plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to section 1302(b)(1)(J) of the Federal Act and such other dental benefits as the Exchange Authority or the Secretary may specify by regulation.

(4) Insurers may jointly offer a comprehensive plan through the Exchange Authority in which the dental benefits are provided by an Insurer through a

Qualified Dental Plan and the other benefits are provided by an Insurer through a Qualified Health Plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

"**§ 58-50-360. Choice.**

(a) In accordance with section 1312(f)(2)(A) of the Federal Act, a Qualified Employer may either designate one or more Qualified Health Plans from which its employees may choose or designate any level of coverage to be made available to employees through the SHOP Exchange.

(b) In accordance with section 1312(b) of the Federal Act, a Qualified Individual enrolled in any Qualified Health Plan may pay any applicable premium owed by such individual to the Health Insurer issuing such Qualified Health Plan.

(c) In accordance with section 1312(c) of the Federal Act, the following risk pools are established:

(1) Individual Market. – A Health Insurer shall consider all enrollees in all health plans other than Grandfathered Health Plans offered by such Insurer in the individual market, including those enrollees who do not enroll in such plans through the Individual Exchange, to be members of a single risk pool.

(2) Small Group Market. – A Health Insurer shall consider all enrollees in all health plans other than Grandfathered Health Plans offered by such Insurer in the small group market, including those enrollees who do not enroll in such plans through the SHOP Exchange, to be members of a single risk pool.

(d) In accordance with section 1312(d) of the Federal Act, this section shall not prohibit either of the following:

(1) A Health Insurer from offering outside of the Individual Exchange or the SHOP Exchange a health plan to a Qualified Individual or a Qualified Employer.

(2) A Qualified Individual from enrolling in, or a Qualified Employer from selecting for its employees, a health plan offered outside of the Exchange Authority.

(e) This section shall not limit the operation of any requirement under State law or regulation with respect to any policy or plan that is offered outside of the Exchange Authority with respect to any requirement to offer benefits.

(f) Nothing in this section shall restrict the choice of a Qualified Individual to enroll or not to enroll in a Qualified Health Plan or to participate in the Individual Exchange.

(g) Nothing in this section shall compel an individual to enroll in a Qualified Health Plan or to participate in the Exchange Authority.

(h) A Qualified Individual may enroll in any Qualified Health Plan, except that in the case of a catastrophic plan described in section 1302(e) of the Federal Act, a Qualified Individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1312(e)(2) of the Federal Act.

(i) Nothing in this act or the Federal Act shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any Health Benefit Plan that is offered outside of the Exchange Authority.

(j) In accordance with section 1312(e) of the Federal Act, the Exchange Authority shall allow Agents or Brokers to do the following:

(1) To enroll Qualified Individuals and Qualified Employers in any Qualified Health Plan offered through the Exchange Authority for which the individual or employer is eligible.

(2) To assist Qualified Individuals in applying for premium tax credits and cost-sharing reductions for any Qualified Health Plan purchased through the Individual Exchange.

(k) Any compensation to Agents and Brokers paid under this Part shall be determined by the insurer.

"**§ 58-50-370. Funding; publication of costs.**

(a) Beginning in 2014, the funding stream that supports the North Carolina Health Insurance Risk Pool shall be utilized to support the operations of the Exchange Authority. Beginning in 2015, the funding stream that supports the North Carolina Health Insurance Risk Pool shall be utilized to support the operations of the Exchange Authority that serve those individuals with incomes less than or equal to four hundred percent (400%) of the federal poverty level and Qualified Employers receiving a tax credit for the purchase of insurance pursuant to the Federal Act. The proportional cost associated with serving individuals with incomes over four hundred percent (400%) of the federal poverty level and the Qualified Employers not receiving a tax credit pursuant to the Federal Act shall be funded by an annual user fee paid by the individual or the employer to the Exchange Authority. The user fee assessed by the Exchange Authority shall be no greater than the anticipated expenses for serving this market for the applicable fiscal year and must be approved by the Commissioner. Additionally, the Exchange Authority is authorized to utilize grant funding for operations, including, but not limited to, grant funding from the Federal Department of Health and Human Services. The Exchange Authority is also authorized to collect and use advertising fees to help support operations of the Exchange Authority.

(b) Prior to the commencement of the 2013 Regular Session of the 2013 General Assembly, the Exchange Authority shall examine its potential operational costs and propose to the General Assembly any additional changes to the funding stream necessary to ensure its solvency. Proposals submitted by the Exchange Authority to ensure the Exchange Authority's solvency shall not include appropriations from the General Fund.

(c) As required by section 1311(d)(5)(A) of the Federal Act, the Exchange Authority shall be self-sustaining by January 1, 2015. A budget for the Exchange Authority shall be prepared by the Exchange Authority and submitted to the Commissioner annually for approval at least 120 days before the beginning of the next fiscal year.

(d) Services performed by the Exchange Authority on behalf of other State or federal programs shall be paid for by those State or federal programs.

(e) Any unspent funding by the Exchange Authority shall be used for future operation of the Exchange Authority or reducing future user fees.

(f) The Exchange Authority shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange Authority, and the administrative costs of the Exchange Authority, on an Internet Web site to educate consumers on such costs. This information shall include information on monies lost to waste, fraud, and abuse.

(g) The Exchange Authority is exempt from any and all State taxes.

"**§ 58-50-380. Audit.**

An audit of the Exchange Authority shall be conducted annually under the oversight of the State Auditor. The cost of the audit shall be reimbursed to the State Auditor from Exchange Authority funds.

SECTION 3. Nothing in this Act shall be construed to interfere with payments to federally qualified health centers. If any item or service covered by a qualified health plan is provided by a federally qualified health center, as defined in section 1905(1)(2)(B) under the Social Security Act 42 U.S.C. 1396d(1)(2)(B), to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or services an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Social Security Act for such item or service.

SECTION 4. Severability. – If any provision of this act is held invalid by a court of competent jurisdiction, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, is repealed. If section 1311 of the federal Patient Protection and Affordable Care Act or the federal Patient Protection and Affordable Care Act in its entirety is repealed or held invalid by a court of competent jurisdiction, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, is repealed. If funding is not provided as set forth in the federal Patient Protection and Affordable Care Act, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, shall not be enforceable.

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

HOUSE BILL 115:
North Carolina Health Benefit Exchange

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	April 18, 2011
Introduced by:	Reps. Dockham, Brubaker, Wray, Murry	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	PCS to Second Edition H115-CSTK-8		

SUMMARY: ***The PCS to House Bill 115 adds a new Part to Article 50 of Chapter 58 of the General Statutes creating the North Carolina Health Benefit Exchange.***

CURRENT LAW: The federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, P.L. 111-152, (hereafter "The ACA") directs that States may set up Health Benefit Exchanges for individuals and small businesses to purchase health insurance. An Exchange for small businesses is known as the Small Business Health Options Program or "SHOP" Exchange. A state is not required to create its own Exchange. If a state does not create its own exchange, the federal government will create one for the state. If the state chooses to create its own Exchange, the Exchange(s) must be functional by 2014, at the time when citizens and legal immigrants will be required to pay a penalty if they do not have qualified health insurance unless they meet specific exemptions. A state's Health Benefit Exchange must ensure that it is financially self-sufficient beginning January 1, 2015. Section 1311(d) of the ACA outlines certain Exchange requirements and functions.

BILL ANALYSIS:

§58-50-300. Definitions. This definition section applies only to the newly created Part 8 of Article 50 of Chapter 58 of the General Statutes.

- A "qualified employer" is a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the SHOP Exchange.
- A "qualified individual" is to be defined as an individual, including a minor, who meets all of the following requirements: is seeking to enroll in a qualified health plan offered to individuals through the Exchange, resides in this State, is not incarcerated at the time of enrollment, other than incarceration pending the disposition of charges, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.
- A "Small employer" is any individual actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than 50 eligible employees, the majority of whom are employed within this State, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists.

58-50-310. Exchange established; board of directors; plan of operation. The Exchange Authority may be supported in whole or in part by State funds but is not an instrumentality of the State. The Exchange Authority is subject to the supervision of the Commissioner of Insurance. This section of the

bill also directs that the Exchange Authority will be operated by the Board of Directors. The Exchange Authority will create two separate Exchanges: the Individual Exchange and the SHOP Exchange.

The Board consists of the following 13 members:

- The Commissioner of Insurance, serving as an ex officio, nonvoting member.
- The Director of the Division of Medical Assistance, serving as an ex officio, nonvoting member.
- Four members appointed by the President Pro Tempore of the Senate:
  - One member who represents the medical provider community, recommended by the North Carolina Medical Society.
  - One member who represents an insurer, and is not a licensed health insurance agent, as recommended by the North Carolina Association of Health Plans.
  - One member who represents business, who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, as recommended by the North Carolina Chamber.
  - One member of the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, who can reasonably be expected to qualify for coverage in the Exchanges.
- Four members appointed by the Speaker of the House of Representatives:
  - One member who represents the medical provider community, as recommended by the North Carolina Hospital Association.
  - One member who represents the insurance industry and is not a licensed health insurance agent.
  - One member who represents small business, who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, as recommended by the National Federation of Independent Business.
  - One member of the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, who can reasonably be expected to qualify for coverage in the Exchanges.
- Three members appointed by the Governor:
  - One member, who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, who has expertise and experience in the development and operation of State-scale information technology systems.
  - One member, who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, who has expertise and experience in rural health policy, rural health economics, or rural health care finance as recommended by the North Carolina Rural Economic Development Center.
  - One member who has expertise and experience as a licensed health insurance agent in this State, as recommended by the North Carolina Association of Health Underwriters, the National Association of Insurance and Financial Advisors – North Carolina, and the Independent Insurance Agents of North Carolina.

Initial appointments are staggered, after which all succeeding appointments will be for three years. Members are not allowed to serve for more than two consecutive terms. A Board member may not influence any decision that might have a material financial effect on him or her or a member of his or her immediate family.

The Board is required to submit to the Commissioner a Plan of Operation for the Exchange. The Plan of Operation will be effective upon written approval of the Commissioner. The Plan of Operation must

ıclude policies and procedures for fiscal operations of the Exchange Authority, a statement acknowledging the fiduciary duty owed by the Exchange Authority to persons it services, and an approach to coordinate with DHHS to fairly allocate administrative costs for eligibility determinations in the Exchange Authority and Medicaid.

§ 58-50-320. Exchange Authority general powers. The Exchange Authority has the power and authority to enter into contracts, to take legal action, and to enter into information-sharing agreements with federal and State agencies and other state exchanges.

§ 58-50-330. General requirements. The Exchange Authority will make qualified health plans available January 1, 2014. The Exchange Authority cannot charge a fee if an individual enrolls in another type of minimum essential coverage if that individual has become newly eligible or insurance has become affordable through their employer. A qualified health plan may include benefits above and beyond the essential benefits, and if a state law or regulation requires doing so, the state will make payment to defray the cost. If payments to defray the costs are not made, the insurer is not required to include those additional benefits in their health plans. Nothing in this Part is meant to conflict with or limit any state insurance laws or regulations adopted by the Commissioner. The Exchange Authority is subject to the Public Meetings laws and Public Records laws. Additionally, the members of the Board and the Executive Director are public servants for purposes of the State Ethics Act.

§ 58-50-340. General duties. Among its duties, the Exchange Authority will facilitate the purchase and ⁻ıle of qualified health plans, operate a toll-free telephone hotline and an internet web-site, rate qualified ɜalth plans, inform individuals of eligibility requirements under Medicaid and CHIP and enroll ...dividuals qualifying for those plans, provide pertinent information to the federal Secretary of the Treasury including information regarding exempted individuals and individuals receiving premium tax credits, take into account any excess of premium growth when recommending to the General Assembly whether or not to open the SHOP Exchange to the large group market, and meet financial integrity requirements and fiduciary duty requirements. Additionally, the Exchange Authority shall also conduct a review of costs and benefits of collecting and distributing premiums for small business, as well as study the feasibility of offering a Basic Health Plan and make recommendations on both issues to the General Assembly.

§ 58-50-350. Health Benefit Plan certification. The conditions under which the Exchange Authority will certify a health benefit plan as a qualified health plan include approval of the Commissioner of specific requirements unless the Exchange Authority determines that making the plan available is not in the interest of qualified individuals and employers. Additionally, the Exchange Authority will require each insurer to submit a justification for any premium increases. There are limits as to why the Exchange Authority may exclude a plan. The Exchange Authority is not allowed to impose premium price controls. The Exchange Authority must establish a process for certifying and decertifying claims, including an appeals process.

§ 58-50-360. Choice. There will be two risk pools: one for the Individual Exchange and one for the SHOP Exchange. Both risk pools will consist of all enrollees within that market, including those not ⁻ırchased on the Exchange. Agents and brokers will be allowed to enroll on the Exchange Authority.

58-50-370. Funding; Publication of costs. The Exchange Authority utilizes the funding stream which currently supports the North Carolina Health Insurance Risk Pool for the operations of the Exchange beginning in 2014. In 2015, that funding stream will support operation of the Exchange

Authority that serves individuals with incomes less than 400% of the federal poverty level as well as qualified employers receiving a tax credit. All other users shall pay an annual user fee to the Exchange Authority, which must be approved by the Commissioner. Services performed by the Exchange Authority on behalf of other state or federal programs shall be paid for by those state or federal programs. The Exchange is exempt from all State taxes.

§ 58-50-380. Audit. There will be an annual audit of the Exchange Authority by the State Auditor.

Nothing in the Act will be construed to interfere with payments to Federally-qualified health centers.

The bill contains a severability clause. If the any portion of the act is found invalid, then the whole act is repealed. If the ACA is repealed or found invalid, then this act is repealed. If the ACA is not funded, the this act is unenforceable.

EFFECTIVE DATE: This act is effective when it becomes law.

H115-SMTK-18(CSTK-8) v1

HOUSE BILL 115
Committee Substitute Favorable 3/30/11

Short Title: North Carolina Health Benefit Exchange. (Public)

Sponsors:

Referred to:

February 17, 2011

A BILL TO BE ENTITLED

AN ACT TO PRESERVE STATE-BASED AUTHORITY TO REGULATE THE NORTH CAROLINA HEALTH INSURANCE MARKET AND TO PREVENT FEDERAL ENCROACHMENT ON STATE AUTHORITY BY ESTABLISHING THE NORTH CAROLINA BENEFIT EXCHANGE.

The General Assembly of North Carolina enacts:

SECTION 1. The purpose of this act is to provide for the establishment of the North Carolina Health Benefits Exchange Authority (Exchange Authority). The purpose of the Exchange Authority is to facilitate the purchase and role of qualified health plans in the individual and small employer market by providing education, outreach, and technical assistance. The General Assembly believes it is in the best interest of the State, and thus the purpose of the Exchange Authority, to promote competition and choice in the health care marketplace and to facilitate innovation by offering products with variation in price and design. The Exchange Authority shall accomplish its purpose through a robust portal that provides meaningful guidance to health benefit plans that meet the needs of the health care marketplace of this State and not through the limitations of health benefit plan options to qualified individuals or qualified employers or by excluding health benefit plans who meet the premium and solvency requirements approved by the North Carolina Department of Insurance. In establishing the Exchange Authority, it is the intent of the General Assembly to reduce the number of uninsured individuals in this State, promote improved competition in the health care marketplace, reduce health care costs by, among other things, improving reimbursements to health care providers for uncompensated care, increasing consumer education, increasing transparency, and assisting individuals and employers in accessing health coverage, premium tax credits, and cost-sharing reductions.

SECTION 2. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 8. North Carolina Health Benefit Exchange Act.

"**§ 58-50-300. Definitions.**

The following definitions apply to this Part:

(1) Agent. – Defined in G.S. 58-33-10(1).

(2) Board. – The Board of Directors of the North Carolina Health Benefit Exchange Authority.

(3) Broker. – Defined in G.S. 58-33-10(3).

(4) Commissioner. – The Commissioner of Insurance of North Carolina or the Commissioner's authorized designee.

(5) Educated Health Care Consumer. – An individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical, and scientific matters.

(6) Essential Health Benefits. – Defined under section 1302(b) of the Federal Act.

(7) Exchange Authority. – The North Carolina Health Benefit Exchange Authority established pursuant to G.S. 58-50-310 and includes the Individual Exchange and the SHOP Exchange, unless otherwise specified.

(8) Executive Director. – The individual selected by a majority vote of the Board members and hired to serve as the Executive Director of the Exchange Authority.

(9) Federal Act. – The federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as further amended, as well as any regulations or guidance issued under those acts.

(10) Grandfathered Health Plan Coverage or Grandfathered Health Plan. – Defined in 45 C.F.R. Part 147.140(a).

(11) Health Benefit Plan. – Defined in G.S. 58-3-167(a)(1).

(12) Health Care Provider. – Defined in G.S. 58-50-270(3a).

(13) Health Insurer or Insurer. – Defined in G.S. 58-68-25(a)(6) and, for the purposes of this act, the terms also include qualified nonprofit health insurance issuers (CO-OP Insurers) as provided in section 1322 of the Federal Act, and multistate Qualified Health Plans as provided in section 1334 of the Federal Act.

(14) Individual Exchange. – The Exchange through which Qualified Individuals may purchase coverage established pursuant to this Part.

(15) Plan of Operation. – The articles, bylaws, and operating rules and procedures adopted by the Board in accordance with this Part.

(16) Qualified Dental Plan. – A limited scope dental plan that has been certified in accordance with G.S. 58-50-350.

(17) Qualified Employer. – A Small Employer that elects to make its full-time employees eligible for one or more Qualified Health Plans offered through the SHOP Exchange, and at the option of the employer, some or all of its part-time employees.

(18) Qualified Health Plan. – A Health Benefit Plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and G.S. 58-50-350.

(19) Qualified Individual. – An individual, including a minor, who meets all of the following requirements:

a. Is seeking to enroll in a Qualified Health Plan offered to individuals through the Individual Exchange.

b. Resides in this State pursuant to G.S. 58-50-175(18).

c. At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges.

d. Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

(20) Secretary. – The Secretary of the federal Department of Health and Human Services.

(21) SHOP Exchange. – The Small Business Health Options Program established in G.S. 58-50-340(a)(13) that is designed to assist Qualified Employers in

the State who are Small Employers in facilitating the enrollment of their employees in Qualified Health Plans offered in the small group market in the State.

(22) Small Employer. – An employer as such term is defined in G.S. 58-50-110(22), subject to the requirements of the Federal Act and the Public Health Service Act (PHSA).

"**§ 58-50-310. Exchange established; Board of Directors; Plan of Operation.**

(a) There is hereby created a nonprofit entity to be known as the North Carolina Health Benefit Exchange Authority, which is subject to the supervision of the Commissioner. Notwithstanding that the Exchange Authority may be supported in whole or in part from State or federal funds, the Exchange Authority is not an instrumentality of the State or federal government and shall be operated by the Board. The purpose of the Exchange Authority is to do the following:

(1) Create and administer an Individual Exchange and a SHOP Exchange which shall be operated as two separate health benefit exchanges and shall not be operated as one health benefit exchange.

(2) Facilitate the purchase and sale of Qualified Health Plans to Qualified Individuals and Qualified Employers.

(3) Assist Qualified Individuals in enrollment in Qualified Health Plans and assist Qualified Employers in facilitating the enrollment of their employees in Qualified Health Plans.

(b) There is established the North Carolina Health Benefit Exchange Authority Board. The Board shall have the duties and powers as established by this section.

(1) The North Carolina Health Benefit Exchange Authority Board shall consist of the Commissioner of Insurance, the Director of the Division of Medical Assistance, who shall both serve as ex officio nonvoting members of the Board, and 11 additional members appointed as follows:

a. Four members appointed by the President Pro Tempore of the Senate as follows:

1. One member who represents the medical provider community, as recommended by the North Carolina Medical Society.

2. One member who represents an insurer, as recommended by the North Carolina Association of Health Plans.

3. One member who represents business, as recommended by the North Carolina Chamber.

4. One member who represents the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider and shall reasonably be expected to qualify for coverage in the Individual Exchange or SHOP Exchange. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member.

b. Four members appointed by the Speaker of the House of Representatives as follows:

1. One member who represents the medical provider community, as recommended by the North Carolina Hospital Association.

2. One member who represents the insurance industry.

3. One member who represents small business, as recommended by the National Federation of Independent Business.
4. One member who represents the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider and shall reasonably be expected to qualify for coverage in the Individual Exchange or SHOP Exchange. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member.

c. Three members appointed by the Governor who do not represent the categories listed in sub-subdivision a. and sub-subdivision b. of this subdivision and have expertise and experience in one or more of the subject area groupings: development and operation of State-scale information technology systems capable of conducting electronic funds transfers, secure data transfers, and other electronic functions relating to the creation and ongoing operations of the Exchange Authority; health economics or health care finance; actuarial science or risk management; health policy analysis or health law; or as a health insurance agent.

(2) The initial appointments by the General Assembly upon the recommendation of the Speaker of the House of Representatives and the President Pro Tempore of the Senate shall be made no later than 30 days after enactment of this Part and shall serve a term of three years. The initial appointments by the Governor shall be made no later than 30 days after enactment of this Part and shall be for a term of two years. All succeeding appointments shall be for terms of three years. Members shall not serve for more than two successive terms. A Board member's term shall continue until the member's successor is appointed by the original appointing authority. Vacancies shall be filled by the appointing authority for the unexpired portion of the term in which they occur. A Board member may be removed by the member's appointing authority or by the Commissioner for cause. The Board shall meet at least quarterly upon the call of the chair. A majority of the total membership of the Commission shall constitute a quorum. The Commissioner shall appoint a chair to serve for the initial two years of the Exchange Authority's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms. Board members shall receive travel allowances under G.S. 138-5 when traveling to and from meetings of the Board but shall not receive any subsistence allowance or per diem under subdivision (a)(1) of that section.

(3) The Board shall employ or fix compensation of the Executive Director.

(4) The Board shall appoint appropriate legal, actuarial, and other persons, entities, or committees as necessary to provide technical assistance in the operation, policy, contractual design, and other functions of the Exchange Authority.

(5) The Board shall adopt bylaws, policies, and procedures as may be necessary or convenient.

(6) Each member of the Board shall comply with the conflict of interest rules and recusal procedures set forth in the Plan of Operation.

(7) No member of the Board or staff shall make, participate in making, or in any way attempt to use his or her official position to influence the making of any

decision that he or she knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on him or her or a member of his or her immediate family, or which will have reasonable foreseeable material effect on any business entity in which the member or his or her immediate family is director, officer, partner, trustee, employee, or holds any position of management.

(8) Each member of the Board shall have the responsibility and duty to meet the requirements of this Part, the Federal Act, and all applicable State and federal laws, rules, and regulations to serve the public interest of the individuals and employers seeking health care coverage through the Exchange Authority, and to ensure the operational well-being and fiscal solvency of the Exchange Authority.

(c) The Board shall submit to the Commissioner a Plan of Operation for the Exchange Authority and any amendments.

(1) The Commissioner shall review and approve or disapprove the Plan of Operation within 90 days after its submission or resubmission. If the Commissioner fails to act within 90 days of submission, the Plan of Operation shall be deemed approved. If the Commissioner disapproves any part of the Plan of Operation, the Commissioner shall provide specific reasons for the disapproval and provide the Board an opportunity to revise and resubmit the Plan of Operation. The Plan of Operation shall become effective upon approval in writing by the Commissioner. If the Board fails to submit a Plan of Operation within 180 days after the appointment of the Board that is approved by the Commissioner, or at any time thereafter fails to submit amendments as required by statute or federal law to the Plan of Operation, the Commissioner shall adopt temporary rules necessary to effectuate the provisions of this section. The rules shall continue in force until modified by the Commissioner or superseded by a Plan of Operation submitted by the Board and approved by the Commissioner.

(2) The Plan of Operation shall establish policies and procedures for operation of the Exchange Authority, including, but not limited to, the following:

a. Process by which the Board sets policies and conducts business, including bylaws.

b. Process for certifying Qualified Health Plans.

c. Plans for determining the need for and selection of eligible entities with whom to contract for performance of Exchange Authority functions or operations.

d. Fiscal operations of the Exchange Authority, addressing the collection, handling, disbursing, accounting, and auditing of assets and monies of the Exchange Authority and any eligible entity with whom the Exchange Authority contracts.

e. Statement acknowledging the fiduciary duty owed by the Exchange Authority to persons receiving Qualified Health Plan coverage through the Exchange Authority.

f. Process for evaluating the effectiveness of the Executive Director and the overall operations of the Exchange Authority.

g. Provide for conflict of interest rules and recusal procedures that require a Board member to recuse himself or herself from an official matter, whenever the Board member or his or her immediate family has any financial involvement or interest in that matter.

h. Identify an approach for coordinating efforts with the Department of Health and Human Services to fairly allocate administrative costs for eligibility determinations in the Exchange Authority and Medicaid.

i. Provide for other matters as may be necessary or proper for the execution of the Executive Director's powers, duties, and obligations under this act.

j. Appeals processes authorized by this Part, including appeals of tax credit eligibility, cost-sharing subsidy, mandate waiver determination, affordability determinations pursuant to G.S. 58-50-340 and appeals of Insurer noncertification or decertification pursuant to G.S. 58-50-350.

"**§ 58-50-320. Exchange Authority general powers.**

(a) The Exchange Authority shall have the general powers and authority granted under the laws of this State and the specific authority to do all of the following:

(1) Contract with an eligible entity for any of its functions described in this act. For the purposes of this act, an eligible entity has the same meaning as section 1311(f)(3)(B) of the Federal Act.

(2) Take legal action as necessary.

(3) Enter into information-sharing agreements with federal and State agencies and other state exchanges to carry out its responsibilities under this act provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all State and federal laws and regulations.

"**§ 58-50-330. General requirements.**

(a) The Exchange Authority shall make Qualified Health Plans available to Qualified Individuals and Qualified Employers beginning with effective dates on or after January 1, 2014.

(b) The Exchange Authority shall not make available any Health Benefit Plan that is not a Qualified Health Plan. The Exchange Authority shall allow a Health Insurer to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange Authority, either separately or in conjunction with a Qualified Health Plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

(c) Neither the Exchange Authority nor an Insurer offering Qualified Health Plans through the Exchange Authority may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

(d) The Exchange Authority may make a Qualified Health Plan available notwithstanding any provision of law that may require benefits other than the Essential Health Benefits specified under section 1302(b) of the Federal Act.

(1) Nothing in this section shall preclude a Qualified Health Plan from including benefits in addition to Essential Health Benefits, including wellness programs.

(2) To the extent that State law or regulation requires that a Qualified Health Plan include benefits in addition to the Essential Health Benefits, the State shall make payments to defray the cost of any additional benefits directly to an individual enrolled in a Qualified Health Plan or on behalf of an individual directly to the Health Insurer in whose Qualified Health Plan such individual is enrolled.

(3) To the extent that funding to defray the cost for such additional benefits is not provided, notwithstanding any requirements in Chapter 58 of the General Statutes, a Health Insurer is not required to include such additional benefits in a Qualified Health Plan, may discontinue such benefits at the time such funding is no longer available, and shall provide written or electronic notice of discontinuation of such benefits to insureds and contracted Health Care Providers as soon as is reasonably practicable. The Exchange Authority shall not require that a Qualified Health Plan provide such additional benefits when funding to defray the cost for such additional benefits is not provided.

(e) Nothing in this Part, and no action taken by the Exchange Authority pursuant to the Part, shall be construed to conflict with, preempt, limit, or supersede any applicable health insurance laws of this State or regulations adopted and orders issued by the Commissioner. Nothing in this Part shall be construed to conflict with, limit, or supersede the statutory or regulatory authority vested with the North Carolina Department of Insurance. Except as expressly provided to the contrary by federal law, Insurers and any other entities or persons participating in the Exchange Authority in this State shall comply fully with all applicable provisions of Chapter 58 of the General Statutes and all related regulations adopted and orders issued by the Commissioner. Participation in the Exchange Authority in any way, including payment or receipt of payment in relation to a Qualified Health Benefits Plan, does not exempt any Insurer, entity, or person from complying fully with Chapter 58 of the General Statutes and all related regulations adopted and orders issued by the Commissioner.

(f) The Executive Director shall make an annual report to the Governor, Speaker of the House of Representatives, the President Pro Tempore of the Senate, and the Commissioner by March 1 of each year. The report shall summarize the activities of the Exchange Authority in the preceding calendar year, including information about the number and types of plans offered; number of Insurers; summary information about premiums, enrollment levels and enrollment/disenrollment activity, duration of coverage; and cost of operating the Exchange Authority.

(g) Neither the Board nor the employees of the Exchange Authority are liable for any obligations of the Exchange Authority. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the Exchange Authority or its agents or employees, the Board, the Executive Director, or the Commissioner or the Commissioner's representatives for any action taken by them in good faith in the performance of their powers and duties under this Part.

(h) The Exchange Authority, including the Board and its employees, is subject to the provisions of Article 33C of Chapter 143 of the General Statutes.

(i) The Executive Director, with the approval of the Board, shall operate the Exchange Authority in a manner so that the estimated cost of operating the Exchange Authority during any calendar year is not anticipated to exceed the total income the Exchange Authority expects to receive from any revenue available to the Exchange Authority.

(j) The Board shall provide for other matters as may be necessary and proper for the execution of the Executive Director's powers, duties, and obligations under this Part.

(k) All documents, papers, letters, maps, books, photographs, films, sound recordings, magnetic or other tapes, electronic data-processing records, artifacts, or other documentary material, regardless of physical form or characteristics within the possession of the Exchange Authority, including its employees and the Board, are subject to the provisions of Chapter 132 of the General Statutes except to the extent that these public records are protected under State or federal law, or are confidential or proprietary property of a person as defined in G.S. 66-152.

(l) The members of the Board and the Executive Director are public servants under G.S. 138A-3(30) and are subject to the provisions of Chapter 138A of the General Statutes.

"**§ 58-50-340. General duties.**

(a) The Exchange Authority shall do the following:

(1) Facilitate the purchase and sale of Qualified Health Plans.

(2) Assist qualified individuals in this State with enrollment in Qualified Health Plans.

(3) Assist qualified employers in this State with enrollment of their employees in Qualified Health Plans.

(4) Implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and this Part, of health benefit plans as Qualified Health Plans.

(5) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance in a manner that is accessible to individuals with different communication needs and that effectively communicates information in a manner that is appropriate to the needs of the population being served by the Exchange Authority.

(6) Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act.

(7) Maintain an Internet Web site through which enrollees and prospective enrollees of Qualified Health Plans and individuals eligible for Medicaid or North Carolina Health Choice may obtain standardized comparative information on such plans.

(8) Assign a rating to each Qualified Health Plan offered through the Exchange Authority in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act, and determine each Qualified Health Plan's level of coverage in accordance with regulations issued by the Secretary under section 1302(d)(2)(A) of the Federal Act.

(9) Use a standardized format for presenting health benefit options in the Exchange Authority, including the use of the uniform outline of coverage established under section 2715 of the PHSA that supports consumer choice by making comprehensive information about health plans available in an objective, easy-to-understand format.

(10) In accordance with section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act, or any applicable State or local public program and if, through screening of the application by the Exchange Authority, the Exchange Authority determines that any individual is eligible for any such program, enroll that individual in that program.

(11) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act.

(12) Establish an Individual Exchange, through which Qualified Individuals may enroll in any qualified plan offered through the Individual Exchange for which they are eligible.

(13) Establish a SHOP Exchange through which Qualified Employers may make its employees eligible for one or more Qualified Health Plans offered through the SHOP Exchange or through which Qualified Employers may specify a level of coverage so that any of its employees may enroll in any Qualified Health Plan offered through the SHOP Exchange at the specified level of coverage.

(14) Subject to section 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because of either of the following:

a. There is no affordable Qualified Health Plan available through the Exchange Authority, or the individual's employer, covering the individual.

b. The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty.

(15) Transfer to the federal Secretary of the Treasury the following:

a. A list of the individuals who are issued a certification under subdivision (14) of this subsection, including the name and taxpayer identification number of each individual.

b. The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because of either of the following:

1. The employer did not provide minimum essential coverage.

2. The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code of 1986 to either be unaffordable to the employee or not provide the required minimum actuarial value.

c. The name and taxpayer identification number of the following:

1. Each individual who notifies the Exchange Authority under section 1411(b)(4) of the Federal Act that he or she has changed employers.

2. Each individual who ceases coverage under a Qualified Health Plan during a plan year and the effective date of that cessation.

(16) Provide to each employer the name of each employee of the employer described in sub-sub-subdivision b.2. of subdivision (15) of this subsection who ceases coverage under a Qualified Health Plan during a plan year and the effective date of the cessation.

(17) Perform duties required of the Exchange Authority by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions.

(18) Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act, and standards developed by the Secretary, and award grants to enable Navigators who are certified and trained by the North Carolina Department of Insurance to do the following:

a. Conduct public education activities to raise awareness of the availability of Qualified Health Plans.

b. Distribute fair and impartial information concerning enrollment in Qualified Health Plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act.

c. Facilitate enrollment in Qualified Health Plans.

d. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHSA, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their Health Benefit Plan, coverage, or a determination under that plan or coverage.

e. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange Authority.

(19) Take into account any excess of premium growth outside of the Exchange Authority as compared to the rate of such growth inside the Exchange Authority when determining under section 1302(f)(2)(B) of the Federal Act whether to recommend to the General Assembly that Qualified Health Plans be offered in the large group market through the SHOP Exchange.

(20) Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, and collect the amount credited from the offering employer and remit the amount of the free choice voucher to the appropriate health carrier.

(21) Consult with stakeholders relevant to carrying out the activities required under this act, including, but not limited to, the following:

a. Educated health care consumers who are enrollees in Qualified Health Plans.

b. Individuals and entities with experience in facilitating enrollment in Qualified Health Plans.

c. Representatives of small businesses and self-employed individuals.

d. Representatives of Health Insurers that offer Qualified Health Plans through the Exchange Authority.

e. Representatives of Health Insurers that are not offering qualified plans through the Exchange Authority.

f. Representatives of Health Care Providers.

g. The Division of Medical Assistance.

h. The North Carolina Department of Insurance.

i. Advocates for enrolling hard to reach populations.

(22) Meet all of the following financial integrity requirements:

a. Keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the Secretary, the Governor, the Commissioner, and the General Assembly a report concerning such accountings.

b. Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Federal Act and allow the Secretary, in coordination with the Inspector General of the U.S. Department of Health and Human Services, to do all of the following:

1. Investigate the affairs of the Exchange Authority.

2. Examine the properties and records of the Exchange Authority.

3. Require periodic reports in relation to the activities undertaken by the Exchange Authority.

c. In carrying out its activities under this act, not use any funds intended for the administrative and operational expenses of the Exchange

Authority for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or State legislative and regulatory modifications.

(23) Meet the following fiduciary duties and liability:

a. Any person who acts on behalf of an Exchange Authority shall act as a fiduciary. Such person shall ensure that the Exchange Authority is operated (i) solely in the interests of individuals participating in qualified health plans offered through the Exchange Authority and (ii) for the exclusive purpose of facilitating the purchase of Qualified Health Plans.

b. Any person who acts as a fiduciary on behalf of the Exchange Authority who breaches any of their responsibilities, obligations, or duties imposed by this section shall be liable to make good to the Exchange Authority, the Qualified Health Plans offered through the Exchange Authority, or participants of Qualified Health Plans offered through the Exchange Authority any losses resulting from each breach and shall be subject to such other legal or equitable relief as the court may deem appropriate, including removal of such fiduciary.

(24) With respect to eligibility determinations, provide for (i) review of enrollee appeals of Exchange Authority premium tax credit and cost-sharing reductions and mandate exemption determinations and establish procedures for identifying and confirming income levels of applicants for Exchange Authority coverage and eligibility for receipt of premiums and tax credits and (ii) employer appeals of employer-sponsored plan availability or affordability determinations.

(25) Conduct a review of the costs and benefits of collecting and distributing premiums for small businesses. No later than January 1, 2015, the Exchange Authority shall report the results of the review, including analysis of the financial impact of such collection and distribution, and its recommendations to the North Carolina General Assembly. The Exchange Authority may implement and carry out a process for collecting and distributing premiums if it has sufficient funding to implement the initiative and upon approval by vote by both chambers of the North Carolina General Assembly.

(26) Study the feasibility of offering a Basic Health Plan pursuant to section 1331 of the Federal Act and make a recommendation to the 2013 Regular Session of the 2013 General Assembly.

(27) Provide for publicity and outreach campaigns to raise awareness of the existence of the Exchange Authority and disseminate information regarding eligibility criteria, enrollment procedures, availability of premium tax credits and cost-sharing reductions, small employer tax credits, and other relevant information.

"**§ 58-50-350. Health Benefit Plan certification.**

(a) The Exchange Authority shall certify a Health Benefit Plan as a Qualified Health Plan if the Department of Insurance determines that it satisfies the requirements set forth in subdivisions (1) through (6) of this subsection unless the Exchange Authority determines that making the plan available through the Exchange Authority is not in the interest of Qualified Individuals and Qualified Employers in this State.

(1) The plan provides the Essential Health Benefits package described in section 1302(a) of the Federal Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of Qualified Dental

Plans, as provided in subsection (e) of this section, if both of the following occur:

a. The Exchange Authority has determined that at least one Qualified Dental Plan is available to supplement the plan's coverage.

b. The Insurer makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange Authority, that the plan does not provide the full range of essential pediatric benefits, and that Qualified Dental Plans providing those benefits and other dental benefits not covered by the plan are offered through the Exchange Authority.

(2) The premium rates and contract language have been approved by the Commissioner.

(3) The plan provides at least a bronze level of coverage, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage.

(4) The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the Federal Act, and if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act.

(5) The Health Insurer offering the plan meets the following requirements:

a. Is licensed and in good standing to offer health insurance coverage in this State.

b. Offers at least one Qualified Health Plan in the silver level and at least one plan in the gold level through each component of the Exchange Authority in which the Insurer participates, where "component" refers to the SHOP Exchange and the Individual Exchange.

c. Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange Authority and without regard to whether the plan is offered directly from the Insurer or through an insurance producer.

d. Does not charge any cancellation fees or penalties in violation of G.S. 58-50-330(c).

e. Complies with the regulations developed by the Secretary under section 1311(d) of the Federal Act and such other requirements as the Exchange Authority may establish.

(6) The plan meets the requirements of certification as promulgated by regulation pursuant to this section and by the Secretary under section 1311(c) of the Federal Act.

(b) The Exchange Authority shall not exclude a health plan through the imposition of premium price controls nor shall it exclude a health plan based on the following:

(1) That the plan is a fee-for-service plan.

(2) That the Health Benefit Plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange Authority determines are inappropriate or too costly.

(c) The Exchange Authority shall require each Health Insurer seeking certification of a plan as a Qualified Health Plan to do the following:

(1) Submit a justification for any premium increase before implementation of that increase. The Insurer shall prominently post such information on its Internet Web site. The Exchange Authority shall take this information, along

with the information and the recommendations provided to the Exchange Authority by the Commissioner under section 2794(b) of the PHSA, relating to patterns or practices of excessive or unjustified premium increases, into consideration when determining whether to continue to allow the Insurer to make plans available through the Exchange Authority. In no case shall an Exchange Authority impose any premium price controls or restrict premiums that otherwise meet the requirements of State law.

(2) Make available to the public and submit to the Exchange Authority, the Secretary, and the Commissioner, accurate and timely disclosure of the following:

a. Claims payment policies and practices.
b. Periodic financial disclosures.
c. Data on enrollment.
d. Data on disenrollment.
e. Data on the number of claims that are denied.
f. Data on rating practices.
g. Information on cost-sharing and payments with respect to any out-of-network coverage.
h. Information on enrollee and participant rights under title I of the Federal Act.
i. Other information as determined appropriate by the Secretary.

The information shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act.

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, co-payments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet Web site and through other means for individuals without access to the Internet.

(d) The Exchange Authority shall establish and publish a transparent, objective process for denying certification or decertifying Qualified Health Plans.

(1) The Exchange Authority shall give each Health Insurer the opportunity to appeal a decertification decision or the denial of certification as a Qualified Health Plan.

(2) The Exchange Authority shall give each Health Insurer that appeals a decertification decision or the denial of certification the opportunity for the following:

a. The submission and consideration of facts, arguments, or proposals of adjustment of the health plan or plans at issue.
b. A hearing and a decision on the record, to the extent that the Exchange Authority and the Health Insurer are unable to reach agreement following the submission of the information in sub-subdivision a. of this subdivision.

(3) Any hearing held pursuant to subdivision (2) of this subsection shall be conducted by an impartial party agreed to by the Exchange Authority and the Health Insurer. If the Exchange Authority and the Health Insurer cannot agree on an impartial party, then the hearing must be held by an administrative law judge.

(4) The hearing decision may be appealed to the North Carolina Court of Appeals by the aggrieved party.

(e) The Exchange Authority shall not exempt any Health Insurer seeking certification of a Qualified Health Plan, regardless of the type or size of the Insurer, from State licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among Health Insurers participating in the Exchange Authority.

(1) The provisions of this act that are applicable to Qualified Health Plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of subdivisions (2), (3), and (4) of this subsection or by regulations adopted by the Commissioner.

(2) The Insurer shall be licensed to offer dental coverage but need not be licensed to offer other health benefits.

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by Health Benefit Plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to section 1302(b)(1)(J) of the Federal Act and such other dental benefits as the Exchange Authority or the Secretary may specify by regulation.

(4) Insurers may jointly offer a comprehensive plan through the Exchange Authority in which the dental benefits are provided by an Insurer through a Qualified Dental Plan and the other benefits are provided by an Insurer through a Qualified Health Plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

"**§ 58-50-360. Choice.**

(a) In accordance with section 1312(f)(2)(A) of the Federal Act, a Qualified Employer may either designate one or more Qualified Health Plans from which its employees may choose or designate any level of coverage to be made available to employees through the SHOP Exchange.

(b) In accordance with section 1312(b) of the Federal Act, a Qualified Individual enrolled in any Qualified Health Plan may pay any applicable premium owed by such individual to the Health Insurer issuing such Qualified Health Plan.

(c) In accordance with section 1312(c) of the Federal Act, the following risk pools are established:

(1) Individual Exchange. – A Health Insurer shall consider all enrollees in all health plans other than Grandfathered Health Plans offered by such Insurer in the individual market, including those enrollees who do not enroll in such plans through the Individual Exchange, to be members of a single risk pool.

(2) SHOP Exchange. – A Health Insurer shall consider all enrollees in all health plans other than Grandfathered Health Plans offered by such Insurer in the small group market, including those enrollees who do not enroll in such plans through the SHOP Exchange, to be members of a single risk pool.

(d) In accordance with section 1312(d) of the Federal Act, this section shall not prohibit either of the following:

(1) A Health Insurer from offering outside of the Individual Exchange or the SHOP Exchange a health plan to a Qualified Individual or a Qualified Employer.

(2) A Qualified Individual from enrolling in, or a Qualified Employer from selecting for its employees, a health plan offered outside of the Exchange Authority.

(e) This section shall not limit the operation of any requirement under State law or regulation with respect to any policy or plan that is offered outside of the Exchange Authority with respect to any requirement to offer benefits.

(f) Nothing in this section shall restrict the choice of a Qualified Individual to enroll or not to enroll in a Qualified Health Plan or to participate in the Individual Exchange.

(g) Nothing in this section shall compel an individual to enroll in a Qualified Health Plan or to participate in the Exchange Authority.

(h) A Qualified Individual may enroll in any Qualified Health Plan, except that in the case of a catastrophic plan described in section 1302(e) of the Federal Act, a Qualified Individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1312(e)(2) of the Federal Act.

(i) Nothing in this act or the Federal Act shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any Health Benefit Plan that is offered outside of the Exchange Authority.

(j) In accordance with section 1312(e) of the Federal Act, the Exchange Authority shall allow Agents or Brokers to do the following:

(1) To enroll Qualified Individuals and Qualified Employers in any Qualified Health Plan offered through the Exchange Authority for which the individual or employer is eligible.

(2) To assist Qualified Individuals in applying for premium tax credits and cost-sharing reductions for any Qualified Health Plan purchased through the Individual Exchange.

(k) Any compensation to Agents and Brokers paid under this Part shall be determined by the insurer.

"**§ 58-50-370. Funding; publication of costs.**

(a) Beginning in 2014, the funding stream that supports the North Carolina Health Insurance Risk Pool shall be utilized to support the operations of the Exchange Authority. Beginning in 2015, the funding stream that supports the North Carolina Health Insurance Risk Pool shall be utilized to support the operations of the Exchange Authority that serve those individuals with incomes less than or equal to four hundred percent (400%) of the federal poverty level and Qualified Employers receiving a tax credit for the purchase of insurance pursuant to the Federal Act. The proportional cost associated with serving individuals with incomes over four hundred percent (400%) of the federal poverty level and the Qualified Employers not receiving a tax credit pursuant to the Federal Act shall be funded by an annual user fee paid by the individual or the employer to the Exchange Authority. The user fee assessed by the Exchange Authority shall be no greater than the anticipated expenses for serving this market for the applicable fiscal year and must be approved by the Commissioner. Additionally, the Exchange Authority is authorized to utilize grant funding for operations, including, but not limited to, grant funding from the Department of Health and Human Services. The Exchange Authority is also authorized to collect and use advertising fees to help support operations of the Exchange Authority.

(b) Prior to the commencement of the 2013 Regular Session of the 2013 General Assembly, the Exchange Authority shall examine its potential operational costs and propose to the General Assembly any additional changes to the funding stream necessary to ensure its solvency.

(c) As required by section 1311(d)(5)(A) of the Federal Act, the Exchange Authority shall be self-sustaining by January 1, 2015. A budget for the Exchange Authority shall be prepared by the Exchange Authority and submitted to the Commissioner annually for approval.

(d) Services performed by the Exchange Authority on behalf of other State or federal programs shall be paid for by those State or federal programs.

(e) Any unspent funding by the Exchange Authority shall be used for future operation of the Exchange Authority or reducing future user fees.

(f) The Exchange Authority shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange Authority, and the administrative costs

of the Exchange Authority, on an Internet Web site to educate consumers on such costs. This information shall include information on monies lost to waste, fraud, and abuse.

(g) The Exchange Authority is exempt from any and all State taxes.

"**§ 58-50-380. Regulations.**

The Commissioner shall promulgate regulations pursuant to Chapter 150B of the General Statutes, including temporary rules, to implement the provisions of this Part.

"**§ 58-50-390. Audit.**

An audit of the Exchange Authority shall be conducted annually under the oversight of the State Auditor. The cost of the audit shall be reimbursed to the State Auditor from Exchange Authority funds.

SECTION 3. Nothing in this Act shall be construed to interfere with payments to federally qualified health centers. If any item or service covered by a qualified health plan is provided by a federally qualified health center, as defined in section 1905(1)(2)(B) under the Social Security Act 42 U.S.C. 1396d(1)(2)(B), to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or services an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Social Security Act for such item or service.

SECTION 4. Severability. – If any provision of this act is held invalid by a court of competent jurisdiction, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, is repealed. If section 1311 of the federal Patient Protection and Affordable Care Act or the federal Patient Protection and Affordable Care Act in its entirety is repealed or held invalid by a court of competent jurisdiction, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, is repealed. If funding is not provided as set forth in the federal Patient Protection and Affordable Care Act, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, shall not be enforceable.

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

2011-2012

HOUSE INSURANCE

MINUTES

MINUTES

HOUSE COMMITTEE ON INSURANCE

April 26, 2011

The House Committee on Insurance met in Room 1228 of the Legislative Building on April 26, 2011, at 1:00 pm. The following members were present: Representatives Dockham, Chair, Blust, Brown, Brubaker, Bryant, Collins, Crawford, Current, Faison, Floyd, Folwell, Graham, Hamilton, Howard, Hurley, Insko, Jackson, Johnson, McElraft, McGuirt, Mills, Murry, Pierce, Shepard, Steen, Stevens, Warren, Wilkins, and Wray. Tim Hovis, Bill Patterson, and Kory Goldsmith, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes. (Attachment I)

Representative Dockham, Chair, called the meeting to order at 1:00 pm. He introduced the pages and the Sergeant of Arms staff. (Attachment II) The following bills were considered:

HB 298, entitled, AN ACT TO MAKE CHANGES IN THE INSURANCE LAWS TO PRIVATIZE ONLINE AND ADMINISTRATIVE PROCESS FOR LICENSE APPLICANTS, ENSURE ACCURACY IN CERTIFICATES OF INSURANCE, REQUIRE PRIOR APPROVAL OF SMALL GROUP HEALTH INSURANCE RATES AND ENCOURAGE THE SALE OF CHILD-ONLY HEALTH INSURANCE POLICIES, AMEND THE RISK-BASED CAPITAL LAW TO MAINTAIN NAIC ACCREDITATION, PROVIDE AN EXEMPTION FOR LICENSING OF CLAIMS INPUT EMPLOYEES FOR PORTABLE ELECTRONIC DEVICES, PROHIBIT FEDERAL PREEMPTION OF CROP ADJUSTERS' REGULATION, AND EASE THE REGULATORY BURDEN ON THE ASSOCIATION AGGREGATE SECURITY SYSTEM – AB. A proposed committee substitute was presented. Representative Faison moved to adopt the proposed committee substitute for consideration. The motion passed. The Chair recognized Ms. Rose Vaughn Williams, Legislative Counsel with the NC Department of Insurance, to explain the bill. (ATTACHMENT III) After some discussion, Representative Brubaker moved for 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. The motion passed.

HB 299, ENTITLED, AN ACT TO CONFORM PROVISIONS OF NORTH CAROLINA SURPLUS LINES INSURANCE LAWS TO THE FEDERAL NONADMITTED AND REINSURANCE REFORM ACT OF 2010, TO STREAMLINE APPLICATIONS FOR COMMERCIAL PURCHASERS, AND TO PREVENT ANY LOSS OF PREMIUM TAX REVENUE TO THE STATE – AB. Representative Dockham, bill sponsor, presented a proposed committee substitute. Representative Steen moved for adoption of the committee substitute for discussion. The motion passed. The Chair recognized Ms. Rose Vaughn Williams to explain the bill. (Attachment IV) Representative Dockham moved to amend the committee substitute on page 2, line 12 by deleting the word "state" and substituting the following "state and the most cost-efficient method of administering the collection and distribution of tax revenues." (ATTACHMENT V) Representative Bryant moved to accept the amendment for

discussion. The motion passed. After some discussion Representative Brubaker moved to roll the amendment into a committee substitute, with a favorable report as to the house committee substitute bill, which changes the title, unfavorable as to the original bill, and recommendation that the house committee substitute bill be re-referred to the Committee on Finance. The motion passed.

HB 578, entitled, AN ACT TO EXEMPT HEALTH CARE SHARING ORGANIZATIONS FROM THE HEALTH INSURANCE REGULATORY LAWS. Representative Dockham recognized Representative Murry, the bill sponsor, who presented a proposed committee substitute. Representative Mcguirt moved for adoption of the proposed committee substitute for discussion. The motion passed. Representative Murry explained the proposed committee substitute bill. This is a very simple, straight-forward bill that will allow Health Care Sharing Organizations to continue to operate in North Carolina free from regulation by the Department of Insurance. This low-cost alternative to insurance facilitates sharing the medical needs of participants through contributions from one participant to another. Health Care Sharing involves no assumption of risk or promise to pay among the participants, and no assumption of risk or promise to pay by the health care sharing organization to the participants. The participants engage in voluntary sharing arrangements without a contractual transfer of risk. Health Care Sharing does not constitute insurance and these non-profit organizations have been operating in North Carolina since the late 1980's without interference from the Department of Insurance. Representative Murry invited Mr. Joe Guarinao, Government Affairs liaison for the Alliance of Health Care Sharing Ministries, to expand on this legislation. (ATTACHMENT VI) At the request of Representative Faison, Ms. Rose Vaughn Williams explained that NCDOI has determined that these organizations were not considered insurance. The bill can be helpful to the Department as they try to discern whether a certain activity is unauthorized insurance. Statutory language will draw a clear line that this action is allowed, but other actions are not. DOI is aware that other states were pursuing similar legislation, and that Washington state was attempting to prosecute one of these organizations, but the state legislature passed legislation similar to this to allow it. NCDOI does not oppose HB 578. After some discussion Representative Brubaker moved for a favorable report as to the committee substitute bill, unfavorable as to the original bill. The motion passed.

There being no further business, the Chair adjourned the meeting at 1:50 pm.

Respectfully submitted,

Representative Jerry C. Dockham, Chair

Regina Irwin, Committee Assistant

Attachments

AGENDA

HOUSE COMMITTEE ON INSURANCE

April 26, 2011

Room 1228

1:00 pm

OPENING REMARKS

Representative Jerry Dockham, Chairman
Insurance Committee

AGENDA ITEMS

HB 298 **INSURANCE AMENDMENTS.-AB**
Representative Jerry Dockham, Sponsor

HB 299 **SURPLUS LINES/PREMIUM TAX.-AB**
Representative Jerry Dockham, Sponsor

HB 578 **HEALTH CARE SHARING ORGANIZATIONS.**
Representative Tom Murry, Sponsor
Representative Dockham, Sponsor
Representative Barnhart, Sponsor

ADJOURNMENT

ATTACHMENT I

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

APRIL 26, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rose Williams	NCDOI
Cathy Stahl	SL Law Firm
John McMillan	MFTS
Joe Guarino	AHCSM, Peoria, IL
Jane Fitzgerald	AHCSM
Paul Taylor	Infirmary Inc.
Jennifer Cohen	IFNC
Kelley Erskine	IIANC
Michelle Frazier	MFTS
	BRSA
Cynthia Barnett	CS Committee on Publications for NC

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

APRIL 26, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
F. Stuart Powell Jr	IIANC
John McLeffi	Travelers Companies Inc
JAN ANDREWS	DEPT INSURANCE
Jean Holliday	NCDOI
Dryan Heckle	NCDOI
ERNEST L. NICKERSON	NCDOI
Fred Fuller	NC DOI
Robert C. Mack	NCDOI
John Bowdish	Aetna Seneca
Barbara Conley	BBCG
DAVID LIGGETT	RAGSDALE LIGGETT PLLC

VISITOR REGISTRATION SHEET

INSURANCE — APRIL 26, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lauren Whaley	NCCUL
Butch Gunnells	NC Bar
Allison Waller	Nelson Mullins
Fred Bone	Bone Asso.
Keri Burke	NWC
Dan Lam	SA
Chas Byrne	NCMS
Dana Sipe	Smith Anderson
Kristi Huff	NCHCFA
Amy Whited	NC Med. Society
Becki Faddeen	NCASA

VISITOR REGISTRATION SHEET

INSURANCE — APRIL 26, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Martha Bowell	IIANC
[illegible]	IIANC
Joel Maynard	[illegible]
Adam Linker	NC Justice
Skip Brazier	MetLife
[illegible]	[illegible]
Dwan Finch	Nurse of the Day
Michael Isler	PCI
[illegible]	NMRS
Ben Scoggin	TIS
Harry Dixon	SECU

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

APRIL 26, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lisa Piercy	Ragsdale Liggett PLLC
R W Kaylor	Kaylor Law Firm
Harry Taylor	NWC
John T Bode	BCS
Susan Valenni	Nationwide
Sherman McCoy	Nationwide

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

APRIL 26, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dean Plunkett	PS
JOE LANIER	NELSON MULLINS

PLEASE PRINT

ATTACHMENT II

HOUSE PAGES

NAME OF COMMITTEE: INSURANCE DATE: APRIL 26, 2011

1. NAME: Sarah Doerrer

County: Wake

Sponsor: Rep. Murry

2. NAME: Jana LaBrose

County: Caldwell

Sponsor: Rep. Starnes

3. NAME: Carly Smith

County: Stanly

Sponsor: Speaker Tillis

4. NAME: Adrian (Kermit) Thompson

County: Wayne

Sponsor: Rep. Sager

5. NAME:

County:

Sponsor:

SERGEANTS-AT-ARMS

1. Name: Billy Jones

2. Name: Garland Shepard

3. Name: Martha Gadison

4. Name:

5: Name:

2011 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
HB 298 A BILL TO BE ENTITLED AN ACT TO MAKE CHANGES IN THE INSURANCE LAWS TO PRIVATIZE ONLINE AND ADMINISTRATIVE PROCESSES FOR LICENSE APPLICANTS, ENSURE ACCURACY IN CERTIFICATES OF INSURANCE, REQUIRE PRIOR APPROVAL OF SMALL GROUP HEALTH INSURANCE RATES AND ENCOURAGE THE SALE OF CHILD-ONLY HEALTH INSURANCE POLICIES, AMEND THE RISK-BASED CAPITAL LAW TO MAINTAIN NAIC ACCREDITATION, PROVIDE AN EXEMPTION FOR LICENSING OF CLAIMS INPUT EMPLOYEES FOR PORTABLE ELECTRONIC DEVICES, PROHIBIT FEDERAL PREEMPTION OF CROP ADJUSTERS' REGULATION, AND EASE THE REGULATORY BURDEN ON THE ASSOCIATION AGGREGATE SECURITY SYSTEM.

☒ 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.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 298
PROPOSED COMMITTEE SUBSTITUTE H298-PCS90096-RG-8

Short Title: Insurance Amendments.-AB (Public)

Sponsors:

Referred to:

March 10, 2011

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES IN THE INSURANCE LAWS TO PRIVATIZE ONLINE AND ADMINISTRATIVE PROCESSES FOR LICENSE APPLICANTS, CODIFY THE EXISTING SENIORS' HEALTH INSURANCE INFORMATION PROGRAM, ENSURE ACCURACY IN CERTIFICATES OF INSURANCE, REQUIRE PRIOR APPROVAL OF SMALL GROUP HEALTH INSURANCE RATES AND ENCOURAGE THE SALE OF CHILD-ONLY HEALTH INSURANCE POLICIES, AMEND THE RISK-BASED CAPITAL LAW TO MAINTAIN NAIC ACCREDITATION, PROVIDE AN EXEMPTION FOR LICENSING OF CLAIMS INPUT EMPLOYEES FOR PORTABLE ELECTRONIC DEVICES, PROHIBIT FEDERAL PREEMPTION OF CROP ADJUSTERS' REGULATION, AND EASE THE REGULATORY BURDEN ON THE NORTH CAROLINA SELF-INSURANCE SECURITY ASSOCIATION AND THE ASSOCIATION AGGREGATE SECURITY SYSTEM.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-2-69(g) reads as rewritten:

"(g) The Commissioner may contract with the NAIC or other persons for the provision of online services to applicants and licensees, for the provision of administrative ~~services to licensees, or~~ services, for the provision of license processing and support services, and for the provision of regulatory data systems to the Commissioner. The NAIC or other person with whom the Commissioner contracts may charge applicants and licensees a reasonable fee for ~~the costs associated with the licensees' use~~ the provision of online ~~services and~~services, the provision of administrative ~~services.~~ services, the provision of license processing and support services, and the provision of regulatory data systems to the Commissioner. The fee shall be agreed to by the Commissioner and the other contracting party and shall be stated in the contract. The fee is in addition to any applicable license application and renewal fees. Contracts for the provision of online services, contracts for the provision of administrative services, and contracts for the provision of regulatory data systems shall not be subject to Article 3, 3C, or 8 of Chapter 143 of the General Statutes or to Article 3D of Chapter 147 of the General Statutes. However, the Commissioner shall: (i) submit all proposed statewide and agency term contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subsection to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all contracts to be awarded by the Commissioner under this subsection a standard clause which provides that the State Auditor and internal auditors of the Commissioner may audit the records of the contractor

during the term of the agreement or contract to verify accounts and data affecting fees and performance. The Commissioner shall not award a cost plus percentage of cost agreement or contract for any purpose."

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

"**§ 58-2-31. Seniors' Health Insurance Information Program.**

The Seniors' Health Insurance Information Program is established within the Department as a statewide health benefits counseling program to provide the State's Medicare beneficiaries with counseling in Medicare, Medicare supplement insurance, long-term care insurance, and related health care coverage plans."

SECTION 3. G.S. 58-3-150 reads as rewritten:

"**§ 58-3-150. Forms to be approved by Commissioner.**

(a) It is unlawful for any insurance company licensed and admitted to do business in this State to issue, sell, or dispose of any policy, contract, ~~or~~ certificate, or certificate of insurance, or use applications in connection therewith, until the forms of the same have been submitted to and approved by the Commissioner, and copies filed in the Department. If a policy form filing is disapproved by the Commissioner, the Commissioner may return the filing to the filer. As used in this section, "policy form" includes endorsements, riders, or amendments to policies that have already been approved by the Commissioner.

(b) With respect to group and blanket accident and health insurance, group life insurance, and group annuity policies issued and delivered to a trust or to an association outside of this State and covering persons resident in this State, the group certificates to be delivered or issued for delivery in this State shall be filed with and approved by the Commissioner pursuant to subsection (a) of this section.

(c) If not submitted electronically, all contracts, literature, advertising materials, letters, and other documents submitted to the Department to comply with the filing requirements of this Chapter or an administrative rule adopted pursuant to this Chapter shall be submitted on paper eight and one-half inches by eleven inches. Brochures and pamphlets shall not be stapled or bound.

(d) As used in this section, "certificate of insurance" means a document prepared or issued by an insurance company or producer that is used to verify or evidence the existence of property or casualty insurance coverage. "Certificate of insurance" shall not include a policy of insurance or insurance binder.

(e) A certificate of insurance is not a policy of insurance and does not amend, extend, or alter the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to a certificate of insurance holder new or additional rights beyond what the referenced policy of insurance expressly provides.

(f) It is unlawful for any person to knowingly prepare, issue, request, or require a certificate of insurance that meets any of the following criteria:

(1) Has not been filed with and approved by the Commissioner.

(2) Contains any false or misleading information concerning the policy of insurance to which the certificate of insurance makes reference.

(3) Purports to alter, amend, or extend the coverage provided by the policy of insurance to which the certificate of insurance makes reference.

(g) A holder of a certificate of insurance shall have a legal right to notice of cancellation, nonrenewal, or any material change, or any similar notice concerning a policy of insurance only if the holder is named within the policy or any endorsement and the policy or endorsement requires notice to be provided to the holder. The terms and conditions of the notice, including the required timing of the notice, are governed by the policy of insurance and cannot be altered by a certificate of insurance."

SECTION 4. Article 50 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-50-131. Premium rates for health benefit plans; approval authority; hearing.**

(a) No schedule of premium rates for coverage for a health benefit plan subject to this act, or any amendment to the schedule, shall be used in conjunction with any such health benefit plan until a copy of the schedule of premium rates or premium rate amendment has been filed with and approved by the Commissioner. Any schedule of premium rates or premium rate amendment filed under this section shall be established in accordance with G.S. 58-50-130(b). The schedule of premium rates shall not be excessive, unjustified, inadequate, or unfairly discriminatory and shall exhibit a reasonable relationship to the benefits provided by the contract of insurance. Each filing shall include a certification by an individual who is a member in good standing with the Society of Actuaries.

(b) The Commissioner shall approve or disapprove a schedule of premium rates within 60 days of receipt of a complete filing. It shall be unlawful to use a schedule of premium rates until approved. If the Commissioner disapproves the filing, the Commissioner shall notify the filer, shall specify the reasons for disapproval, and shall provide an opportunity for refiling.

(c) The Commissioner shall adopt rules as necessary or proper (i) to prevent the federal preemption of health insurance regulation in the State, (ii) to implement the provisions of this section, and (iii) to establish minimum standards for loss ratios of policies subject to this section with accepted actuarial principles and practices to assure that the benefits are reasonable in relation to the premium charged. The Commissioner shall adopt rules to require the submission of supporting data and any information that the Commissioner considers necessary or proper to determine whether the filed schedule of premium rates meets the standards set forth in this section."

SECTION 5. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-285. Nondependent child coverage defined; open enrollment.**

(a) As used in this section, the following definitions apply:

(1) "Health benefit plan" has the same meaning as G.S. 58-3-167(a)(1).

(2) "Individual market" has the same meaning as G.S. 58-68-25(a)(9).

(3) "Insurer" has the same meaning as G.S. 58-3-167(a)(2).

(4) "Nondependent child coverage" or "nondependent child policy" means an individual health benefit plan which provides coverage to an individual under age 19. This shall not include health benefit plans that cover children under age 19 as dependents.

(5) "Open enrollment" means, with respect to "nondependent child coverage," the period of time during which any individual under age 19 has the opportunity to apply for coverage under a health benefit plan offered by an insurer and shall not be denied eligibility for coverage under the plan due to factors relating to the individual's health status.

(b) An insurer who offers nondependent child coverage shall offer open enrollment either continuously throughout the year or for the months of January and July of each year. Coverage issued under this section shall be issued without any riders based on the health status of the child. Nothing in this section shall require an insurer to offer nondependent child coverage or maternity coverage within an offer of nondependent child coverage.

(c) The Commissioner shall adopt rules as necessary or proper to implement the provisions of this section.

(d) Nothing in this section shall prohibit an insurer from adjusting the initial premium charged an individual afforded coverage under this section based upon medical underwriting to the extent that such an adjustment is in compliance with the applicable product's current rate filing approved by the Commissioner."

SECTION 6. G.S. 58-12-2 reads as rewritten:

"**§ 58-12-2. Definitions.**

As used in this Article, the following terms have the following meanings:

(1) Adjusted risk-based capital report. – A risk-based capital report that has been adjusted by the Commissioner under G.S. 58-12-6.

(2) Corrective order. – An order issued by the Commissioner specifying corrective actions that the Commissioner has determined are required.

(3) Domestic insurer. – Any insurance company or health organization organized in this State under ~~Article 7,~~ Article 7 of this Chapter as specified in subdivisions (4b) and (5a) of this section or under Article 15, 65, or 67 of this Chapter.

(4) Foreign insurer. – Any insurance company or health organization that is admitted to do business in this State under Article 16 or 67 of this Chapter but is not domiciled in this State.

(4a) Health organization. – Any insurer which is required by the Commissioner to use the NAIC Health Annual Statement Blank when filing the annual statement prescribed by G.S. 58-2-165 or any health maintenance organization, limited health service organization, dental or vision plan, hospital, medical, or dental indemnity or service corporation, or other organization licensed under Article 65 or 67 of this Chapter. "Health organization" does not include an insurer that is licensed as either a life or health insurer or a property or casualty insurer under this Chapter and that is otherwise subject to either the life or property and casualty risk-based capital requirements.

(4b) Life or health insurer. – Any insurance company licensed to write the kinds of insurance specified in G.S. 58-7-15(1), (2), or (3); or a licensed property and casualty insurer writing only the kinds of insurance specified in G.S. 58-7-15(3). "Life or health insurer" does not mean any insurer that is required by the Commissioner to use the NAIC Health Annual Statement Blank when it files the annual statement prescribed by G.S. 58-2-165.

(5) Negative trend. – A negative trend, with respect to a life or health insurer, over a period of time, as determined in accordance with the "trend test calculation" included in the risk-based capital instructions.

(5a) Property or casualty insurer. – Any insurance company licensed to write the kinds of insurance specified in G.S. 58-7-15(4) through (22); but not monoline mortgage guaranty insurers, financial guaranty insurers, or title ~~insurers.~~insurers; nor any insurer that is required by the Commissioner to use the NAIC Health Annual Statement Blank when filing the annual statement prescribed by G.S. 58-2-165.

(6) Risk-based capital instructions. – The risk-based capital report including risk-based capital instructions adopted by the NAIC, as those risk-based capital instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(7) Risk-based capital level. – An insurer's company action level risk-based capital, regulatory action level risk-based capital, authorized control level risk-based capital, or mandatory control level risk-based capital where:

a. "Company action level risk-based capital" means, with respect to any insurer, the product of 2.0 and its authorized control level risk-based capital.

b. "Regulatory action level risk-based capital" means the product of 1.5 and its authorized control level risk-based capital.

c. "Authorized control level risk-based capital" means the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

d. "Mandatory control level risk-based capital" means the product of .70 and the authorized control level risk-based capital.

(8) Risk-based capital plan. – A comprehensive financial plan containing the elements specified in G.S. 58-12-11(b). If the Commissioner rejects the risk-based capital plan, and it is revised by the insurer, with or without the Commissioner's recommendation, the plan shall be called the "revised risk-based capital plan".

(9) Risk-based capital report. – The report required in G.S. 58-12-6.

(10) Total adjusted capital. – The sum of:

a. An insurer's statutory capital and surplus, as determined in accordance with the statutory accounting applicable to the annual financial statements required under G.S. 58-2-165; and

b. Such other items, if any, as the risk-based capital instructions may provide."

SECTION 7. G.S. 58-12-11(a) reads as rewritten:

"(a) "Company action level event" means any of the following events:

(1) The filing of a risk-based capital report by an insurer that indicates that:

a. The insurer's total adjusted capital is greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based ~~capital, if the insurer is a property or casualty insurer or a health organization;~~ capital; or

b. ~~The~~ In the case of a life or health insurer, the insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and 2.5 and has a negative ~~trend, if the insurer is a life or health insurer.~~trend; or

c. In the case of a property or casualty insurer or a health organization, the insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty or health organization risk-based capital instructions.

(2) The notification by the Commissioner to the insurer of an adjusted ~~risk-bases~~ risk-based capital report that indicates the event in sub-subdivision ~~(1)a. or b.~~(1)a., (1)b., or (1)c. of this subsection if the insurer does not challenge the adjusted risk-based capital report under G.S. 58-12-30.

(3) If the insurer challenges an adjusted risk-based capital report that indicates the event in sub-subdivision ~~(1)a. or b.~~ (1)a., (1)b., or (1)c. of this subsection under G.S. 58-12-30, the notification by the Commissioner to the insurer that the Commissioner has rejected the insurer's challenge."

SECTION 8. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-27. Claims handling for portable consumer electronic devices.**

(a) As used in this section, the following definitions apply:

(1) "Automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation, and system-generated final resolution of claims on insurance policies that cover

only portable consumer electronic devices, which system shall meet the following criteria:

a. Be utilized only by a licensed adjuster, licensed agent, or supervised individuals operating pursuant to this section.

b. Comply with all claims payment requirements of this Chapter.

c. Be certified as compliant with this section by a licensed adjuster who is an officer of a licensed business entity under this Chapter.

(2) "Portable consumer electronic devices" include the following, which must be easily carried or conveyed by hand: smartphones, navigation devices, cellular phones, personal digital assistants, iPads, iPhones, Androids, video games, wireless reading devices, laptops, tablets, netbooks, MP3 players, digital cameras, and other electronic devices that are portable in nature, their accessories, and services related to the use of the device.

(b) No adjuster license is required for an individual who, in connection with insurance covering only portable consumer electronic devices as defined in subdivision (a)(2) of this section, collects claim information from or furnishes claim information to insureds, who conducts data entry, including entering data into an automated claims adjudication system, and who does not exercise any discretion in the disposition of the portable consumer electronic device claim; provided that the individual is supervised by a licensed adjuster or licensed agent and there are no more than 25 individuals who may adjust claims under the supervision of the licensed adjuster or licensed agent. No agent acting as a supervisor pursuant to this section is required to be licensed as an adjuster.

(c) If other property losses occur in conjunction with the loss associated with the portable consumer electronic device, the individual who performs duties as described in G.S. 58-33-10(2) on the total loss, including the loss associated with the portable consumer electronic device, must hold an adjuster's license."

SECTION 9. G.S. 58-33-30(e) reads as rewritten:

"(e) Examination.

(1) After completion and filing of the application with the Commissioner, the Commissioner shall require each applicant for license as an agent or an adjuster to take an examination as to the applicant's competence to be licensed. The applicant must take and pass the examination according to requirements prescribed by the Commissioner. This subsection shall not apply to adjusters who adjust only federal crop insurance claims and are certified in accordance with subdivision (2a) of this subsection.

(2) The Commissioner may require any licensed agent, adjuster, or motor vehicle damage appraiser to take and successfully pass an examination in writing, testing his competence and qualifications as a condition to the continuance or renewal of his license, if the licensee has been found guilty of any violation of any provision of this Chapter. If an individual fails to pass such an examination, the Commissioner shall revoke all licenses issued in his name and no license shall be issued until such individual has passed an examination as provided in this Article.

(2a) Adjusters who adjust federal crop insurance claims shall be certified as having passed a proficiency examination approved by the federal Risk Management Agency (RMA) as a condition of obtaining an adjuster's license under this Chapter or another proficiency examination approved by the Commissioner. An adjuster who intends to adjust crop insurance claims shall furnish the Commissioner proof that the adjuster is certified as having passed the required examination pursuant to this section.

(3) Each examination shall be as the Commissioner prescribes and shall be of sufficient scope to test the applicant's knowledge of:
a. The terms and provisions of the policies or contracts of insurance the applicant proposes to effect; or
b. The types of claims or losses the applicant proposes to adjust; and
c. The duties and responsibilities of the license; and
d. The current laws of this State applicable to the license.

(4) The answers of the applicant to the examination shall be provided by the applicant under the Commissioner's supervision. The Commissioner shall give examinations at such times and places within this State as the Commissioner considers necessary reasonably to serve the convenience of both the Commissioner and applicants: Provided that the Commissioner may contract directly with persons for the processing of examination application forms and for the administration and grading of the examinations required by this section; the Commissioner may charge a reasonable fee in addition to the registration fee charged under G.S. 58-33-125, to offset the cost of the examination contract authorized by this subsection; and such contracts shall not be subject to Article 3 of Chapter 143 of the General Statutes. However, the Commissioner shall: (i) submit all proposed statewide and agency term agreements or contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subdivision to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all contracts to be awarded by the Commissioner under this subdivision a standard clause which provides that the State Auditor and internal auditors of the Commissioner may audit the records of the contractor during the term of the contract to verify accounts and data affecting fees and performance. The Commissioner shall not award a cost plus percentage of cost contract for any purpose.

(5) The Commissioner shall collect in advance the examination and registration fees provided in G.S. 58-33-125 and in subsection (4) of this section. The Commissioner shall make or cause to be made available to all applicants, for a reasonable fee to offset the costs of production, materials that he considers necessary for the applicants' proper preparation for examinations. The Commissioner may contract directly with publishers and other suppliers for the production of the preparatory materials, and contracts so let by the Commissioner shall not be subject to Article 3 of Chapter 143 of the General Statutes. However, the Commissioner shall: (i) submit all proposed statewide and agency term contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subdivision to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all contracts to be awarded by the Commissioner under this subdivision a standard clause which provides that the State Auditor and internal auditors of the Commissioner may audit the records of the contractor during the term of the contract to verify accounts and data affecting fees and performance. The Commissioner shall not award a cost plus percentage of cost contract for any purpose.

(6) In addition to the examinations for the kinds of insurance specified in G.S. 58-33-25(c)(1) and (2), before any resident may sell Medicare supplement or long-term care insurance policies defined respectively in

Articles 54 and 55 of this Chapter, the resident must take and pass a supplemental written examination according to requirements prescribed by the Commissioner.

(7) 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."

SECTION 10. Article 4 of Chapter 97 of the General Statutes reads as rewritten:

"Article 4.

"North Carolina Self-Insurance Security Association.

"**§ 97-130. Definitions.**

As used in this Article:

(1) "Association" means the North Carolina Self-Insurance Security Association established by G.S. 97-131.

(1a) "Association Aggregate Security System" means the security system established by the Association under G.S. 97-133 whereby individual self-insurers collectively secure their aggregate self-insured workers' compensation liabilities through the North Carolina Self-Insurance Security Association.

(2) "Board" means the Board of Directors of the Association established by G.S. 97-132.

(3) "Commissioner" means the North Carolina Commissioner of Insurance.

(4) "Covered claim" means an unpaid claim against an insolvent individual self-insurer or group self-insurer that relates to an injury that occurs while the individual self-insurer or group self-insurer is a member of the Association and that is compensable under this Chapter.

(5) "Fund" means the North Carolina Self-Insurance Security Fund established by G.S. 97-133.

(5a) "Group" or "Group self-insurer" means a group self-insurer licensed by the Commissioner under Part 1, Article 47 of Chapter 58 of the General Statutes.

(5b) "Individual self-insurer" means an individual employer licensed by the Commissioner under Article 5 of this Chapter.

(6) "Member self-insurer" or "member" means an individual self-insurer or group self-insurer that is required to be a member of the Association under this Article or Part 1, Article 47 of Chapter 58 of the General Statutes.

(7) "Plan" means the Plan of Operation authorized by G.S. 97-134.

(8) Repealed by Session Laws 2005-400, s. 1.2, effective January 1, 2006.

(9) "Servicing facility" means those persons delegated by the Board ~~and approved by the Commissioner~~ to settle or compromise claims and to expend Fund assets to pay claims.

"**§ 97-131. Creation.**

...

(b) All individual self-insurers and group self-insurers shall be and remain members of the Association as a condition of being licensed to self-insure in this State. The Association shall perform its functions under a Plan of Operation established or amended, or both, by the ~~Board and approved by the Commissioner,~~ Board and shall exercise its powers through the Board.

(1) An individual self-insurer or a group self-insurer shall be deemed to be a member of the Association for purposes of another member's insolvency, as defined in G.S. 97-135, when:

a. The individual self-insurer or group self-insurer is a member of the Association when an insolvency occurs, or

b. The individual self-insurer or group self-insurer has been a member of the Association at some point in time during the 12-month period immediately preceding the insolvency in question.

(2) An individual self-insurer or a group self-insurer shall be deemed to be a member of the Association for purposes of its own insolvency if it is a member when the compensable injury occurs.

(3) In determining the membership of the Association for the purposes of subdivisions (1) and (2) of this subsection for any date after the effective date of this Article, no individual self-insurer or group self-insurer may be deemed to be a member of the Association on any date after the effective date of this Article, unless that employer is on that date licensed as an individual self-insurer by the Commissioner under Article 5 of this Chapter or a group of employers is at that time licensed as a group self-insurer by the Commissioner under Article 47 of Chapter 58 of the General Statutes.

"**§ 97-132. Board of directors.**

The Board shall consist of not less than nine directors serving terms as established in the Plan. The directors shall be selected by the members of the ~~Association, subject to the approval of the Commissioner,~~ Association and shall serve for three-year terms and until a successor is elected and qualified. There is no limitation on the number of terms a director may serve. ~~In approving selections to the Board, the Commissioner shall consider, among other things, whether individual self-insurers and group self-insurers are fairly represented.~~ Directors may be reimbursed from the assets of the Association for expenses incurred by them as directors.

"**§ 97-133. Powers and duties of the Association.**

(a) The Association shall:

(1) Repealed by Session Laws 1999-219, s. 7.2, effective June 25, 1999.

(1a) Administer a fund, to be known as the North Carolina Self-Insurance Security Fund, which shall receive the assets of the North Carolina Self-Insurance Guaranty Fund previously established under subdivision (2) of this subsection, the assessments required by subdivisions (2a) and (3a) of this subsection and any other sums received by the Association. ~~In its discretion, the Board may determine that the assets of the Fund should be segregated or that a separate accounting shall be made in order to identify that portion of the Fund which represents assessments paid by individual self-insurers and that portion of the Fund which represents assessments paid by group self-insurers. If the Board segregates the Fund in this manner, the Association shall thereafter pay covered claims against individual member self-insurers from that portion of the Fund that represents assessments against individual self-insurers and shall thereafter pay covered claims against group member self-insurers from that portion of the Fund that represents assessments against group self-insurers.~~ The costs of administering the Association shall be borne by the Fund. The Association is authorized to secure insurance, primary excess insurance, reinsurance, bonds, other insurance, financial guarantees and related financial instruments to effectuate the purposes of the Association. The Board will invest the Fund assets pursuant to an investment policy adopted by the Board and reviewed and approved annually by the Department of the State Treasurer. The earnings from investment of Fund assets shall be placed in or credited to the Fund.

(2) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

(2a) ~~Establish, operate, and maintain~~ Establish and operate the Association Aggregate Security System as defined in G.S. 97-130 and G.S. 97-165 as follows:

a. The Association shall annually ~~prepare and submit to the Commissioner a written plan to~~ operate and provide an Association Aggregate Security System through a combination of cash on deposit in the Fund, securities, surety bonds, irrevocable letters of credit, ~~insurance~~ insurance, reinsurance, or other financial instruments or guarantees owned or entered into by the ~~Association and acceptable to the Commissioner.~~ Association. ~~The written plan shall include, but not be limited to, (i) a description of the institutions that will issue or guarantee the securities, surety bonds, irrevocable letters of credit, insurance or other financial instruments or guarantees, including, but not limited to, the credit rating, financial strength, and AM best rating, if applicable to the institutions (ii) applicable cash flow information and financial assumptions (iii) a description of the methodology to be used by the Association to assess and collect the Association Aggregate Security System assessments to be made pursuant to subdivision (3a) of this subsection and (iv) a proposed timetable for the release of existing individual company deposits posted pursuant to G.S. 97-185(c), provided, however, that no individual company deposits posted pursuant to G.S. 97-185(c) shall be released without the written consent of the Commissioner. The noncash elements of the composite security may be one year or multiple year instruments.~~

~~b. Within 90 days following the submission of the initial plan under sub-subdivision a. of this subdivision, the Commissioner shall either approve or disapprove the initial plan and shall notify the Association in writing. If the Commissioner does not approve or disapprove the initial plan within 90 days following submission, then the initial plan shall be deemed to be approved by the Commissioner. All subsequent plans shall be either approved or disapproved within 60 days following submission.~~

~~c. The Commissioner shall also determine the total undiscounted claims liability of each individual self insurer that will participate in the Association Aggregate Security System as well as the aggregate total undiscounted outstanding claims liabilities of all the individual self-insurers that are to participate in the Association Aggregate Security System and shall notify the Association of this determination.~~

~~d. Upon approval by the Commissioner of the Association's plan for the Association Aggregate Security System, the~~ The Association shall assess the individual self-insurers that participate in the Association Aggregate Security System pursuant to subdivision (3a) of this subsection.

e. ~~If the Commissioner disapproves the plan for any year,~~ If the Association determines it is not feasible or practical to operate the Association Aggregate Security System in any given year, it may terminate or suspend the Association Aggregate Security System and shall notify the Commissioner at least 90 days prior to the termination or suspension of the Association Aggregate Security

System for that particular year. During any period that the Associate Aggregate Security System is terminated or suspended, every self-insurer shall deposit with the Commissioner, or continue to deposit, the amount required by G.S. 97-185(b3) in the manner prescribed by G.S. 97-185(c).

f. Group self-insurers shall not participate in the Association Aggregate Security System.

(3) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

(3a) Assess members of the Association as follows:

a. Association Aggregate Security System assessments. – The Association shall assess each individual self-insurer participating in the Association Aggregate Security System a security system assessment. The amount of the security system assessment charged to each individual self-insurer participating in the Association Aggregate Security System shall be based on the Association's reasonable consideration of all of the following factors:

1. The total amount of assessments necessary to provide aggregate security for all participating individual self-insurers.
2. The individual self-insurer's total workers' compensation liabilities under the Act.
3. The financial strength and creditworthiness of the participating individual self-insurer.
4. Any other relevant factors.

b. Special assessment. – In the event that there are covered claims against an insolvent member or members and the assets of the Fund are not sufficient to pay the obligations of the Association, then the Association may collect a special assessment from the members in an amount sufficient to pay the aggregate value of such covered claims. Each member's special assessment shall be determined by the Board and shall be based on the proportion of the member's total obligations under the Act to the aggregate total of all members' obligations under the Act.

c. Initial assessments. – An individual self-insurer that becomes a member and does not initially participate in the Association Aggregate Security System shall pay an initial assessment to the Association in an amount determined by the Board. A group self-insurer, upon receiving its initial license from the Commissioner, shall pay an initial assessment to the Association in an amount determined by the Board.

d. Each member shall be notified of assessments no later than 30 days before the assessment is due.

e. Delinquent assessments, except as otherwise provided, shall bear interest at a rate to be established by the Board.

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).

(4) Be obligated to pay covered claims.

(5) After paying any covered claim, be subrogated to the rights of the injured employee and dependents and be entitled to enforce liability against the self-insurer or any third party by any appropriate action brought in its own name or in the name of the injured employee and dependents.

(6) Expend Fund assets in amounts necessary to pay all of the following:

a. The obligations of the Association under this Article subsequent to an insolvency.

b. The expenses of handling covered claims subsequent to an insolvency.

c. The cost of examinations under G.S. 97-137.

d. The costs of implementing and operating the Association Aggregate Security System.

e. All other expenses authorized by this Article.

(7) Investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation; and deny all other claims. The Association may review settlements to which the insolvent member was a party to determine the extent to which such settlements may be properly contested.

(8) Notify such persons as the Commissioner directs under G.S. 97-136.

(9) Handle claims through its directors, its employees, or through one or more members or other persons designated as servicing facilities. Designation ~~of a servicing facility is subject to the approval of the Commissioner, but designation~~ of a member as a servicing facility may be declined by such member.

(10) Reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association.

(11) Pay any other expenses of the Association authorized by this section.

(12) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

(13) Require each member to annually determine its total undiscounted workers' compensation claims liability and require each member to notify the Association of this determination.

(b) The Association may:

(1) Employ or retain such persons, including, but not limited to, adjustors, brokers, accountants, attorneys, financial advisors, investment bankers, placement agents, and consultants, as the Board may determine are necessary to handle claims, perform other duties of, provide services to, and consult with the Association.

(2) Borrow funds necessary to effect the purposes of this Article in accord with the Plan, including entering into standby lines of credit.

(3) Sue or be sued.

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this section.

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this section.

~~(6) Reimburse the Department of Insurance up to twenty thousand dollars ($20,000) for consultants retained by the Department to review the initial plan submitted pursuant to G.S. 97-133(a)(2a).~~

(c) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

(c1) The Association shall provide in its Plan that the functions of administration and adjusting claims shall not be performed by the same entity that provides legal representation to the Association for claims.

(d) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

"§ 97-134. Plan of Operation.

The Plan is as follows:

(1) The ~~Association~~ Board shall ~~submit to the Commissioner~~ adopt a Plan of Operation and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. ~~The Plan and any amendments become effective upon approval in writing by the Commissioner. If the Association at any time fails to submit a suitable Plan or suitable amendment to the Plan the Commissioner shall, after notice and hearing, adopt such reasonable rules as are necessary or advisable to effectuate this Article. The rules shall continue in force until modified by the Commissioner or superseded by a Plan submitted by the Association and approved by the Commissioner.~~

(2) All member self-insurers shall comply with the Plan.

(3) The Plan shall:

a. Establish the procedures whereby all the powers and duties of the Association under G.S. 97-133 will be performed.

b. Establish procedures for investing and managing Fund assets.

c. Adopt a reasonable mechanism and procedure to achieve equity in assessing members under G.S. 97-133.

d. Establish the amount and method of reimbursing members of the Board under G.S. 97-132.

e. Establish procedures by which claims may be filed with the Association and establish acceptable forms of proof of covered claims.

f. Establish regular places and times for meetings of the Board.

g. Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the Board.

h. Provide that any member self-insurer aggrieved by any final action or decision of the Association may appeal to the Commissioner within 30 days after the action or decision.

~~i. Establish the procedures whereby selections for the Board shall be submitted to the Commissioner.~~

j. Contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

...

"§ 97-136. Powers and duties of the Commissioner.

(a) The Commissioner shall:

(1) Notify the Association of the existence of an insolvent member self-insurer not later than 30 days after he receives notice of an insolvency pursuant to the standards set forth in G.S. 97-135.

~~(2) Approve or disapprove the plan for an Association Aggregate Security System as required under G.S. 97-133(a)(2a)b. and notify the Association of the information required under G.S. 97-133(a)(2a)c.~~

...

"§ 97-137. Examination of the Association.

The Association shall be subject to examination and regulation by the Commissioner. The Board shall submit, not later than ~~March 30~~ June 1 of each year, a financial report for the preceding calendar year in a form approved by the Commissioner.

...."

SECTION 11. G.S. 97-185(a1) reads as rewritten:

"(a1) All individual self-insurers as defined in G.S. 97-130(5b) shall participate in the Association Aggregate Security System established under G.S. 97-131 unless excluded by the Board of Directors of the North Carolina Self-Insurance Security Association. The Board of Directors of the North Carolina Self-Insurance Security Association shall exclude all of the following from the Association Aggregate Security System:

(1) Individual self-insurers whose licenses have previously been revoked by the Commissioner.

(2) Individual self-insurers with a debt rating as established by Standard & Poor's Rating Service or by Moody's Investor Service, below the minimum Standard & Poor's ~~and~~ or Moody's ratings if a minimum debt rating has been established ~~in the written plan~~ by the Board of Directors of the North Carolina Self-Insurance Security Association for the Association Aggregate Security ~~System submitted by the Association and approved by the Commissioner under G.S. 97-133(a)(2a).~~System.

(3) Individual self-insurers that have defaulted on the payment of their self-insured workers' compensation liabilities.

(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.

The Board of Directors of the North Carolina Self-Insurance Security Association shall notify the Commissioner of the individual self-insurers that are excluded from participating in the Association Aggregate Security System."

SECTION 12. Article 8 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-8-36. Administrative fees.**

Statewide multiline limited assessable mutual insurance companies are not subject to the provisions of G.S. 58-33-85(b)."

SECTION 13. G.S. 58-64-85 reads as rewritten:

"**§ 58-64-85. Other licensing or regulation.**

(a) Nothing in this Article affects the authority of the Department of Health and Human Services or any successor agency otherwise provided by law to license or regulate any health service facility or domiciliary service facility.

(b) Facilities and providers licensed under this Article that also are subject to the provisions of the North Carolina Condominium Act under Chapter 47C of the General Statutes shall not be subject to the provisions of Chapter 39A of the General Statutes, provided that the facility's declaration of condominium does not require the payment of any fee or charge not otherwise provided for in a resident's contract for continuing care, or other separate contract for the provisions of membership or services."

SECTION 14. Sections 1, 4, 10, and 11 of this act become effective July 1, 2011. Sections 3, 5, 6, and 7 of this act become effective October 1, 2011. Section 8 of this act becomes effective July 1, 2012, and applies to licenses issued on or after that date. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 298
PROPOSED COMMITTEE SUBSTITUTE H298-CSRG-8 [v.2]

4/25/2011 2:34:09 PM

Short Title: Insurance Amendments.-AB (Public)

Sponsors:

Referred to:

March 10, 2011

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES IN THE INSURANCE LAWS TO PRIVATIZE ONLINE AND ADMINISTRATIVE PROCESSES FOR LICENSE APPLICANTS, CODIFY THE EXISTING SENIORS' HEALTH INSURANCE INFORMATION PROGRAM, ENSURE ACCURACY IN CERTIFICATES OF INSURANCE, REQUIRE PRIOR APPROVAL OF SMALL GROUP HEALTH INSURANCE RATES AND ENCOURAGE THE SALE OF CHILD-ONLY HEALTH INSURANCE POLICIES, AMEND THE RISK-BASED CAPITAL LAW TO MAINTAIN NAIC ACCREDITATION, PROVIDE AN EXEMPTION FOR LICENSING OF CLAIMS INPUT EMPLOYEES FOR PORTABLE ELECTRONIC DEVICES, PROHIBIT FEDERAL PREEMPTION OF CROP ADJUSTERS' REGULATION, AND EASE THE REGULATORY BURDEN ON THE NORTH CAROLINA SELF-INSURANCE SECURITY ASSOCIATION AND THE ASSOCIATION AGGREGATE SECURITY SYSTEM.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-2-69(g) reads as rewritten:

"(g) The Commissioner may contract with the NAIC or other persons for the provision of online services to applicants and licensees, for the provision of administrative ~~services to licensees, or~~ services, for the provision of license processing and support services, and for the provision of regulatory data systems to the Commissioner. The NAIC or other person with whom the Commissioner contracts may charge applicants and licensees a reasonable fee for ~~the costs associated with the licensees' use~~ the provision of online ~~services and~~services, the provision of administrative ~~services.~~ services, the provision of license processing and support services, and the provision of regulatory data systems to the Commissioner. The fee shall be agreed to by the Commissioner and the other contracting party and shall be stated in the contract. The fee is in addition to any applicable license application and renewal fees. Contracts for the provision of online services, contracts for the provision of administrative services, and contracts for the provision of regulatory data systems shall not be subject to Article 3, 3C, or 8 of Chapter 143 of the General Statutes or to Article 3D of Chapter 147 of the General Statutes. However, the Commissioner shall: (i) submit all proposed statewide and agency term contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subsection to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all contracts to be awarded by the Commissioner under this subsection a standard clause which provides that the State Auditor and internal auditors of the Commissioner may audit the records of the contractor

during the term of the agreement or contract to verify accounts and data affecting fees and performance. The Commissioner shall not award a cost plus percentage of cost agreement or contract for any purpose."

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

"**§ 58-2-31. Seniors' Health Insurance Information Program.**

The Seniors' Health Insurance Information Program is established within the Department as a statewide health benefits counseling program to provide the State's Medicare beneficiaries with counseling in Medicare, Medicare supplement insurance, long-term care insurance, and related health care coverage plans."

SECTION 3. G.S. 58-3-150 reads as rewritten:

"**§ 58-3-150. Forms to be approved by Commissioner.**

(a) It is unlawful for any insurance company licensed and admitted to do business in this State to issue, sell, or dispose of any policy, contract, ~~or~~ certificate, or certificate of insurance, or use applications in connection therewith, until the forms of the same have been submitted to and approved by the Commissioner, and copies filed in the Department. If a policy form filing is disapproved by the Commissioner, the Commissioner may return the filing to the filer. As used in this section, "policy form" includes endorsements, riders, or amendments to policies that have already been approved by the Commissioner.

(b) With respect to group and blanket accident and health insurance, group life insurance, and group annuity policies issued and delivered to a trust or to an association outside of this State and covering persons resident in this State, the group certificates to be delivered or issued for delivery in this State shall be filed with and approved by the Commissioner pursuant to subsection (a) of this section.

(c) If not submitted electronically, all contracts, literature, advertising materials, letters, and other documents submitted to the Department to comply with the filing requirements of this Chapter or an administrative rule adopted pursuant to this Chapter shall be submitted on paper eight and one-half inches by eleven inches. Brochures and pamphlets shall not be stapled or bound.

(d) As used in this section, "certificate of insurance" means a document prepared or issued by an insurance company or producer that is used to verify or evidence the existence of property or casualty insurance coverage. "Certificate of insurance" shall not include a policy of insurance or insurance binder.

(e) A certificate of insurance is not a policy of insurance and does not amend, extend, or alter the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to a certificate of insurance holder new or additional rights beyond what the referenced policy of insurance expressly provides.

(f) It is unlawful for any person to knowingly prepare, issue, request, or require a certificate of insurance that meets any of the following criteria:

(1) Has not been filed with and approved by the Commissioner.

(2) Contains any false or misleading information concerning the policy of insurance to which the certificate of insurance makes reference.

(3) Purports to alter, amend, or extend the coverage provided by the policy of insurance to which the certificate of insurance makes reference.

(g) A holder of a certificate of insurance shall only have a legal right to notice of cancellation, nonrenewal, or any material change, or any similar notice concerning a policy of insurance if the holder is named within the policy or any endorsement and the policy or endorsement requires notice to be provided to the holder. The terms and conditions of the notice, including the required timing of the notice, are governed by the policy of insurance and cannot be altered by a certificate of insurance."

SECTION 4. Article 50 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-50-131. Premium rates for health benefit plans; approval authority; hearing.**

(a) No schedule of premium rates for coverage for a health benefit plan subject to this act, or any amendment to the schedule, shall be used in conjunction with any such health benefit plan until a copy of the schedule of premium rates or premium rate amendment has been filed with and approved by the Commissioner. Any schedule of premium rates or premium rate amendment filed under this section shall be established in accordance with G.S. 58-50-130(b). The schedule of premium rates shall not be excessive, unjustified inadequate, or unfairly discriminatory and shall exhibit a reasonable relationship to the benefits provided by the contract of insurance. Each filing shall include a certification by an individual who is a member in good standing with the Society of Actuaries.

(b) The Commissioner shall approve or disapprove a schedule of premium rates within 60 days of receipt of a complete filing. It shall be unlawful to use a schedule of premium rates until approved. If the Commissioner disapproves the filing, the Commissioner shall notify the filer, shall specify the reasons for disapproval, and shall provide an opportunity for refiling.

(c) The Commissioner shall adopt rules as necessary or proper (i) to prevent the federal preemption of health insurance regulation in the State, (ii) to implement the provisions of this section, and (iii) to establish minimum standards for loss ratios of policies subject to this section with accepted actuarial principles and practices to assure that the benefits are reasonable in relation to the premium charged. The Commissioner shall adopt rules to require the submission of supporting data and any information that the Commissioner considers necessary or proper to determine whether the filed schedule of premium rates meets the standards set forth in this section."

SECTION 5. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-285. Nondependent child coverage defined; open enrollment.**

(a) As used in this section, the following definitions apply:

(1) "Nondependent child coverage" or "nondependent child policy" means an individual health benefit plan which provides coverage to an individual under age 19. This shall not include health benefit plans that cover children under age 19 as a dependent.

(2) "Health benefit plan" has the same meaning as G.S. 58-3-167(a)(1).

(3) "Individual market" has the same meaning as G.S. 58-68-25(a)(9).

(4) "Insurer" has the same meaning as G.S. 58-3-167(a)(2).

(5) "Open enrollment" means, with respect to "nondependent child coverage," the period of time during which any individual under age 19 has the opportunity to apply for coverage under a health benefit plan offered by an insurer and shall not be denied eligibility for coverage under the plan due to factors relating to the individual's health status.

(b) An insurer who offers nondependent child coverage shall offer open enrollment either continuously throughout the year or for the months of January and July of each year. Coverage issued under this section shall be issued without any riders based on the health status of the child. Nothing in this section shall require an insurer to offer nondependent child coverage or maternity coverage within an offer of nondependent child coverage.

(c) The Commissioner shall adopt rules as necessary or proper to implement the provisions of this section.

(d) Nothing in this section shall prohibit an insurer from adjusting the initial premium charged an individual afforded coverage under this section based upon medical underwriting to the extent that such an adjustment is in compliance with the applicable product's current rate filing approved by the Commissioner."

SECTION 6. G.S. 58-12-2 reads as rewritten:

"**§ 58-12-2. Definitions.**

As used in this Article, the following terms have the following meanings:

(1) Adjusted risk-based capital report. – A risk-based capital report that has been adjusted by the Commissioner under G.S. 58-12-6.

(2) Corrective order. – An order issued by the Commissioner specifying corrective actions that the Commissioner has determined are required.

(3) Domestic insurer. – Any insurance company or health organization organized in this State under ~~Article 7,~~ Article 7 of this Chapter as specified in subdivisions (4b) and (5a) of this section, or under Article 15, 65, or 67 of this Chapter.

(4) Foreign insurer. – Any insurance company or health organization that is admitted to do business in this State under Article 16 or 67 of this Chapter but is not domiciled in this State.

(4a) Health organization. – Any insurer which is required by the Commissioner to use the NAIC Health Annual Statement Blank when filing the annual statement prescribed by G.S. 58-2-165 or any health maintenance organization, limited health service organization, dental or vision plan, hospital, medical, or dental indemnity or service corporation, or other organization licensed under Article 65 or 67 of this Chapter. "Health organization" does not include an insurer that is licensed as either a life or health insurer or a property or casualty insurer under this Chapter and that is otherwise subject to either the life or property and casualty risk-based capital requirements.

(4b) Life or health insurer. – Any insurance company licensed to write the kinds of insurance specified in G.S. 58-7-15(1), (2), or (3); or a licensed property and casualty insurer writing only the kinds of insurance specified in G.S. 58-7-15(3). "Life or health insurer" does not mean any insurer that is required by the Commissioner to use the NAIC Health Annual Statement Blank when it files the annual statement prescribed by G.S. 58-2-165.

(5) Negative trend. – A negative trend, with respect to a life or health insurer, over a period of time, as determined in accordance with the "trend test calculation" included in the risk-based capital instructions.

(5a) Property or casualty insurer. – Any insurance company licensed to write the kinds of insurance specified in G.S. 58-7-15(4) through (22); but not monoline mortgage guaranty insurers, financial guaranty insurers, or title ~~insurers.~~insurers; nor any insurer that is required by the Commissioner to use the NAIC Health Annual Statement Blank when filing the annual statement prescribed by G.S. 58-2-165.

(6) Risk-based capital instructions. – The risk-based capital report including risk-based capital instructions adopted by the NAIC, as those risk-based capital instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(7) Risk-based capital level. – An insurer's company action level risk-based capital, regulatory action level risk-based capital, authorized control level risk-based capital, or mandatory control level risk-based capital where:

a. "Company action level risk-based capital" means, with respect to any insurer, the product of 2.0 and its authorized control level risk-based capital.

b. "Regulatory action level risk-based capital" means the product of 1.5 and its authorized control level risk-based capital.

c. "Authorized control level risk-based capital" means the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

d. "Mandatory control level risk-based capital" means the product of .70 and the authorized control level risk-based capital.

(8) Risk-based capital plan. – A comprehensive financial plan containing the elements specified in G.S. 58-12-11(b). If the Commissioner rejects the risk-based capital plan, and it is revised by the insurer, with or without the Commissioner's recommendation, the plan shall be called the "revised risk-based capital plan".

(9) Risk-based capital report. – The report required in G.S. 58-12-6.

(10) Total adjusted capital. – The sum of:

a. An insurer's statutory capital and surplus, as determined in accordance with the statutory accounting applicable to the annual financial statements required under G.S. 58-2-165; and

b. Such other items, if any, as the risk-based capital instructions may provide."

SECTION 7. G.S. 58-12-11(a) reads as rewritten:

"(a) "Company action level event" means any of the following events:

(1) The filing of a risk-based capital report by an insurer that indicates that:

a. The insurer's total adjusted capital is greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based ~~capital, if the insurer is a property or casualty insurer or a health organization;~~ capital; or

b. ~~The~~ In the case of a life or health insurer, the insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and 2.5 and has a negative ~~trend, if the insurer is a life or health insurer.~~trend; or

c. In the case of a property or casualty insurer or a health organization, the insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty or health organization risk-based capital instructions.

(2) The notification by the Commissioner to the insurer of an adjusted ~~risk-bases~~ risk-based capital report that indicates the event in sub-subdivision ~~(1)a. or b.~~(1)a., (1)b., or (1)c. of this subsection if the insurer does not challenge the adjusted risk-based capital report under G.S. 58-12-30.

(3) If the insurer challenges an adjusted risk-based capital report that indicates the event in sub-subdivision ~~(1)a. or b.~~ (1)a., (1)b., or (1)c. of this subsection under G.S. 58-12-30, the notification by the Commissioner to the insurer that the Commissioner has rejected the insurer's challenge."

SECTION 8. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-27. Claims handling for portable consumer electronic devices.**

(a) As used in this section, the following definitions apply:

(1) "Automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation, and system generated final resolution of claims on insurance policies that only cover

portable consumer electronic devices, which system shall meet the following criteria:

a. Be utilized only by a licensed adjuster, licensed agent, or supervised individuals operating pursuant to this section.

b. Comply with all claims payment requirements of this Chapter.

c. Be certified as compliant with this section by a licensed adjuster who is an officer of a licensed business entity under this Chapter.

(2) "Portable consumer electronic devices" include the following, which must be easily carried or conveyed by hand: smartphones, navigation devices, cellular phones, personal digital assistants, iPads, iPhones, Androids, video games, wireless reading devices, laptops, tablets, netbooks, MP3 players, digital cameras, and other electronic devices that are portable in nature, their accessories, and services related to the use of the device.

(b) No adjuster license is required for an individual who, in connection with insurance covering only portable consumer electronic devices as defined in subdivision (a)(2) of this section, collects claim information from or furnishes claim information to insureds, who conducts data entry, including entering data into an automated claims adjudication system, and who does not exercise any discretion in the disposition of the portable consumer electronic device claim; provided that the individual is supervised by a licensed adjuster or licensed agent and there are no more than 25 individuals who may adjust claims under the supervision of the licensed adjuster or licensed agent. No agent acting as a supervisor pursuant to this section is required to be licensed as an adjuster.

(c) If other property losses occur in conjunction with the loss associated with the portable consumer electronic device, the individual who performs duties as described in G.S. 58-33-10(2) on the total loss, including the loss associated with the portable consumer electronic device, must hold an adjuster license."

SECTION 9. G.S. 58-33-30(e) reads as rewritten:

"(e) Examination.

(1) After completion and filing of the application with the Commissioner, the Commissioner shall require each applicant for license as an agent or an adjuster to take an examination as to the applicant's competence to be licensed. The applicant must take and pass the examination according to requirements prescribed by the Commissioner. This subsection shall not apply to adjusters who adjust only federal crop insurance claims and are certified in accordance with subsection (2a) of this section.

(2) The Commissioner may require any licensed agent, adjuster, or motor vehicle damage appraiser to take and successfully pass an examination in writing, testing his competence and qualifications as a condition to the continuance or renewal of his license, if the licensee has been found guilty of any violation of any provision of this Chapter. If an individual fails to pass such an examination, the Commissioner shall revoke all licenses issued in his name and no license shall be issued until such individual has passed an examination as provided in this Article.

(2a) Adjusters who adjust federal crop insurance claims shall be certified as having passed a proficiency examination approved by the federal Risk Management Agency (RMA) as a condition of obtaining an adjuster's license under this Chapter, or another proficiency examination approved by the Commissioner. An adjuster who intends to adjust crop insurance claims shall furnish the Commissioner proof that the adjuster is certified as having passed the required examination pursuant to this section.

(3) Each examination shall be as the Commissioner prescribes and shall be of sufficient scope to test the applicant's knowledge of:
a. The terms and provisions of the policies or contracts of insurance the applicant proposes to effect; or
b. The types of claims or losses the applicant proposes to adjust; and
c. The duties and responsibilities of the license; and
d. The current laws of this State applicable to the license.

(4) The answers of the applicant to the examination shall be provided by the applicant under the Commissioner's supervision. The Commissioner shall give examinations at such times and places within this State as the Commissioner considers necessary reasonably to serve the convenience of both the Commissioner and applicants: Provided that the Commissioner may contract directly with persons for the processing of examination application forms and for the administration and grading of the examinations required by this section; the Commissioner may charge a reasonable fee in addition to the registration fee charged under G.S. 58-33-125, to offset the cost of the examination contract authorized by this subsection; and such contracts shall not be subject to Article 3 of Chapter 143 of the General Statutes. However, the Commissioner shall: (i) submit all proposed statewide and agency term agreements or contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subdivision to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all contracts to be awarded by the Commissioner under this subdivision a standard clause which provides that the State Auditor and internal auditors of the Commissioner may audit the records of the contractor during the term of the contract to verify accounts and data affecting fees and performance. The Commissioner shall not award a cost plus percentage of cost contract for any purpose.

(5) The Commissioner shall collect in advance the examination and registration fees provided in G.S. 58-33-125 and in subsection (4) of this section. The Commissioner shall make or cause to be made available to all applicants, for a reasonable fee to offset the costs of production, materials that he considers necessary for the applicants' proper preparation for examinations. The Commissioner may contract directly with publishers and other suppliers for the production of the preparatory materials, and contracts so let by the Commissioner shall not be subject to Article 3 of Chapter 143 of the General Statutes. However, the Commissioner shall: (i) submit all proposed statewide and agency term contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subdivision to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all contracts to be awarded by the Commissioner under this subdivision a standard clause which provides that the State Auditor and internal auditors of the Commissioner may audit the records of the contractor during the term of the contract to verify accounts and data affecting fees and performance. The Commissioner shall not award a cost plus percentage of cost contract for any purpose.

(6) In addition to the examinations for the kinds of insurance specified in G.S. 58-33-25(c)(1) and (2), before any resident may sell Medicare supplement or long-term care insurance policies defined respectively in

Articles 54 and 55 of this Chapter, the resident must take and pass a supplemental written examination according to requirements prescribed by the Commissioner.

(7) 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."

SECTION 10. Article 4 of Chapter 97 of the General Statutes reads as rewritten:

"Article 4.

North Carolina Self-Insurance Security Association.

"§ 97-130. Definitions.

As used in this Article:

(1) "Association" means the North Carolina Self-Insurance Security Association established by G.S. 97-131.

(1a) "Association Aggregate Security System" means the security system established by the Association under G.S. 97-133 whereby individual self-insurers collectively secure their aggregate self-insured workers' compensation liabilities through the North Carolina Self-Insurance Security Association.

(2) "Board" means the Board of Directors of the Association established by G.S. 97-132.

(3) "Commissioner" means the North Carolina Commissioner of Insurance.

(4) "Covered claim" means an unpaid claim against an insolvent individual self-insurer or group self-insurer that relates to an injury that occurs while the individual self-insurer or group self-insurer is a member of the Association and that is compensable under this Chapter.

(5) "Fund" means the North Carolina Self-Insurance Security Fund established by G.S. 97-133.

(5a) "Group" or "Group self-insurer" means a group self-insurer licensed by the Commissioner under Part 1, Article 47 of Chapter 58 of the General Statutes.

(5b) "Individual self-insurer" means an individual employer licensed by the Commissioner under Article 5 of this Chapter.

(6) "Member self-insurer" or "member" means an individual self-insurer or group self-insurer that is required to be a member of the Association under this Article or Part 1, Article 47 of Chapter 58 of the General Statutes.

(7) "Plan" means the Plan of Operation authorized by G.S. 97-134.

(8) Repealed by Session Laws 2005-400, s. 1.2, effective January 1, 2006.

(9) "Servicing facility" means those persons delegated by the Board ~~and approved by the Commissioner~~ to settle or compromise claims and to expend Fund assets to pay claims.

"§ 97-131. Creation.

...

(b) All individual self-insurers and group self-insurers shall be and remain members of the Association as a condition of being licensed to self-insure in this State. The Association shall perform its functions under a Plan of Operation established or amended, or both, by the ~~Board and approved by the Commissioner,~~ Board and shall exercise its powers through the Board.

(1) An individual self-insurer or a group self-insurer shall be deemed to be a member of the Association for purposes of another member's insolvency, as defined in G.S. 97-135, when:

a. The individual self-insurer or group self-insurer is a member of the Association when an insolvency occurs, or

b. The individual self-insurer or group self-insurer has been a member of the Association at some point in time during the 12-month period immediately preceding the insolvency in question.

(2) An individual self-insurer or a group self-insurer shall be deemed to be a member of the Association for purposes of its own insolvency if it is a member when the compensable injury occurs.

(3) In determining the membership of the Association for the purposes of subdivisions (1) and (2) of this subsection for any date after the effective date of this Article, no individual self-insurer or group self-insurer may be deemed to be a member of the Association on any date after the effective date of this Article, unless that employer is on that date licensed as an individual self-insurer by the Commissioner under Article 5 of this Chapter or a group of employers is at that time licensed as a group self-insurer by the Commissioner under Article 47 of Chapter 58 of the General Statutes.

"**§ 97-132. Board of directors.**

The Board shall consist of not less than nine directors serving terms as established in the Plan. The directors shall be selected by the members of the ~~Association, subject to the approval of the Commissioner,~~ Association and shall serve for three-year terms and until a successor is elected and qualified. There is no limitation on the number of terms a director may serve. ~~In approving selections to the Board, the Commissioner shall consider, among other things, whether individual self-insurers and group self-insurers are fairly represented.~~ Directors may be reimbursed from the assets of the Association for expenses incurred by them as directors.

"**§ 97-133. Powers and duties of the Association.**

(a) The Association shall:

(1) Repealed by Session Laws 1999-219, s. 7.2, effective June 25, 1999.

(1a) Administer a fund, to be known as the North Carolina Self-Insurance Security Fund, which shall receive the assets of the North Carolina Self-Insurance Guaranty Fund previously established under subdivision (2) of this subsection, the assessments required by subdivisions (2a) and (3a) of this subsection and any other sums received by the Association. ~~In its discretion, the Board may determine that the assets of the Fund should be segregated or that a separate accounting shall be made in order to identify that portion of the Fund which represents assessments paid by individual self-insurers and that portion of the Fund which represents assessments paid by group self-insurers. If the Board segregates the Fund in this manner, the Association shall thereafter pay covered claims against individual member self-insurers from that portion of the Fund that represents assessments against individual self-insurers and shall thereafter pay covered claims against group member self-insurers from that portion of the Fund that represents assessments against group self-insurers.~~ The costs of administering the Association shall be borne by the Fund. The Association is authorized to secure insurance, primary excess insurance, reinsurance, bonds, other insurance, financial guarantees and related financial instruments to effectuate the purposes of the Association. The Board will invest the Fund assets pursuant to an investment policy adopted by the Board and reviewed and approved annually by the Department of the State Treasurer. The earnings from investment of Fund assets shall be placed in or credited to the Fund.

(2) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

(2a) ~~Establish, operate, and maintain~~ Establish and operate the Association Aggregate Security System as defined in G.S. 97-130 and G.S. 97-165 as follows:

a. The Association shall annually ~~prepare and submit to the Commissioner a written plan to~~ operate and provide an Association Aggregate Security System through a combination of cash on deposit in the Fund, securities, surety bonds, irrevocable letters of credit, ~~insurance~~ insurance, reinsurance, or other financial instruments or guarantees owned or entered into by the ~~Association and acceptable to the Commissioner.~~ Association. ~~The written plan shall include, but not be limited to, (i) a description of the institutions that will issue or guarantee the securities, surety bonds, irrevocable letters of credit, insurance or other financial instruments or guarantees, including, but not limited to, the credit rating, financial strength, and AM best rating, if applicable to the institutions (ii) applicable cash flow information and financial assumptions (iii) a description of the methodology to be used by the Association to assess and collect the Association Aggregate Security System assessments to be made pursuant to subdivision (3a) of this subsection and (iv) a proposed timetable for the release of existing individual company deposits posted pursuant to G.S. 97-185(c), provided, however, that no individual company deposits posted pursuant to G.S. 97-185(c) shall be released without the written consent of the Commissioner. The noncash elements of the composite security may be one year or multiple year instruments.~~

~~b. Within 90 days following the submission of the initial plan under sub-subdivision a. of this subdivision, the Commissioner shall either approve or disapprove the initial plan and shall notify the Association in writing. If the Commissioner does not approve or disapprove the initial plan within 90 days following submission, then the initial plan shall be deemed to be approved by the Commissioner. All subsequent plans shall be either approved or disapproved within 60 days following submission.~~

~~c. The Commissioner shall also determine the total undiscounted claims liability of each individual self-insurer that will participate in the Association Aggregate Security System as well as the aggregate total undiscounted outstanding claims liabilities of all the individual self-insurers that are to participate in the Association Aggregate Security System and shall notify the Association of this determination.~~

~~d. Upon approval by the Commissioner of the Association's plan for the Association Aggregate Security System, the~~ The Association shall assess the individual self-insurers that participate in the Association Aggregate Security System pursuant to subdivision (3a) of this subsection.

e. ~~If the Commissioner disapproves the plan for any year,~~ If the Association determines it is not feasible or practical to operate the Association Aggregate Security System in any given year, it may terminate or suspend the Association Aggregate Security System and shall notify the Commissioner at least 90 days prior to the termination or suspension of the Association Aggregate Security

System for that particular year. During any period that the Associate Aggregate Security System is terminated or suspended, every self-insurer shall deposit with the Commissioner, or continue to deposit, the amount required by G.S. 97-185(b3) in the manner prescribed by G.S. 97-185(c).

f. Group self-insurers shall not participate in the Association Aggregate Security System.

(3) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

(3a) Assess members of the Association as follows:

a. Association Aggregate Security System assessments. – The Association shall assess each individual self-insurer participating in the Association Aggregate Security System a security system assessment. The amount of the security system assessment charged to each individual self-insurer participating in the Association Aggregate Security System shall be based on the Association's reasonable consideration of all of the following factors:

1. The total amount of assessments necessary to provide aggregate security for all participating individual self-insurers.
2. The individual self-insurer's total workers' compensation liabilities under the Act.
3. The financial strength and creditworthiness of the participating individual self-insurer.
4. Any other relevant factors.

b. Special assessment. – In the event that there are covered claims against an insolvent member or members and the assets of the Fund are not sufficient to pay the obligations of the Association, then the Association may collect a special assessment from the members in an amount sufficient to pay the aggregate value of such covered claims. Each member's special assessment shall be determined by the Board and shall be based on the proportion of the member's total obligations under the Act to the aggregate total of all members' obligations under the Act.

c. Initial assessments. – An individual self-insurer that becomes a member and does not initially participate in the Association Aggregate Security System shall pay an initial assessment to the Association in an amount determined by the Board. A group self-insurer, upon receiving its initial license from the Commissioner, shall pay an initial assessment to the Association in an amount determined by the Board.

d. Each member shall be notified of assessments no later than 30 days before the assessment is due.

e. Delinquent assessments, except as otherwise provided, shall bear interest at a rate to be established by the Board.

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).

(4) Be obligated to pay covered claims.

(5) After paying any covered claim, be subrogated to the rights of the injured employee and dependents and be entitled to enforce liability against the self-insurer or any third party by any appropriate action brought in its own name or in the name of the injured employee and dependents.

(6) Expend Fund assets in amounts necessary to pay all of the following:

a. The obligations of the Association under this Article subsequent to an insolvency.

b. The expenses of handling covered claims subsequent to an insolvency.

c. The cost of examinations under G.S. 97-137.

d. The costs of implementing and operating the Association Aggregate Security System.

e. All other expenses authorized by this Article.

(7) Investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation; and deny all other claims. The Association may review settlements to which the insolvent member was a party to determine the extent to which such settlements may be properly contested.

(8) Notify such persons as the Commissioner directs under G.S. 97-136.

(9) Handle claims through its directors, its employees, or through one or more members or other persons designated as servicing facilities. Designation ~~of a servicing facility is subject to the approval of the Commissioner, but designation~~ of a member as a servicing facility may be declined by such member.

(10) Reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association.

(11) Pay any other expenses of the Association authorized by this section.

(12) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

(13) Require each member to annually determine its total undiscounted workers compensation claims liability and require each member to notify the Association of this determination.

(b) The Association may:

(1) Employ or retain such persons, including, but not limited to, adjustors, brokers, accountants, attorneys, financial advisors, investment bankers, placement agents, and consultants, as the Board may determine are necessary to handle claims, perform other duties of, provide services to, and consult with the Association.

(2) Borrow funds necessary to effect the purposes of this Article in accord with the Plan, including entering into standby lines of credit.

(3) Sue or be sued.

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this section.

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this section.

~~(6) Reimburse the Department of Insurance up to twenty thousand dollars ($20,000) for consultants retained by the Department to review the initial plan submitted pursuant to G.S. 97-133(a)(2a).~~

(c) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

(c1) The Association shall provide in its Plan that the functions of administration and adjusting claims shall not be performed by the same entity that provides legal representation to the Association for claims.

(d) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

"§ 97-134. Plan of Operation.

The Plan is as follows:

(1) The ~~Association~~ Board shall ~~submit to the Commissioner~~ adopt a Plan of Operation and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. ~~The Plan and any amendments become effective upon approval in writing by the Commissioner. If the Association at any time fails to submit a suitable Plan or suitable amendment to the Plan the Commissioner shall, after notice and hearing, adopt such reasonable rules as are necessary or advisable to effectuate this Article. The rules shall continue in force until modified by the Commissioner or superseded by a Plan submitted by the Association and approved by the Commissioner.~~

(2) All member self-insurers shall comply with the Plan.

(3) The Plan shall:

a. Establish the procedures whereby all the powers and duties of the Association under G.S. 97-133 will be performed.

b. Establish procedures for investing and managing Fund assets.

c. Adopt a reasonable mechanism and procedure to achieve equity in assessing members under G.S. 97-133.

d. Establish the amount and method of reimbursing members of the Board under G.S. 97-132.

e. Establish procedures by which claims may be filed with the Association and establish acceptable forms of proof of covered claims.

f. Establish regular places and times for meetings of the Board.

g. Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the Board.

h. Provide that any member self-insurer aggrieved by any final action or decision of the Association may appeal to the Commissioner within 30 days after the action or decision.

~~i. Establish the procedures whereby selections for the Board shall be submitted to the Commissioner.~~

j. Contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

...

"§ 97-136. Powers and duties of the Commissioner.

(a) The Commissioner shall:

(1) Notify the Association of the existence of an insolvent member self-insurer not later than 30 days after he receives notice of an insolvency pursuant to the standards set forth in G.S. 97-135.

~~(2) Approve or disapprove the plan for an Association Aggregate Security System as required under G.S. 97-133(a)(2a)b. and notify the Association of the information required under G.S. 97-133(a)(2a)c.~~

"§ 97-137. Examination of the Association.

The Association shall be subject to examination and regulation by the Commissioner. The Board shall submit, not later than ~~March 30~~ June 1 of each year, a financial report for the preceding calendar year in a form approved by the Commissioner.

...."

SECTION 11. G.S. 97-185(a1) reads as rewritten:

"(a1) All individual self-insurers as defined in G.S. 97-130(5b) shall participate in the Association Aggregate Security System established under G.S. 97-131 unless excluded by the Board of Directors of the North Carolina Self-Insurance Security Association. The Board of Directors of the North Carolina Self-Insurance Security Association shall exclude all of the following from the Association Aggregate Security System:

(1) Individual self-insurers whose licenses have previously been revoked by the Commissioner.

(2) Individual self-insurers with a debt rating as established by Standard & Poor's Rating Service or by Moody's Investor Service, below the minimum Standard & Poor's ~~and~~ or Moody's ratings if a minimum debt rating has been established ~~in the written plan~~ by the Board of Directors of the North Carolina Self-Insurance Security Association for the Association Aggregate Security ~~System submitted by the Association and approved by the Commissioner under G.S. 97-133(a)(2a).~~System.

(3) Individual self-insurers that have defaulted on the payment of their self-insured workers' compensation liabilities.

(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.

The Board of Directors of the North Carolina Self-Insurance Security Association shall notify the Commissioner of the individual self-insurers that are excluded from participating in the Association Aggregate Security System."

SECTION 12. Article 8 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-8-36. Administrative fees.**

Statewide multi-line limited assessable mutual insurance companies are not subject to the provisions of G.S. 58-33-85(b)."

SECTION 13. G.S. 58-64-85 reads as rewritten:

"**§ 58-64-85. Other licensing or regulation.**

(a) Nothing in this Article affects the authority of the Department of Health and Human Services or any successor agency otherwise provided by law to license or regulate any health service facility or domiciliary service facility.

(b) Facilities and providers licensed under this Article that also are subject to the provisions of the North Carolina Condominium Act under Chapter 47C of the General Statutes shall not be subject to the provisions of Chapter 39A of the General Statutes, provided that the facility's declaration of condominium does not require the payment of any fee or charge not otherwise provided for in a resident's contract for continuing care, or other separate contract for the provisions of membership or services."

SECTION 14. Sections 1, 4, 10, and 11 of this act become effective July 1, 2011. Sections 3, 5, 6, and 7 of this act become effective October 1, 2011. Section 8 of this act becomes effective July 1, 2012, and applies to licenses issued on or after that date. The remainder of this act is effective when it becomes law.

HOUSE BILL 298:
Insurance Amendments.-AB

2011-2012 General Assembly

Committee:	House Insurance, if favorable, Finance	**Date:**	April 24, 2011
Introduced by:	Rep. Dockham	**Prepared by:**	Tim Hovis
Analysis of:	PCS to First Edition H298-CSRG-8		Committee Counsel

SUMMARY: House Bill 298 makes various changes to the insurance laws including laws governing licensing requirements, the provision of services for license applicants, certificates of insurance, health insurance, risk-based capital requirements for insurers, and Department oversight of the Association Aggregate Security System for workers compensation self-insurers.

House Bill 298 makes the following changes:

Section 1 authorizes the Commissioner of Insurance to contract with the National Association of Insurance Commissioners (NAIC) and other third parties to provide online license processing and support services to license applicants. The bill also authorizes the third party to charge a reasonable fee, as agreed to by the Commissioner, for these services.

Section 2 codifies the existing Senior Health Insurance Information Program (SHIIP) in Chapter 58 of the General Statutes governing insurance. Currently, this Program is referenced in the Administrative Code (11 NCAC 17).

Section 3 makes it unlawful to prepare or issue a certificate of insurance that: (1) is in a form not approved by the Commissioner; (2) contains any false or misleading information; or (3) purports to alter or amend the coverage provided by the policy. A certificate of insurance is a short summary of a policy provided by an insurer upon request to verify the existence of coverage.

Section 4 grants the Commissioner the authority to approve or disapprove rates filed by insurers for small group coverage prior to an insurer's use of the filed rates. This is known as "prior approval." Prior approval is needed to avoid possible federal intervention in the approval of rates if the State does not have this authority.

Section 5 creates a defined open enrollment period in the months of January and July of each year for nondependent child coverage, also known as "child only" coverage. An insurer is not required, however, to offer child only coverage, or maternity coverage as part of an offer of child only coverage.

Sections 6 and 7 adopt NAIC model language implementing a new "trend test" calculation. The trend test is currently used to allow the Department to identify a company with insufficient capital in light of the company's assumed risk. The Department can then require the development of a comprehensive financial plan by the company. Failure to adopt the new NAIC Model trend test language could result in loss of state accreditation by the NAIC.

Section 8 exempts from adjuster licensing requirements those individuals who, in connection solely with insurance covering only portable consumer electronic devices, collect claims information and conduct data entry, and exercise no discretion in the disposition of the portable electronic device claim. For the exemption to apply, the individual must be supervised by a licensed adjuster or licensed agent who supervises no more than 25 individuals adjusting claims.

Section 9 exempts crop loss adjusters from the examination requirements applicable to property and casualty adjusters if: (1) the crop adjuster adjusts only federal crop insurance claims; and (2) the adjuster

passes a proficiency examination approved by the federal Risk Management Agency or the Commissioner.

Sections 10 and 11 make changes to ease Department regulation of the Association Aggregate Security System (System) of the North Carolina Self-Insurance Guaranty Association (Association). The Association provides for the payment of Workers' Compensation claims against member self-insurers in the case of insolvency of one of its members. The System was established by the Association to allow individual self-insurers to collectively secure workers' compensation liabilities through the Association. The Association submits its Plan of Operation to the Commissioner for approval and also must annually submit its plan for the System to the Commissioner for approval. The bill makes the following changes:

- Deletes language requiring the Commissioner's approval of the Association's Board of Directors (G.S. 97-132), the Association's Plan of Operation (G.S. 97-134), the System's plan (G.S. 97-133(a)(2a), and the Association's servicing facility (G.S. 97-133(a)(9)).
- Removes language allowing separation of the Association's Self-Insurance Security Fund into separate funds for group self-insurers and individual self-insurers (G.S. 97-133(a)(1a)).
- Requires each member of the Association to annually determine and report its total undiscounted workers compensation claims liability to the Association (G.S. 97-133(a)(13)).
- Allows the Board to set its own minimum debt rating for participation in the System (Section 11).

Section 12 exempts mutual insurance companies from requirement that application and policy fees may not be charged by an insurer without the insured's prior written consent. Under current law, mutual insurance companies are generally exempt from Department regulatory requirements.

Section 13 provides that a fee charged by a licensed continuing care facility in a facility's declaration of condominium which is also provided in a resident's contract for continuing care with the facility is not a transfer fee for the purposes of Chapter 39A of the General Statutes. Chapter 39A prohibits the enforcement of transfer fee covenants running with a title to real property.

EFFECTIVE DATE: Sections 1, 4, 10 and 11 become effective July 1, 2011. Sections 3, 5, 6, and 7 become effective October 1, 2011. Section 8 becomes effective July 1, 2012 and applies to licenses issued on or after that date. The remainder of the act is effective when it becomes law.

H298-SMRG-12(CSRG-8) v2

HOUSE BILL 298

Short Title:	Insurance Amendments.-AB	(Public)
Sponsors:	Representative Dockham (Primary Sponsor). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Insurance, if favorable, Finance.	

March 10, 2011

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES IN THE INSURANCE LAWS TO PRIVATIZE ONLINE AND ADMINISTRATIVE PROCESSES FOR LICENSE APPLICANTS, ENSURE ACCURACY IN CERTIFICATES OF INSURANCE, REQUIRE PRIOR APPROVAL OF SMALL GROUP HEALTH INSURANCE RATES AND ENCOURAGE THE SALE OF CHILD-ONLY HEALTH INSURANCE POLICIES, AMEND THE RISK-BASED CAPITAL LAW TO MAINTAIN NAIC ACCREDITATION, PROVIDE AN EXEMPTION FOR LICENSING OF CLAIMS INPUT EMPLOYEES FOR PORTABLE ELECTRONIC DEVICES, PROHIBIT FEDERAL PREEMPTION OF CROP ADJUSTERS' REGULATION, AND EASE THE REGULATORY BURDEN ON THE ASSOCIATION AGGREGATE SECURITY SYSTEM.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-2-69(g) reads as rewritten:

"(g) The Commissioner may contract with the NAIC or other persons for the provision of online services to applicants and licensees, for the provision of administrative ~~services to licensees, or~~ services, for the provision of license processing and support services, and for the provision of regulatory data systems to the Commissioner. The NAIC or other person with whom the Commissioner contracts may charge applicants and licensees a reasonable fee for ~~the costs associated with the licensees' use~~ the provision of online ~~services and~~services, the provision of administrative ~~services.~~ services, the provision of license processing and support services, and the provision of regulatory data systems to the Commissioner. The fee shall be agreed to by the Commissioner and the other contracting party and shall be stated in the contract. The fee is in addition to any applicable license application and renewal fees. Contracts for the provision of online services, contracts for the provision of administrative services, and contracts for the provision of regulatory data systems shall not be subject to Article 3, 3C, or 8 of Chapter 143 of the General Statutes or to Article 3D of Chapter 147 of the General Statutes. However, the Commissioner shall: (i) submit all proposed statewide and agency term contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subsection to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all contracts to be awarded by the Commissioner under this subsection a standard clause which provides that the State Auditor and internal auditors of the Commissioner may audit the records of the contractor during the term of the agreement or contract to verify accounts and data affecting fees and performance. The Commissioner shall not award a cost plus percentage of cost agreement or contract for any purpose."

SECTION 2. G.S. 58-3-150 reads as rewritten:

"**§ 58-3-150. Forms to be approved by Commissioner.**

(a) It is unlawful for any insurance company licensed and admitted to do business in this State to issue, sell, or dispose of any policy, contract, ~~or~~ certificate, or certificate of insurance or use applications in connection therewith, until the forms of the same have been submitted to and approved by the Commissioner, and copies filed in the Department. If a policy form filing is disapproved by the Commissioner, the Commissioner may return the filing to the filer. As used in this section, "policy form" includes endorsements, riders, or amendments to policies that have already been approved by the Commissioner.

(b) With respect to group and blanket accident and health insurance, group life insurance, and group annuity policies issued and delivered to a trust or to an association outside of this State and covering persons resident in this State, the group certificates to be delivered or issued for delivery in this State shall be filed with and approved by the Commissioner pursuant to subsection (a) of this section.

(c) If not submitted electronically, all contracts, literature, advertising materials, letters, and other documents submitted to the Department to comply with the filing requirements of this Chapter or an administrative rule adopted pursuant to this Chapter shall be submitted on paper eight and one-half inches by eleven inches. Brochures and pamphlets shall not be stapled or bound.

(d) A certificate of insurance is not a policy of insurance and does not amend, extend, or alter the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to a certificate holder new or additional rights beyond what the referenced policy of insurance expressly provides.

(e) It is unlawful for any person to knowingly prepare, issue, request, or require a certificate of insurance that meets any of the following criteria:

(1) Has not been filed with and approved by the Commissioner.

(2) Contains any false or misleading information concerning the policy of insurance to which the certificate makes reference.

(3) Purports to alter, amend, or extend the coverage provided by the policy of insurance to which the certificate makes reference.

(f) As used in this section, "certificate of insurance" means a document prepared or issued by an insurance company or producer that is used to verify or evidence the existence of property or casualty insurance coverage. "Certificate of insurance" shall not include a policy of insurance or insurance binder.

(g) A certificate holder shall only have a legal right to notice of cancellation, nonrenewal, or any material change, or any similar notice concerning a policy of insurance if the certificate holder is named within the policy or any endorsement and the policy or endorsement requires notice to be provided to the certificate holder. The terms and conditions of the notice, including the required timing of the notice, are governed by the policy of insurance and cannot be altered by a certificate of insurance."

SECTION 3. Article 50 of Chapter 58 is amended by adding the following new section to read:

"**§ 58-50-131. Premiums for health benefit plans; approval authority; hearing.**

(a) No schedule of premiums for coverage for a health benefit plan subject to this act, or any amendment to the schedule, shall be used in conjunction with any such health benefit plan until a copy of the schedule of premiums or amendment has been filed with and approved by the Commissioner. Any schedule of premiums or amendment filed under this section shall be established in accordance with G.S. 58-50-130(b). The schedule of premiums shall not be excessive, inadequate, or unfairly discriminatory, and shall exhibit a reasonable relationship to the benefits provided by the contract of insurance. Each filing shall include a certification by an individual who is a member in good standing with the Society of Actuaries.

(b) The Commissioner shall approve or disapprove a schedule of premium rates within 60 days of receipt of a complete filing. It shall be unlawful to use a schedule of premiums until approved. If the Commissioner disapproves the filing, the Commissioner shall notify the filer, shall specify the reasons for disapproval, and shall provide an opportunity for refiling and for requesting a hearing. A hearing shall be granted within a reasonable period from the date the request is submitted to the Commissioner in writing by the person filing.

(c) The Commissioner shall adopt rules as necessary or proper (i) to prevent the federal preemption of health insurance regulation in the State and (ii) to implement the provisions of this section and (iii) to establish minimum standards for loss ratios of policies subject to this section on the basis of incurred claims experience and earned premium in accordance with accepted actuarial principles and practices to assure that the benefits are reasonable in relation to the premium charged. The Commissioner shall adopt rules to require the submission of supporting data and any information that the Commissioner considers necessary or proper to determine whether the filed schedule of premiums meets the standards set forth in this section."

SECTION 4. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-285. Nondependent child coverage defined; open enrollment.**

(a) As used in this section, the following definitions apply:

(1) "Nondependent child coverage" or "nondependent child policy" means an individual health benefit plan which provides coverage to an individual under age 19. This shall not include health benefit plans that cover children under age 19 as a dependent.

(2) "Health benefit plan" has the same meaning as G.S. 58-3-167(a)(1).

(3) "Individual market" has the same meaning as G.S. 58-68-25(a)(9).

(4) "Insurer" has the same meaning as G.S. 58-3-167(a)(2).

(5) "Open enrollment" means, with respect to "nondependent child coverage," the period of time during which any individual under age 19 has the opportunity to apply for coverage under a health benefit plan offered by an insurer and shall not be denied eligibility for coverage under the plan due to factors relating to the individual's health status.

(b) An insurer who offers nondependent child coverage shall offer open enrollment either continuously throughout the year or for the months of January and July of each year. Coverage issued under this section shall be issued without any riders based on the health status of the child. Nothing in this section shall require an insurer to offer nondependent child coverage.

(c) The Commissioner shall adopt rules as necessary or proper to implement the provisions of this section.

(d) Nothing in this section shall prohibit an insurer from adjusting the initial premium charged an individual afforded coverage under this section based upon medical underwriting to the extent that such an adjustment is in compliance with the applicable product's current rate filing approved by the Commissioner."

SECTION 5. G.S. 58-12-2 reads as rewritten:

"**§ 58-12-2. Definitions.**

As used in this Article, the following terms have the following meanings:

(1) Adjusted risk-based capital report. – A risk-based capital report that has been adjusted by the Commissioner under G.S. 58-12-6.

(2) Corrective order. – An order issued by the Commissioner specifying corrective actions that the Commissioner has determined are required.

(3) Domestic insurer. – Any insurance company or health organization organized in this State under ~~Article 7,~~ Article 7 of this Chapter as specified

in subdivisions (4b) and (5a) of this section, or under Article 15, 65, or 67 of this Chapter.

(4) Foreign insurer. – Any insurance company or health organization that is admitted to do business in this State under Article 16 or 67 of this Chapter but is not domiciled in this State.

(4a) Health organization. – Any insurer which is required by the Commissioner to use the NAIC Health Annual Statement Blank when filing the annual statement prescribed by G.S. 58-2-165 or any health maintenance organization, limited health service organization, dental or vision plan, hospital, medical, or dental indemnity or service corporation, or other organization licensed under Article 65 or 67 of this Chapter. "Health organization" does not include an insurer that is licensed as either a life or health insurer or a property or casualty insurer under this Chapter and that is otherwise subject to either the life or property and casualty risk-based capital requirements.

(4b) Life or health insurer. – Any insurance company licensed to write the kinds of insurance specified in G.S. 58-7-15(1), (2), or (3); or a licensed property and casualty insurer writing only the kinds of insurance specified in G.S. 58-7-15(3). "Life or health insurer" does not mean any insurer that is required by the Commissioner to sue the NAIC Health Annual Statement Blank when it files the annual statement prescribed by G.S. 58-2-165.

(5) Negative trend. – A negative trend, with respect to a life or health insurer, over a period of time, as determined in accordance with the "trend test calculation" included in the risk-based capital instructions.

(5a) Property or casualty insurer. – Any insurance company licensed to write the kinds of insurance specified in G.S. 58-7-15(4) through (22); but not monoline mortgage guaranty insurers, financial guaranty insurers, or title ~~insurers.~~insurers; nor any insurer that is required by the Commissioner to use the NAIC Health Annual Statement Blank when filing the annual statement prescribed by G.S. 58-2-165.

(6) Risk-based capital instructions. – The risk-based capital report including risk-based capital instructions adopted by the NAIC, as those risk-based capital instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(7) Risk-based capital level. – An insurer's company action level risk-based capital, regulatory action level risk-based capital, authorized control level risk-based capital, or mandatory control level risk-based capital where:

a. "Company action level risk-based capital" means, with respect to any insurer, the product of 2.0 and its authorized control level risk-based capital.

b. "Regulatory action level risk-based capital" means the product of 1.5 and its authorized control level risk-based capital.

c. "Authorized control level risk-based capital" means the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

d. "Mandatory control level risk-based capital" means the product of .70 and the authorized control level risk-based capital.

(8) Risk-based capital plan. – A comprehensive financial plan containing the elements specified in G.S. 58-12-11(b). If the Commissioner rejects the risk-based capital plan, and it is revised by the insurer, with or without the

Commissioner's recommendation, the plan shall be called the "revised risk-based capital plan".

(9) Risk-based capital report. – The report required in G.S. 58-12-6.

(10) Total adjusted capital. – The sum of:

a. An insurer's statutory capital and surplus, as determined in accordance with the statutory accounting applicable to the annual financial statements required under G.S. 58-2-165; and

b. Such other items, if any, as the risk-based capital instructions may provide."

SECTION 6. G.S. 58-12-11(a) reads as rewritten:

"(a) "Company action level event" means any of the following events:

(1) The filing of a risk-based capital report by an insurer that indicates that:

a. The insurer's total adjusted capital is greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based ~~capital, if the insurer is a property or casualty insurer or a health organization;~~ capital; or

b. ~~The~~ In the case of a life or health insurer, the insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and 2.5 and has a negative ~~trend, if the insurer is a life or health insurer.~~trend; or

c. In the case of a property or casualty insurer or a health organization, the insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty or health organization risk-based capital instructions.

(2) The notification by the Commissioner to the insurer of an adjusted ~~risk-bases~~ risk-based capital report that indicates the event in sub-subdivision ~~(1)a. or b.~~(1)a., (1)b., or (1)c. of this subsection if the insurer does not challenge the adjusted risk-based capital report under G.S. 58-12-30.

(3) If the insurer challenges an adjusted risk-based capital report that indicates the event in sub-subdivision ~~(1)a. or b.~~ (1)a., (1)b., or (1)c. of this subsection under G.S. 58-12-30, the notification by the Commissioner to the insurer that the Commissioner has rejected the insurer's challenge."

SECTION 7. Article 33 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-33-27. Claims handling; insurance on portable consumer electronic devices.**

(a) As used in this section, the following definitions apply:

(1) "Automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation, and system generated final resolution of claims on insurance policies that cover portable consumer electronic devices, which system shall meet the following criteria:

a. Be utilized only by a licensed adjuster or licensed producer or supervised individuals operating pursuant to this section.

b. Comply with all claims payment requirements of this Chapter.

c. Be certified as compliant with this section by a licensed adjuster who is an officer of a licensed business entity under this Chapter.

(2) "Portable consumer electronic devices" include the following, which must be easily carried or conveyed by hand: smartphones, navigation devices,

cellular phones, personal digital assistants, iPads, iPhones, Androids, video games, wireless reading devices, laptops, tablets, netbooks, MP3 players, digital cameras and other electronic devices that are portable in nature, their accessories, and services related to the use of the device.

(b) No adjuster license is required for an individual who, in connection with insurance on portable consumer electronic devices, collects claim information from or furnishes claim information to insureds or claimants, who conducts data entry, including entering data into an automated claims adjudication system, and who does not exercise any discretion in the disposition of the claim; provided that the individual is an employee of a licensee under this Chapter or an employee of a licensee under this Chapter, if there are no more than 25 individuals under the supervision of a licensed individual adjuster or a licensed individual producer who may adjust claims in accordance with G.S. 58-33-70(b). A producer who is acting as a supervisor pursuant to this section is not required to be licensed as an adjuster."

SECTION 8. G.S. 58-33-30(e) reads as rewritten:

"(e) Examination.

(1) After completion and filing of the application with the Commissioner, the Commissioner shall require each applicant for license as an agent or an adjuster to take an examination as to the applicant's competence to be licensed. The applicant must take and pass the examination according to requirements prescribed by the Commissioner. This subsection shall not apply to adjusters who adjust only federal crop insurance claims and are certified in accordance with subsection (2a) of this section.

(2) The Commissioner may require any licensed agent, adjuster, or motor vehicle damage appraiser to take and successfully pass an examination in writing, testing his competence and qualifications as a condition to the continuance or renewal of his license, if the licensee has been found guilty of any violation of any provision of this Chapter. If an individual fails to pass such an examination, the Commissioner shall revoke all licenses issued in his name and no license shall be issued until such individual has passed an examination as provided in this Article.

(2a) Adjusters who adjust federal crop insurance claims shall be certified as having passed a proficiency examination approved by the federal Risk Management Agency (RMA) as a condition of obtaining an adjuster's license under this Chapter, or another proficiency examination approved by the Commissioner. An adjuster who intends to adjust crop insurance claims shall furnish the Commissioner proof that the adjuster is certified as having passed the required examination pursuant to this section.

(3) Each examination shall be as the Commissioner prescribes and shall be of sufficient scope to test the applicant's knowledge of:

a. The terms and provisions of the policies or contracts of insurance the applicant proposes to effect; or

b. The types of claims or losses the applicant proposes to adjust; and

c. The duties and responsibilities of the license; and

d. The current laws of this State applicable to the license.

(4) The answers of the applicant to the examination shall be provided by the applicant under the Commissioner's supervision. The Commissioner shall give examinations at such times and places within this State as the Commissioner considers necessary reasonably to serve the convenience of both the Commissioner and applicants: Provided that the Commissioner may contract directly with persons for the processing of examination application forms and for the administration and grading of the examinations required

by this section; the Commissioner may charge a reasonable fee in addition to the registration fee charged under G.S. 58-33-125, to offset the cost of the examination contract authorized by this subsection; and such contracts shall not be subject to Article 3 of Chapter 143 of the General Statutes. However, the Commissioner shall: (i) submit all proposed statewide and agency term agreements or contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subdivision to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all contracts to be awarded by the Commissioner under this subdivision a standard clause which provides that the State Auditor and internal auditors of the Commissioner may audit the records of the contractor during the term of the contract to verify accounts and data affecting fees and performance. The Commissioner shall not award a cost plus percentage of cost contract for any purpose.

(5) The Commissioner shall collect in advance the examination and registration fees provided in G.S. 58-33-125 and in subsection (4) of this section. The Commissioner shall make or cause to be made available to all applicants, for a reasonable fee to offset the costs of production, materials that he considers necessary for the applicants' proper preparation for examinations. The Commissioner may contract directly with publishers and other suppliers for the production of the preparatory materials, and contracts so let by the Commissioner shall not be subject to Article 3 of Chapter 143 of the General Statutes. However, the Commissioner shall: (i) submit all proposed statewide and agency term contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subdivision to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all contracts to be awarded by the Commissioner under this subdivision a standard clause which provides that the State Auditor and internal auditors of the Commissioner may audit the records of the contractor during the term of the contract to verify accounts and data affecting fees and performance. The Commissioner shall not award a cost plus percentage of cost contract for any purpose.

(6) In addition to the examinations for the kinds of insurance specified in G.S. 58-33-25(c)(1) and (2), before any resident may sell Medicare supplement or long-term care insurance policies defined respectively in Articles 54 and 55 of this Chapter, the resident must take and pass a supplemental written examination according to requirements prescribed by the Commissioner.

(7) 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."

SECTION 9. G.S. 97-132 reads as rewritten:

"**§ 97-132. Board of directors.**

The Board shall consist of not less than nine directors serving terms as established in the Plan. The directors shall be selected by the members of the ~~Association, subject to the approval of the Commissioner,~~ Association and shall serve for three-year terms and until a successor is elected and qualified. There is no limitation on the number of terms a director may serve. ~~In approving selections to the Board, the Commissioner shall consider, among other things,~~

~~whether individual self-insurers and group self-insurers are fairly represented.~~ Directors may be reimbursed from the assets of the Association for expenses incurred by them as directors."

SECTION 10. G.S. 97-133 reads as rewritten:

"**§ 97-133. Powers and duties of the Association.**

(a) The Association shall:

(1) Repealed by Session Laws 1999-219, s. 7.2, effective June 25, 1999.

(1a) Administer a fund, to be known as the North Carolina Self-Insurance Security Fund, which shall receive the assets of the North Carolina Self-Insurance Guaranty Fund previously established under subdivision (2) of this subsection, the assessments required by subdivisions (2a) and (3a) of this subsection and any other sums received by the Association. ~~In its discretion, the Board may determine that the assets of the Fund should be segregated or that a separate accounting shall be made in order to identify that portion of the Fund which represents assessments paid by individual self-insurers and that portion of the Fund which represents assessments paid by group self-insurers. If the Board segregates the Fund in this manner, the Association shall thereafter pay covered claims against individual member self-insurers from that portion of the Fund that represents assessments against individual self-insurers and shall thereafter pay covered claims against group member self-insurers from that portion of the Fund that represents assessments against group self-insurers.~~ The costs of administering the Association shall be borne by the Fund. The Association is authorized to secure insurance, primary excess insurance, reinsurance, bonds, other insurance, financial guarantees and related financial instruments to effectuate the purposes of the Association. The Board will invest the Fund assets pursuant to an investment policy adopted by the Board and reviewed and approved annually by the Department of the State Treasurer. The earnings from investment of Fund assets shall be placed in or credited to the Fund.

(2) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

(2a) ~~Establish, operate, and maintain~~ Establish and operate the Association Aggregate Security System as defined in G.S. 97-130 and G.S. 97-165 as follows:

a. The Association shall ~~annually prepare and submit to the Commissioner a written plan to~~ provide an Association Aggregate Security System through a combination of cash on deposit in the Fund, securities, surety bonds, irrevocable letters of credit, ~~insurance~~ insurance, reinsurance, or other financial instruments or guarantees owned or entered into by the ~~Association and acceptable to the Commissioner.~~ Association. ~~The written plan shall include, but not be limited to, (i) a description of the institutions that will issue or guarantee the securities, surety bonds, irrevocable letters of credit, insurance or other financial instruments or guarantees, including, but not limited to, the credit rating, financial strength, and AM best rating, if applicable to the institutions (ii) applicable cash flow information and financial assumptions (iii) a description of the methodology to be used by the Association to assess and collect the Association Aggregate Security System assessments to be made pursuant to subdivision (3a) of this subsection and (iv) a proposed timetable for the release of existing individual company deposits posted pursuant to G.S. 97-185(c), provided, however, that no~~

~~individual company deposits posted pursuant to G.S. 97-185(c) shall be released without the written consent of the Commissioner. The noncash elements of the composite security may be one year or multiple year instruments.~~

~~b. Within 90 days following the submission of the initial plan under sub-subdivision a. of this subdivision, the Commissioner shall either approve or disapprove the initial plan and shall notify the Association in writing. If the Commissioner does not approve or disapprove the initial plan within 90 days following submission, then the initial plan shall be deemed to be approved by the Commissioner. All subsequent plans shall be either approved or disapproved within 60 days following submission.~~

~~c. The Commissioner shall also determine the total undiscounted claims liability of each individual self-insurer that will participate in the Association Aggregate Security System as well as the aggregate total undiscounted outstanding claims liabilities of all the individual self-insurers that are to participate in the Association Aggregate Security System and shall notify the Association of this determination.~~

~~d. Upon approval by the Commissioner of the Association's plan for the Association Aggregate Security System, the~~ The Association shall assess the individual self-insurers that participate in the Association Aggregate Security System pursuant to subdivision (3a) of this subsection.

e. ~~If the Commissioner disapproves the plan for any year,~~ If the Association determines it is not feasible or practical to continue the Association Aggregate Security System, it shall notify the Commissioner at least 90 days prior to the termination of the Association Aggregate Security System. ~~every~~ Every self-insurer shall deposit with the Commissioner, or continue to deposit, the amount required by G.S. 97-185(b3) in the manner prescribed by G.S. 97-185(c).

f. Group self-insurers shall not participate in the Association Aggregate Security System.

(3) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

(3a) Assess members of the Association as follows:

a. Association Aggregate Security System assessments. – The Association shall assess each individual self-insurer participating in the Association Aggregate Security System a security system assessment. The amount of the security system assessment charged to each individual self-insurer participating in the Association Aggregate Security System shall be based on the Association's reasonable consideration of all of the following factors:

1. The total amount of assessments necessary to provide aggregate security for all participating individual self-insurers.
2. The individual self-insurer's total workers' compensation liabilities under the Act.
3. The financial strength and creditworthiness of the participating individual self-insurer.
4. Any other relevant factors.

b. Special assessment. – In the event that there are covered claims against an insolvent member or members and the assets of the Fund are not sufficient to pay the obligations of the Association, then the Association may collect a special assessment from the members in an amount sufficient to pay the aggregate value of such covered claims. Each member's special assessment shall be determined by the Board and shall be based on the proportion of the member's total obligations under the Act to the aggregate total of all members' obligations under the Act.

c. Initial assessments. – An individual self-insurer that becomes a member and does not initially participate in the Association Aggregate Security System shall pay an initial assessment to the Association in an amount determined by the Board. A group self-insurer, upon receiving its initial license from the Commissioner, shall pay an initial assessment to the Association in an amount determined by the Board.

d. Each member shall be notified of assessments no later than 30 days before the assessment is due.

e. Delinquent assessments, except as otherwise provided, shall bear interest at a rate to be established by the Board.

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).

(4) Be obligated to pay covered claims.

(5) After paying any covered claim, be subrogated to the rights of the injured employee and dependents and be entitled to enforce liability against the self-insurer or any third party by any appropriate action brought in its own name or in the name of the injured employee and dependents.

(6) Expend Fund assets in amounts necessary to pay all of the following:

a. The obligations of the Association under this Article subsequent to an insolvency.

b. The expenses of handling covered claims subsequent to an insolvency.

c. The cost of examinations under G.S. 97-137.

d. The costs of implementing and operating the Association Aggregate Security System.

e. All other expenses authorized by this Article.

(7) Investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation; and deny all other claims. The Association may review settlements to which the insolvent member was a party to determine the extent to which such settlements may be properly contested.

(8) Notify such persons as the Commissioner directs under G.S. 97-136.

(9) Handle claims through its directors, its employees, or through one or more members or other persons designated as servicing facilities. Designation ~~of a servicing facility is subject to the approval of the Commissioner, but designation~~ of a member as a servicing facility may be declined by such member.

(10) Reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association.

(11) Pay any other expenses of the Association authorized by this section.

(12) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

(13) Require each member to determine annually its total undiscounted claims liability and shall require each member to notify the Association of this determination.

(b) The Association may:

(1) Employ or retain such persons, including, but not limited to, adjustors, brokers, accountants, attorneys, financial advisors, investment bankers, placement agents, and consultants, as the Board may determine are necessary to handle claims, perform other duties of, provide services to, and consult with the Association.

(2) Borrow funds necessary to effect the purposes of this Article in accord with the Plan, including entering into standby lines of credit.

(3) Sue or be sued.

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this section.

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this section.

~~(6) Reimburse the Department of Insurance up to twenty thousand dollars ($20,000) for consultants retained by the Department to review the initial plan submitted pursuant to G.S. 97-133(a)(2a).~~

(c) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

(c1) The Association shall provide in its Plan that the functions of administration and adjusting claims shall not be performed by the same entity that provides legal representation to the Association for claims.

(d) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006."

SECTION 11. G.S. 97-134 reads as rewritten:

"**§ 97-134. Plan of Operation.**

The Plan is as follows:

(1) The ~~Association~~ Board shall ~~submit to the Commissioner~~ adopt a Plan of Operation and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. ~~The Plan and any amendments become effective upon approval in writing by the Commissioner. If the Association at any time fails to submit a suitable Plan or suitable amendment to the Plan the Commissioner shall, after notice and hearing, adopt such reasonable rules as are necessary or advisable to effectuate this Article. The rules shall continue in force until modified by the Commissioner or superseded by a Plan submitted by the Association and approved by the Commissioner.~~

(2) All member self-insurers shall comply with the Plan.

(3) The Plan shall:

a. Establish the procedures whereby all the powers and duties of the Association under G.S. 97-133 will be performed.

b. Establish procedures for investing and managing Fund assets.

c. Adopt a reasonable mechanism and procedure to achieve equity in assessing members under G.S. 97-133.

d. Establish the amount and method of reimbursing members of the Board under G.S. 97-132.

e. Establish procedures by which claims may be filed with the Association and establish acceptable forms of proof of covered claims.

f. Establish regular places and times for meetings of the Board.

g. Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the Board.

h. Provide that any member self-insurer aggrieved by any final action or decision of the Association may appeal to the Commissioner within 30 days after the action or decision.

~~i. Establish the procedures whereby selections for the Board shall be submitted to the Commissioner.~~

j. Contain additional provisions necessary or proper for the execution of the powers and duties of the Association."

SECTION 12. G.S. 97-136(a) reads as rewritten:

"**§ 97-136. Powers and duties of the Commissioner.**

(a) The Commissioner shall:

(1) Notify the Association of the existence of an insolvent member self-insurer not later than 30 days after he receives notice of an insolvency pursuant to the standards set forth in G.S. 97-135.

~~(2) Approve or disapprove the plan for an Association Aggregate Security System as required under G.S. 97-133(a)(2a)b. and notify the Association of the information required under G.S. 97-133(a)(2a)c.~~"

SECTION 13. G.S. 97-137 reads as rewritten:

"**§ 97-137. Examination of the Association.**

The Association shall be subject to examination and regulation by the Commissioner. The Board shall submit, not later than ~~March 30~~ June 1 of each year, a financial report for the preceding calendar year in a form approved by the Commissioner."

SECTION 14. G.S. 97-185 reads as rewritten:

"**§ 97-185. Deposits; surety bonds; letters of credit.**

(a) Repealed by Session Laws 2005-400, s. 13, effective January 1, 2006.

(a1) All individual self-insurers as defined in G.S. 97-130(5b) shall participate in the Association Aggregate Security System established under G.S. 97-131 unless excluded by the Board of Directors of the North Carolina Self-Insurance Security Association. The Board of Directors of the North Carolina Self-Insurance Security Association shall exclude all of the following from the Association Aggregate Security System:

(1) Individual self-insurers whose licenses have previously been revoked by the Commissioner.

(2) Individual self-insurers with a debt rating as established by Standard & Poor's Rating Service or by Moody's Investor Service, below the minimum Standard & Poor's ~~and~~ or Moody's ratings if a minimum debt rating has been established ~~in the written plan~~ by the Board of Directors of the North Carolina Self-Insurance Security Association for the Association Aggregate Security ~~System submitted by the Association and approved by the Commissioner under G.S. 97-133(a)(2a).~~ System.

(3) Individual self-insurers that have defaulted on the payment of their self-insured workers' compensation liabilities.

(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.

The Board of Directors of the North Carolina Self-Insurance Security Association shall notify the Commissioner of the individual self-insurers that are excluded from participating in the Association Aggregate Security System.

(b) Repealed by Session Laws 2003-115, s. 3, effective January 1, 2004.

(b1) Repealed by Session Laws 2005-400, s. 13, effective January 1, 2006.

(b2) An individual self-insurer that is excluded from participation in the Association Aggregate Security System, including individual self-insurers that are granted a license to self-insure after the North Carolina Self-Insurance Security Association annually implements the Association Aggregate Security System, shall deposit with the Commissioner an amount not less than one hundred percent (100%) of the individual self-insurer's total undiscounted outstanding claims liability per the most recent report from a qualified actuary as required by G.S. 97-180(b), but not less than five hundred thousand dollars ($500,000), or such greater amount as the Commissioner prescribes based on, but not limited to, the financial condition of the individual self-insurer and the risk retained by the individual self-insurer.

(b3) During any period of time that no Association Aggregate Security System is in effect, individual self-insurers with a debt rating of BBB or better from Standard & 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 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.

(c) Deposits received, changes to existing deposits, or deposits exchanged after the effective date of this section, shall be comprised of one or more of the following:

(1) Interest-bearing bonds of the United States of America.

(2) Interest-bearing bonds of the State of North Carolina, or of its cities or counties.

(3) Certificates of deposit issued by any solvent bank domesticated in the State of North Carolina that have a maturity of one year or greater.

(4) Surety bonds in a form acceptable to the Commissioner and issued by a corporate surety. A surety bond deposited pursuant to this subsection shall require that the surety reimburse the Commissioner, or his successors, assigns, or transferees, for any costs incurred in the collection of the proceeds of the surety bond, including reasonable attorneys' fees, and any costs incurred in administering the insolvent self-insurer's workers' compensation claims.

(4a) Irrevocable letters of credit in a form acceptable to the Commissioner issued by a bank acceptable to the Commissioner. An irrevocable letter of credit deposited pursuant to this subsection shall require that the bank reimburse the Commissioner, or his successors, assigns, or transferees for any costs

incurred in the collection of the proceeds of the letter of credit, including reasonable attorneys' fees.

(4b) The reimbursement of attorneys' fees and collections cost provided for in subdivisions (4) and (4a) of this subsection shall be no greater than fifteen percent (15%) of the penal amount of the bond and shall not come from the proceeds of the bond or the letter of credit but shall be in addition to the proceeds of the bond or the letter of credit.

(5) Any other investments that are approved by the Commissioner.

(d) All bonds or securities that are posted as a security deposit shall be valued annually at market value. If the market value is less than the face value, the Commissioner may require the self-insurer to post additional securities. In making this determination, the Commissioner shall consider the self-insurer's or guarantor's financial condition, the amount by which market value is less than face value, and the likelihood that the securities will be needed to provide benefits.

(e) Securities deposited under this section shall be assigned to the Commissioner, the Commissioner's successors, assigns, or trustees, on a form prescribed by the Commissioner in a manner that renders the securities negotiable by the Commissioner. If a self-insurer or guarantor is deemed by the Commissioner to be in a hazardous financial condition, the Commissioner may sell or collect, or both, such amounts that will yield sufficient funds to meet the self-insurer's obligations under the Act. In the case of a letter of credit, the Commissioner may draw the full amount of a letter of credit if the letter of credit is not renewed within 90 days prior to its expiration or at any time that the bank issuing the letter of credit is no longer acceptable to the Commissioner. Interest accruing on any negotiable security deposited under this Article shall be collected and transmitted to the self-insurer if the self-insurer or guarantor is not in a hazardous financial condition.

(f) No judgment creditor, other than a claimant entitled to benefits under the Act, may levy upon any deposits made under this section.

(g) Pursuant to the provisions of this section and with the approval of the Commissioner, deposits held by the Commissioner may be replaced with other acceptable forms of deposit in amount determined by the Commissioner. Any deposit to be replaced with another form of deposit shall not be released until the approved replacement deposit is received by the Commissioner.

(h) Any self-insurer that ceases to self-insure, whether by voluntary termination or by revocation of license, shall continue to secure and be liable for its obligations under the Act and shall continue to report to the Commissioner pursuant to G.S. 97-180. Upon the request of the Commissioner, a self-insurer that ceases to self-insure shall submit filings, as prescribed in G.S. 97-180, to determine whether the deposit is sufficient to satisfy those workers' compensation obligations incurred during the period that the self-insurer was licensed as a self-insurer. The Commissioner may require an increase in the deposit amount or may grant a reduction in the deposit amount to ensure that the deposit is sufficient to cover all existing and future obligations incurred by the self-insurer while subject to the provisions of the Act.

(i) An endorsement to a surety bond shall be filed with the Commissioner within 90 days after the effective date of the endorsement."

SECTION 15. Sections 1, 3, and 9 through 14 of this act become effective July 1, 2011. Sections 2, 4, 5, and 6 of this act become effective October 1, 2011. Section 7 of this act becomes effective July 1, 2012, and applies to licenses issued on or after that date. The remainder of this act is effective when it becomes law.

HB 298- Insurance Amendments

This is an Agency bill from the Department of Insurance.

It is a 14 page bill...some of the most important provisions within it are the ones that probably would not stand out to you: One section of this bill (Section 6, page 4)will help NC keep its accreditation with the National Association of Insurance Commissioners. If North Carolina does not enact this into law by January 1, 2012 the state could lose its accreditation with the NAIC...that means that domestic insurers in North Carolina will have to undergo multiple audits in the other states where they do business because those other states will not accept the audits North Carolina does.

Another very important section of the bill is Section 5, (page 3). That section will give the Commissioner more authority to stop a health insurance rate increase in the small group market. Under federal health care reform if this is not passed, the federal government will come in to say what is an acceptable rate. That could be an even higher rate than what we have now...

Legislative staff (or Rose) can explain the bill in detail if you would like, but other parts of the bill would:

- Section 1 Allow the Department to outsource some licensing processes for folks applying for a license. The statute allows them to do this for existing licenses, but does not include new applicants...the number of applicants has increased by more than 500,000 people since 2003.

-Section 2 Codify the SHIIP program (Seniors Health Insurance Information Program). This program has been the best thing since sliced bread for so many folks. It is aided by over 800 volunteers around the state.

- Section 3Ensures accuracy in Certificates of Insurance (by prohibiting and agent from putting things in a certificate of insurance that are not in the policy)

- Section 5 Encourages the sale of "child-only" policies by setting a set enrollment period for health insurance companies who want to sell this product. (Now that the federal law says a health insurance company cannot deny a child

health insurance coverage because of a preexisting condition the companies don't want to insure people who wait until there is a problem or illness to enroll their child in coverage...the companies can require enrollment in particular times of year)

- Section 8. Provides an exemption from adjuster licensing requirements for employees inputting claims data on portable electronic devices. (Folks who are just processing claims on portable electronic devices like cell phones will not have to be licensed, but will need to be supervised by a licensee.)

-Section 9. Exempts those who only adjust crop claims from having to take the property and casualty examination if they take a course on how to adjust crop insurance claims.

-Section 10. 117 companies in NC self insure for Workers Compensation. If one of them goes insolvent and cannot pay its claims the members of the Association all chip in to pay those bills. The companies have formed their own security system to raise money for those costs. This bill will remove some of the Department's involvement in that security system...after all...if the security system cannot pay the bills the companies are liable...so...they have a big interest in seeing to it that the system can succeed and pick up the costs so they don't have to be assessed.

- Section 12 This section exempts limited assessable mutual insurance companies from a fee requirement. (Rep. Brubaker is very interested in this provision)

Section 13. Ensures the fee charged by a continuing care retirement community is not considered a "transfer fee" prohibited by law now. The Department does not think it is but this would clarify that issue.

Please vote for a favorable report.

HB 299 SB 321 Surplus Lines bill

"Surplus Lines" insurance is a line of insurance provided by insurers not licensed in the state. These non-admitted insurers write insurance on risks who cannot obtain coverage from admitted insurers...(they usually write insurance on risks other insurance companies are not willing to insure...for example...a dynamite factory...or, more common:...nursing homes...)(These companies are not admitted to do business in the states, but they are authorized to do so).

The Dodd-Frank Financial Reform Act is a major financial reform law passed by Congress. It included surplus lines insurance reforms that attempt to make the regulation of the surplus lines market in the various states more efficient and more uniform on a national basis.

The new law is expected to increase the level of efficiency in purchasing surplus lines insurance for all those involved in the surplus lines transaction..from the insurance company to the consumers.

That is a good intention but, unfortunately, the law included a provision that says that beginning on July 21, 2011, the surplus lines brokers are to pay the state of the "insured's principal place of business" AKA, the "Home State" all of the surplus lines tax from all the business that surplus lines company does all around the country. This was done to make it easier for surplus lines brokers who were having to figure out where to pay the tax. As the law is now, North Carolina collects 5% of about 500 million, or about $25 million dollars per year.

The federal law left it up to the states to work out amongst them how the tax will be divided up among the states. One purpose of this bill is to get the state involved in a plan to keep our share of this revenue which goes to the General Fund.

We anticipate NC may lose a significant amount of revenue beginning in July 2011, unless a state fix is made in time. It would be good if NC were able to maintain the status quo in what we collect.

The proposed bill also makes conforming changes to our state law to reflect the changes made by the federal law and it gives the Commissioner the authorization to enter into an agreement with other states to try to resolve the tax revenue issue...whether this will be through a clearinghouse operated by the NAIC or compact among states. The federal law takes effect July 21, 2011, but many states have not acted yet to determine which compact or agreement, if any, they will enter. North Carolina would benefit most from being in the compact or agreement that the most states, particularly the states from which we receive the most money, join. We will not know that until more time passes. So, the bill also requires the Revenue Laws Study committee to look at the issue and report back to the short session as to what is in the state's best interest.

DETAILED SUMMARY OF HB 299/SB 321

Section 1.

58-21-3 Cooperative or interstate agreements. This section authorizes the Commissioner to enter into a cooperative or interstate agreement or compact to establish alternative nationwide eligibility requirements for nonadmitted insurers domiciled in other states and to facilitate the collection, allocation and disbursement of premium taxes among states. This section also gives the Commissioner authority to enter into an interstate compact or agreement.

58-21-4 Nonadmitted and Reinsurance Reform Act duties The federal law (Sec 523) prohibits a state from collecting any fees relating to licensing of an individual or entity as a surplus lines broker unless the State has in effect laws that provide for participation by the State in the national insurance producer database of the NAIC for the licensure of surplus lines brokers and the renewal of those licenses. (the purpose of the law is to make things easier for the brokers and more uniform between the states—instead of each state having different laws and requirements.)

SECTION 1.2 Directs the Revenue laws Study Committee, in cooperation with the Commissioner of Insurance, to study the potential impact that would

result from the State's entrance into a nonadmitted insurance interstate agreement and report its findings next year.

Section 2.

58-21-10 Definitions Adds definitions used in the federal law to our statutes.

Section 3.

58-21-11 Home State Adds the definition of "Home State" as it is set out in federal law. Home state refers to the principal place of business of the INSURED...so...if a New York based business does some business in North Carolina, all of the tax will now be paid by the surplus lines broker to New York...it will be up to the agreement reached among the states to figure out how the money from the insurance of the business in North Carolina goes back to North Carolina.

Section 4.

58-21-15 Placement of Surplus Lines Insurance The new federal law provides that the surplus lines insurer only has to be authorized to write the insurance in its domiciliary state. This section reflects that change.

Section 5.

58-21-16 Streamlined application for commercial purchasers The new federal law provides that if a commercial purchaser meets certain conditions, it does not have to comply with state requirements to make a due diligence search to see if the full amount or type of insurance can be obtained from admitted insurers. This section sets out the new exemption and streamlines applications for commercial purchasers. (the broker doesn't have to conduct five diligent searches to see if the policy covers risks in five states, for example)

58-21-17 Placement with alien insurers (In the insurance world "foreign" insurers are insurers from other states. "Alien" insurers are insurers from other countries)

This section of the bill reflects that part of the federal act which says a state can't prohibit a surplus lines broker from placing nonadmitted insurance with or getting it from a nonadmitted insurer domiciled outside the US as long as the company is listed on the NAIC list of Alien Insurers.

Section 6.

58-21-20(a) The federal Act provides that the states can only use eligibility criteria that is set forth in the NAIC Nonadmitted Insurance Model Act (Sections 5A(2) and 5C(2)(a) for US surplus lines insurers.

The changes to this section reflect this new federal requirement by striking our current standards and establishing that the greater of the state's minimum capitalization requirements for surplus lines eligibility or $15 million are the capitalization standards for surplus lines insurer eligibility. The bill allows the Commissioner to allow a lesser amount of capitalization under certain circumstances, but no less than 4.5 million.

Section 7. 58-21-35

Conforming changes to reflect the changes caused by the new law

Section 8. 58-21-65(a)

This change reflects the change in the federal law that declares that only an insured's home state may require a surplus lines broker to be licensed to conduct non-admitted business with respect to such insured.

Section 9. Revise definition of "Risk Retention Group" based on the definition in the US Code.

2011 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
HB 299 A BILL TO BE ENTITLED AN ACT TO CONFORM PROVISIONS OF NORTH CAROLINA SURPLUS LINES INSURANCE LAWS TO THE FEDERAL NONADMITTED AND REINSURANCE REFORM ACT OF 2010 AND TO PREVENT ANY LOSS OF PREMIUM TAX REVENUE TO THE STATE.

☒ With a favorable report as to the House committee substitute bill, which changes the title, unfavorable as to the original bill, and recommendation that the House committee substitute bill be re-referred to the Committee on FINANCE.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House/Senate) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 299
PROPOSED COMMITTEE SUBSTITUTE H299-PCS50310-RG-9

Short Title: Surplus Lines/Premium Tax.-AB (Public)

Sponsors:

Referred to:

March 10, 2011

A BILL TO BE ENTITLED

AN ACT TO CONFORM PROVISIONS OF NORTH CAROLINA SURPLUS LINES INSURANCE LAWS TO THE FEDERAL NONADMITTED AND REINSURANCE REFORM ACT OF 2010, TO STREAMLINE APPLICATIONS FOR COMMERCIAL PURCHASERS, TO PREVENT ANY LOSS OF PREMIUM TAX REVENUE TO THE STATE, AND TO CONFORM THE DEFINITION OF RISK RETENTION GROUP TO FEDERAL LAW.

The General Assembly of North Carolina enacts:

SECTION 1.1. Article 21 of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-21-3. Cooperative or interstate agreements.**

(a) The Commissioner is authorized to enter into a cooperative agreement or interstate agreement or compact to do the following:

(1) Establish additional and alternative nationwide uniform eligibility requirements that shall be applicable to nonadmitted insurers domiciled in another state or territory of the United States.

(2) Facilitate the collection, allocation, and disbursement of premium taxes attributable to the placement of nonadmitted insurance, provide for uniform methods of allocation and reporting among nonadmitted insurance risk classifications, and share information among states relating to nonadmitted insurance premium taxes.

(b) The Commissioner is authorized to enter into an interstate compact or interstate agreement for the purpose of carrying out the Nonadmitted and Reinsurance Reform Act of 2010.

"**§ 58-21-4. Nonadmitted and Reinsurance Reform Act duties.**

(a) For the purposes of carrying out the provisions of the Nonadmitted and Reinsurance Reform Act of 2010, the Commissioner is authorized to utilize the national insurance producer database of the NAIC, or any other equivalent uniform national database, for the licensure of an individual or an entity as a surplus lines producer and for renewal of such license.

(b) In order to assist in the performance of the Commissioner's duties, under the Nonadmitted and Reinsurance Reform Act of 2010, the Commissioner may contract with nongovernmental entities, including the NAIC or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions that the Commissioner and the nongovernmental entity may deem to be appropriate, including (i) the collection of fees related to producer

licensing and (ii) the collection of the premium tax under G.S. 58-21-85. The NAIC or other entity with whom the Commissioner contracts may charge a reasonable fee to the insurer, insured, or other appropriate person for the functions performed."

SECTION 1.2. The Revenue Laws Study Committee shall, in cooperation with the Commissioner of Insurance, study the potential impact that would result from the State's entrance into a nonadmitted insurance multistate agreement or other compact or interstate agreement for the purpose of carrying out the Nonadmitted and Reinsurance Reform Act of 2010 in order to prevent the State from losing revenue after July 21, 2011, the effective date of the Nonadmitted and Reinsurance Reform Act. The Committee shall determine if entering into a compact or agreement would result in retention of surplus lines tax revenue for the State and, if so, which compact or agreement would result in the most retention of surplus lines tax revenue for the State and the most cost-efficient method of administering the collection and distribution of tax revenues. The Committee shall report its findings and recommendations, including any proposed legislation, to the 2012 Regular Session of the 2011 General Assembly.

SECTION 2. G.S. 58-21-10 reads as rewritten:

"**§ 58-21-10. Definitions.**

As used in this Article:

(1) "Admitted insurer" means an insurer licensed to ~~do an insurance business~~ engage in the business of insurance in this State.

(1a) "Affiliate" means, with respect to an insured, any entity that controls, is controlled by, or is under common control with the insured.

(1b) "Affiliated group" means any group of entities that are all affiliated.

(2) "Capital", as used in the financial requirements of G.S. 58-21-20, means funds paid in for stock or other evidence of ownership.

(2a) "Control" means an entity that has "control" over another entity if either of the following occurs:

a. The entity directly or indirectly or acting through one or more other persons owns, controls, or has the power to vote twenty-five percent (25%) or more of any class of voting securities of the other entity.

b. The entity controls in any manner the election of a majority of the directors or trustees of the other entity.

(3) "Eligible surplus lines insurer" means a nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance under G.S. 58-21-20.

(4) "Export" means to place surplus lines insurance with a nonadmitted insurer.

(5) "Nonadmitted insurer" means an insurer not licensed to do an insurance business in this State. ~~This definition~~ "Nonadmitted insurer" includes insurance exchanges authorized under the laws of various states. "Nonadmitted insurer" does not include a risk retention group, as defined in G.S. 58-22-10(10).

(6) "Producing broker" means an agent or broker licensed under Article 33 of this Chapter who deals directly with the party seeking insurance and who may also be a surplus lines licensee.

(6a) "Reciprocal state" means a state that has enacted provisions substantially similar to the following:

a. G.S. 58-21-85, 58-21-95(5), 58-21-75(10), 58-21-35(7b), and 58-28-5(b).

b. The allocation schedule and reporting form contained in G.S. 58-21-85.

(7) "Surplus", as used in the financial requirements of G.S. 58-21-20, means funds over and above liabilities and capital of the company for the protection of policyholders.

(8) "Surplus lines insurance" means any insurance in this State of risks resident, located, or to be performed in this State, permitted to be placed through a surplus lines licensee with a nonadmitted insurer eligible to accept such insurance, other than reinsurance, commercial aircraft insurance, wet marine and transportation insurance, insurance independently procured pursuant to G.S. 58-28-5, life and accident or health insurance, and annuities.

(9) "Surplus lines licensee" means a person licensed under G.S. 58-21-65 to place insurance on risks resident, located, or to be performed in this State with nonadmitted insurers eligible to accept such insurance.

(10) "Wet marine and transportation insurance" means:

a. Insurance upon vessels, crafts, hulls and of interests therein or with relation thereto;

b. Insurance of marine builder's risks, marine war risks and contracts of marine protection and indemnity insurance;

c. Insurance of freights and disbursements pertaining to a subject of insurance coming within this subsection; and

d. Insurance of personal property and interests therein, in the course of exportation from or importation into any country, or in the course of transportation coastwise or on inland waters including transportation by land, water, or air from point of origin to final destination, in connection with any and all risks or perils of navigation, transit or transportation, and while being prepared for and while awaiting shipment, and during any delays, transshipment, or reshipment incident thereto."

SECTION 3. Article 21 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-21-11. Home state.**

(a) Except as provided in subsection (b) of this section, the term "home state" means, with respect to an insured, either of the following:

(1) The state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence.

(2) If one hundred percent (100%) of the insured risk is located out of the state referred to in subdivision (1) of this subsection, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(b) Affiliated Groups. – If two or more insureds from an affiliated group are named insureds on a single nonadmitted insurance contract, the term "home state" means the home state, as determined pursuant to subsection (a) of this section, of the member of the affiliated group that has the largest percentage of premium attributed to it under that insurance contract."

SECTION 4. G.S. 58-21-15 reads as rewritten:

"**§ 58-21-15. Placement of surplus lines insurance.**

~~Insurance may be procured through a surplus lines licensee from nonadmitted insurers if:~~Surplus lines may be placed by a surplus lines licensee if all of the following apply:

(1) Each insurer is an eligible surplus lines ~~insurer;~~insurer.

(1a) Each insurer is authorized to write the kind of insurance in its domiciliary jurisdiction.

(2) The full amount or kind of insurance cannot be obtained from insurers who are admitted to do business in this State. Such full amount or kind of

insurance may be procured from eligible surplus lines insurers, provided that a diligent search is made among the insurers who are admitted to transact and are actually writing the particular kind and class of insurance in this ~~State; and~~State.

(3) All other requirements of this Article are met."

SECTION 5. Article 21 of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-21-16. Streamlined application for commercial purchasers.**

(a) A surplus lines licensee seeking to procure or place nonadmitted insurance in this State for an exempt commercial purchaser shall not be required to satisfy any requirement under G.S. 58-21-15 to make a due diligence search to determine whether the full amount or type of insurance sought by such exempt commercial purchaser can be obtained from admitted insurers if all of the following apply:

(1) The licensee procuring or placing the surplus lines insurance has disclosed to the exempt commercial purchaser that such insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight.

(2) The exempt commercial purchaser has subsequently requested in writing the licensee to procure or place such insurance from a nonadmitted insurer.

(b) As used in this section, the following definitions apply:

(1) "Exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement, meets all of the following requirements:

a. The person employs or retains a qualified risk manager to negotiate insurance coverage.

b. The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of one hundred thousand dollars ($100,000) in the immediately preceding 12 months.

c. The person meets at least one of the following criteria:

1. The person possesses a net worth in excess of twenty million dollars ($20,000,000), as such amount is adjusted pursuant to subsection (c) of this section.

2. The person generates annual revenues in excess of fifty million dollars ($50,000,000), as such amount is adjusted pursuant to subsection (c) of this section.

3. The person employs more than 500 full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than 1,000 employees in the aggregate.

4. The person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least thirty million dollars ($30,000,000), as such amount is adjusted pursuant to subsection (c) of this section.

5. The person is a municipality with a population in excess of 50,000 persons.

(2) "Qualified risk manager" means, with respect to a policyholder of commercial insurance, a person who meets all of the following requirements:

a. Is an employee of, or third-party consultant retained by, the commercial policyholder.

b. Provides skilled services in loss prevention, loss reduction, or risk and insurance coverage analysis, and purchase of insurance.

c. Has one of the following:

1. A bachelor's degree or higher from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by the Commissioner to demonstrate minimum competence in risk management and one of the following:

I. Three years of experience in risk financing, claims administration, loss prevention, risk and insurance analysis, or purchasing commercial lines of insurance.

II. One of the following designations:

A. Chartered Property and Casualty Underwriter (CPCU) issued by the American Institute for CPCU/Insurance Institute of America.

B. Associate in Risk Management (ARM) issued by the American Institute for CPCU/Insurance Institute of America.

C. Certified Risk Manager (CRM) issued by the National Alliance for Insurance Education & Research.

D. RIMS Fellow (RF) issued by the Global Risk Management Institute.

E. A designation, certification, or license determined by the Commissioner to demonstrate minimum competency in risk management.

2. Seven years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; and has any one of the designations specified in sub-sub-sub-sub-subdivisions A. through E. of sub-sub-sub-subdivision II. of this sub-subdivision.

3. Ten years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance.

4. A graduate degree from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by the Commissioner to demonstrate minimum competence in risk management.

(c) Effective on the fifth January 1 occurring after the date of the enactment of this section and each fifth January 1 occurring thereafter, the dollar amounts in sub-sub-subdivisions (b)(1)c.1., 2., 3., and 4. of this section shall be adjusted to reflect the percentage change for such five-year period in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the U.S. Department of Labor.

"**§ 58-21-17. Placement with alien insurers.**

Nothing in this Article prohibits a surplus lines licensee from placing surplus lines insurance with, or procuring surplus lines insurance from, a nonadmitted insurer domiciled outside the United States that is listed on the Quarterly Listing of Alien Insurers maintained by the International Insurers Department of the NAIC."

SECTION 6. G.S. 58-21-20(a) reads as rewritten:

"(a) ~~No surplus lines licensee shall place any coverage with a nonadmitted insurer, unless at the time of placement, such nonadmitted insurer:~~A surplus lines licensee shall not place coverage with a nonadmitted insurer unless, at the time of placement, the surplus lines licensee has determined that the nonadmitted insurer satisfies the following:

(1) Has established satisfactory evidence of good repute and financial ~~integrity; and~~integrity.

(2) Qualifies under one of the following subdivisions:

a. Has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction, which equals the greater of either:

1. This State's minimum capital and surplus requirements under ~~G.S. 58-7-75, or~~G.S. 58-7-75.

2. Fifteen million dollars ~~($15,000,000),~~($15,000,000). ~~whichever is greater, except that nonadmitted insurers already qualified under this Article must have ten million dollars ($10,000,000) by December 31, 1991, twelve million five hundred thousand dollars ($12,500,000) by December 31, 1992, and fifteen million dollars ($15,000,000) by December 31, 1993. The requirements of this sub-subdivision may be satisfied by an insurer possessing less than the commitment capital and surplus upon an affirmative finding of acceptability by the Commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, and the insurer's record and reputation within the industry. In no event shall the Commissioner make an affirmative finding of acceptability when the insurer's capital and surplus is less than four million five hundred thousand dollars ($4,500,000).~~

~~In addition, an alien insurer qualifies under this subdivision if it complies with the capital and surplus requirements of this subdivision and maintains in the United States an irrevocable trust fund in either a national bank or a member of the Federal Reserve System, in an amount not less than five million four hundred thousand dollars ($5,400,000) for the protection of all of its policyholders in the United States, and the trust fund consists of cash, securities, letters of credit, or of investment of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers authorized to write like kinds of insurance in this State. The trust fund, which shall be included in any calculation of capital and surplus or its equivalent, shall have an expiration date which at no time shall be less than five years; or~~The requirements of this sub-subdivision may be satisfied by an insurer's possessing less than the minimum capital and surplus upon an affirmative finding of acceptability by the Commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability, and company record and reputation within the industry. In no event shall the Commissioner make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than four million five hundred thousand dollars ($4,500,000).

b. In the case of any Lloyd's plans or other similar group of insurers, which consists of unincorporated individual insurers, or a combination of both unincorporated and incorporated insurers, maintains a trust fund in an amount of not less than one hundred million dollars ($100,000,000) as security to the full amount thereof for all policyholders and creditors in the United States of each member of the group, and the trust shall likewise comply with the terms and conditions established in subdivision (2)a. of this section for alien ~~insurers; and~~insurers.

c. In the case of an "insurance exchange" created by the laws of individual states, maintain capital and surplus, or the substantial equivalent thereof, of not less than seventy-five million dollars ($75,000,000) in the aggregate. For insurance exchanges which maintain funds in an amount of not less than fifteen million dollars ($15,000,000) for the protection of all insurance exchange policyholders, each individual syndicate shall maintain minimum capital and surplus, or the substantial equivalent thereof, of not less than five million dollars ($5,000,000). If the insurance exchange does not maintain funds in an amount of not less than fifteen million dollars ($15,000,000) for the protection of all insurance exchange policyholders, each individual syndicate shall meet the minimum capital and surplus requirements of subdivision (2)a. of this section.

d. In the case of a group of incorporated insurers under common administration, which has continuously transacted an insurance business outside the United States for at least three years immediately before this time, and which submits to this State's authority to examine its books and records and bears the expense of the examination, and maintains an aggregate policyholders' surplus of not less than ten billion dollars ($10,000,000,000), and maintains in trust a surplus of not less than one hundred million dollars ($100,000,000) for the benefit of United States surplus lines policyholders of any member of the group, and each insurer maintains capital and surplus of not less than twenty-five million dollars ($25,000,000) per company.

(3) Has caused to be provided to the Commissioner a copy of its current annual statement certified by such insurer; such statement to be provided no more than two months, and for alien insurers six months, after the close of the period reported upon and that is either:

a. Filed with and approved by the regulatory authority in the domicile of the nonadmitted insurer; or

b. Certified by an accounting or auditing firm licensed in the jurisdiction of the insurer's domicile; or

c. In the case of an insurance exchange, the statement may be an aggregate combined statement of all underwriting syndicates operating during the period reported."

SECTION 7. G.S. 58-21-35(a) reads as rewritten:

"**§ 58-21-35. Duty to file and retain reports.**

(a) Within 30 days after the placing of any surplus lines insurance, the surplus lines licensee shall file with the Commissioner a report in a format prescribed by the Commissioner regarding the insurance and including the following information:

(1) The name of the insured.

(2) The identity of the insurer or insurers.
(3) A description of the subject and location of the risk.
(4) The amount of premium charged for the insurance.
(5) The amount of premium tax for the insurance.
(6) The policy period.
(7) The policy number.
(7a) An acknowledged statement that the surplus lines licensee has complied with ~~G.S. 58-21-15.~~G.S. 58-21-15 or G.S. 58-21-16, whichever is applicable.
(8) The name, address, telephone number, facsimile telephone number, and electronic mail address of the licensee, as applicable.
(9) Any other relevant information the Commissioner may reasonably require.

(b) The licensee shall complete and retain a copy of the report in paper or electronic form as required by the Commissioner. The report required by this section and the quarterly report required by G.S. 58-21-80 shall be completed on a standardized form or forms prescribed by the Commissioner and are not public records under G.S. 132-1 or G.S. 58-2-100."

SECTION 8. G.S. 58-21-65(a) reads as rewritten:

"(a) ~~No~~ For insureds whose home state is this State, no agent or broker licensed by the Commissioner shall procure any contract of surplus lines insurance with any nonadmitted insurer, unless he possesses a current surplus lines insurance license issued by the Commissioner."

SECTION 9. G.S. 58-22-10(10) reads as rewritten:

"(10) "Risk retention group" means any corporation or other limited liability association:
a. Whose primary activity consists of assuming and spreading all or any portion of the liability exposure of its group members;
b. That is organized for the primary purpose of conducting the activity described under sub-subdivision a. of this subdivision;
c. That
(i) Is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or
(ii) Before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before that date, had certified to the insurance regulator of at least one state that it satisfied the capitalization requirements of such state; except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since that date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability, as such terms were defined in the Product Liability Risk Retention Act of 1981 before the effective date of the Risk Retention Act of 1986;
d. That does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such person;
e. That
~~(i) Has as its members only persons who have an ownership interest in the group and that has as its owners only persons~~

~~who are members who are provided insurance by the risk retention group; or~~

~~(ii) Has as its sole member and sole owner an organization that is owned by persons who are provided insurance by the risk retention group;~~

(i) Has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group; or

(ii) Has as its sole owner an organization that meets all of the following:

(I) Its members are only persons who comprise the membership of the risk retention group; and

(II) Its owners are only persons who comprise the membership of the risk retention group and who are provided insurance by such group;

f. Whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar, or common business trade, product, services, premises, or operations;

g. Whose activities do not include the provision of insurance other than:

(i) Liability insurance for assuming and spreading all or any portion of the similar or related liability exposure of its group members; and

(ii) Reinsurance with respect to the similar or related liability exposure of any other risk retention group, or any ~~members~~ member of such other group, that is engaged in businesses or activities so that such group or member meets the requirement described in sub-subdivision f. of this subdivision from membership in the risk retention group that provides such reinsurance; and

h. The name of which includes the phrase "Risk Retention Group"."

SECTION 10. This act becomes effective June 1, 2011.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 299
PROPOSED COMMITTEE SUBSTITUTE H299-CSRG-9 [v.2]

4/25/2011 3:41:44 PM

Short Title: Surplus Lines/Premium Tax.-AB (Public)

Sponsors:

Referred to:

March 10, 2011

A BILL TO BE ENTITLED

AN ACT TO CONFORM PROVISIONS OF NORTH CAROLINA SURPLUS LINES INSURANCE LAWS TO THE FEDERAL NONADMITTED AND REINSURANCE REFORM ACT OF 2010, TO STREAMLINE APPLICATIONS FOR COMMERCIAL PURCHASERS, TO PREVENT ANY LOSS OF PREMIUM TAX REVENUE TO THE STATE, AND TO CONFORM THE DEFINITION OF RISK RETENTION GROUP TO FEDERAL LAW.

The General Assembly of North Carolina enacts:

SECTION 1.1. Article 21 of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-21-3. Cooperative or interstate agreements.**

(a) The Commissioner is authorized to enter into a cooperative agreement or interstate agreement or compact to do the following:

(1) Establish additional and alternative nationwide uniform eligibility requirements that shall be applicable to nonadmitted insurers domiciled in another state or territory of the United States.

(2) Facilitate the collection, allocation, and disbursement of premium taxes attributable to the placement of nonadmitted insurance, provide for uniform methods of allocation and reporting among nonadmitted insurance risk classifications, and share information among states relating to nonadmitted insurance premium taxes.

(b) The Commissioner is authorized to enter into an interstate compact or interstate agreement for the purpose of carrying out the Nonadmitted and Reinsurance Reform Act of 2010.

"**§ 58-21-4. Nonadmitted and Reinsurance Reform Act duties.**

(a) For the purposes of carrying out the provisions of the Nonadmitted and Reinsurance Reform Act of 2010, the Commissioner is authorized to utilize the national insurance producer database of the NAIC, or any other equivalent uniform national database, for the licensure of an individual or an entity as a surplus lines producer and for renewal of such license.

(b) In order to assist in the performance of the Commissioner's duties, under the Nonadmitted and Reinsurance Reform Act of 2010, the Commissioner may contract with nongovernmental entities, including the NAIC or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions that the Commissioner and the non-governmental entity may deem to be appropriate, including (i) the collection of fees, related to

producer licensing and (ii) the collection of the premium tax under G.S. 58-21-85. The NAIC or other entity with whom the Commissioner contracts may charge a reasonable fee to the insurer, insured or other appropriate person for the functions performed."

SECTION 1.2. The Revenue Laws Study Committee shall, in cooperation with the Commissioner of Insurance, study the potential impact that would result from the State's entrance into a nonadmitted insurance multi-state agreement or other compact or interstate agreement for the purpose of carrying out the Nonadmitted and Reinsurance Reform Act of 2010, in order to prevent the State from losing revenue after July 21, 2011, the effective date of the Nonadmitted and Reinsurance Reform Act. The Committee shall determine if entering into a compact or agreement would result in retention of surplus lines tax revenue for the state and, if so, which compact or agreement would result in the most retention of surplus lines tax revenue for the State. The Committee shall report its findings and recommendations, including any proposed legislation, to the 2012 Session of the 2011 General Assembly.

SECTION 2. G.S. 58-21-10 reads as rewritten:

"**§ 58-21-10. Definitions.**

As used in this Article:

(1) "Admitted insurer" means an insurer licensed to ~~do an insurance business~~ engage in the business of insurance in this State.

(1a) "Affiliate" means, with respect to an insured, any entity that controls, is controlled by, or is under common control with the insured.

(1b) "Affiliated group" means any group of entities that are all affiliated.

(2) "Capital", as used in the financial requirements of G.S. 58-21-20, means funds paid in for stock or other evidence of ownership.

(2a) "Control" means an entity that has "control" over another entity if either of the following occurs:

a. The entity directly or indirectly or acting through one or more other persons owns, controls, or has the power to vote twenty-five percent (25%) or more of any class of voting securities of the other entity.

b. The entity controls in any manner the election of a majority of the directors or trustees of the other entity.

(3) "Eligible surplus lines insurer" means a nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance under G.S. 58-21-20.

(4) "Export" means to place surplus lines insurance with a nonadmitted insurer.

(5) "Nonadmitted insurer" means an insurer not licensed to do an insurance business in this State. ~~This definition~~ "Nonadmitted insurer" includes insurance exchanges authorized under the laws of various states. "Nonadmitted insurer" does not include a risk retention group, as defined in G.S. 58-22-10(10).

(6) "Producing broker" means an agent or broker licensed under Article 33 of this Chapter who deals directly with the party seeking insurance and who may also be a surplus lines licensee.

(6a) "Reciprocal state" means a state that has enacted provisions substantially similar to the following:

a. G.S. 58-21-85, 58-21-95(5), 58-21-75(10), 58-21-35(7b), and 58-28-5(b).

b. The allocation schedule and reporting form contained in G.S. 58-21-85.

(7) "Surplus", as used in the financial requirements of G.S. 58-21-20, means funds over and above liabilities and capital of the company for the protection of policyholders.

(8) "Surplus lines insurance" means any insurance in this State of risks resident, located, or to be performed in this State, permitted to be placed through a surplus lines licensee with a nonadmitted insurer eligible to accept such insurance, other than reinsurance, commercial aircraft insurance, wet marine and transportation insurance, insurance independently procured pursuant to G.S. 58-28-5, life and accident or health insurance, and annuities.

(9) "Surplus lines licensee" means a person licensed under G.S. 58-21-65 to place insurance on risks resident, located, or to be performed in this State with nonadmitted insurers eligible to accept such insurance.

(10) "Wet marine and transportation insurance" means:

a. Insurance upon vessels, crafts, hulls and of interests therein or with relation thereto;

b. Insurance of marine builder's risks, marine war risks and contracts of marine protection and indemnity insurance;

c. Insurance of freights and disbursements pertaining to a subject of insurance coming within this subsection; and

d. Insurance of personal property and interests therein, in the course of exportation from or importation into any country, or in the course of transportation coastwise or on inland waters including transportation by land, water, or air from point of origin to final destination, in connection with any and all risks or perils of navigation, transit or transportation, and while being prepared for and while awaiting shipment, and during any delays, transshipment, or reshipment incident thereto."

SECTION 3. Article 21 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-21-11. Home state.**

(a) Except as provided in subsection (b) of this section, the term "home state" means, with respect to an insured, either of the following:

(1) The state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence.

(2) If one hundred percent (100%) of the insured risk is located out of the state referred to in subdivision (1) of this subsection, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(b) Affiliated Groups. – If two or more insureds from an affiliated group are named insureds on a single nonadmitted insurance contract, the term "home state" means the home state, as determined pursuant to subsection (a) of this section, of the member of the affiliated group that has the largest percentage of premium attributed to it under that insurance contract."

SECTION 4. G.S. 58-21-15 reads as rewritten:

"**§ 58-21-15. Placement of surplus lines insurance.**

~~Insurance may be procured through a surplus lines licensee from nonadmitted insurers if:~~Surplus lines may be placed by a surplus lines licensee if all of the following apply:

(1) Each insurer is an eligible surplus lines ~~insurer;~~insurer.

(1a) Each insurer is authorized to write the kind of insurance in its domiciliary jurisdiction.

(2) The full amount or kind of insurance cannot be obtained from insurers who are admitted to do business in this State. Such full amount or kind of insurance may be procured from eligible surplus lines insurers, provided that a diligent search is made among the insurers who are admitted to transact

and are actually writing the particular kind and class of insurance in this ~~State; and~~State.

(3) All other requirements of this Article are met."

SECTION 5. Article 21 of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-21-16. Streamlined application for commercial purchasers.**

(a) A surplus lines licensee seeking to procure or place nonadmitted insurance in this State for an exempt commercial purchaser shall not be required to satisfy any requirement under G.S. 58-21-15 to make a due diligence search to determine whether the full amount or type of insurance sought by such exempt commercial purchaser can be obtained from admitted insurers if all of the following apply:

(1) The licensee procuring or placing the surplus lines insurance has disclosed to the exempt commercial purchaser that such insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight.

(2) The exempt commercial purchaser has subsequently requested in writing the licensee to procure or place such insurance from a nonadmitted insurer.

(b) As used in this section, the following definitions apply:

(1) "Exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement, meets all of the following requirements:

a. The person employs or retains a qualified risk manager to negotiate insurance coverage.

b. The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of one hundred thousand dollars ($100,000) in the immediately preceding 12 months.

c. The person meets at least one of the following criteria:

1. The person possesses a net worth in excess of twenty million dollars ($20,000,000), as such amount is adjusted pursuant to subsection (c) of this section.

2. The person generates annual revenues in excess of fifty million dollars ($50,000,000), as such amount is adjusted pursuant to subsection (c) of this section.

3. The person employs more than 500 full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than 1,000 employees in the aggregate.

4. The person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least thirty million dollars ($30,000,000), as such amount is adjusted pursuant to subsection (c) of this section.

5. The person is a municipality with a population in excess of 50,000 persons.

(2) "Qualified risk manager" means, with respect to a policyholder of commercial insurance, a person who meets all of the following requirements:

a. Is an employee of, or third-party consultant retained by, the commercial policyholder.

b. Provides skilled services in loss prevention, loss reduction, or risk and insurance coverage analysis, and purchase of insurance.

c. Has one of the following:

1. A bachelor's degree or higher from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by the Commissioner to demonstrate minimum competence in risk management and one of the following:
   I. Three years of experience in risk financing, claims, administration, loss prevention, risk and insurance analysis, or purchasing commercial lines of insurance.
   II. One of the following designations:
      A. Chartered Property and Casualty Underwriter (CPCU) issued by the American Institute for CPCU/Insurance Institute of America.
      B. Associate in Risk Management (ARM) issued by the American Institute for CPCU/Insurance Institute of America.
      C. Certified Risk Manager (CRM) issued by the National Alliance for Insurance Education & Research.
      D. RIMS Fellow (RF) issued by the Global Risk Management Institute.
      E. A designation, certification, or license determined by the Commissioner to demonstrate minimum competency in risk management.
2. Seven years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; and has any one of the designations specified in sub-sub-sub-sub-subdivisions A. through E. of sub-sub-sub-subdivision II. of this sub-subdivision.
3. Ten years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance.
4. A graduate degree from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by the Commissioner to demonstrate minimum competence in risk management.

(c) Effective on the fifth January 1 occurring after the date of the enactment of this section and each fifth January 1 occurring thereafter, the dollar amounts in sub-sub-subdivisions (b)(1)c.1. 2., 3., and 4. of this section shall be adjusted to reflect the percentage change for such five-year period in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the U.S. Department of Labor.

"**§ 58-21-17. Placement with alien insurers.**

Nothing in this Article prohibits a surplus lines licensee from placing surplus lines insurance with, or procuring surplus lines insurance from, a nonadmitted insurer domiciled outside the United States that is listed on the Quarterly Listing of Alien Insurers maintained by the International Insurers Department of the NAIC."

SECTION 6. G.S. 58-21-20(a) reads as rewritten:

"(a) ~~No surplus lines licensee shall place any coverage with a nonadmitted insurer, unless at the time of placement, such nonadmitted insurer:~~A surplus lines licensee shall not

place coverage with a nonadmitted insurer unless, at the time of placement, the surplus lines licensee has determined that the nonadmitted insurer satisfies the following:

(1) Has established satisfactory evidence of good repute and financial ~~integrity; and~~integrity.

(2) Qualifies under one of the following subdivisions:

a. Has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction, which equals the greater of either:

1. This State's minimum capital and surplus requirements under ~~G.S. 58-7-75, or~~G.S. 58-7-75.

2. Fifteen million dollars ~~($15,000,000),~~($15,000,000). ~~whichever is greater, except that nonadmitted insurers already qualified under this Article must have ten million dollars ($10,000,000) by December 31, 1991, twelve million five hundred thousand dollars ($12,500,000) by December 31, 1992, and fifteen million dollars ($15,000,000) by December 31, 1993. The requirements of this sub-subdivision may be satisfied by an insurer possessing less than the commitment capital and surplus upon an affirmative finding of acceptability by the Commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, and the insurer's record and reputation within the industry. In no event shall the Commissioner make an affirmative finding of acceptability when the insurer's capital and surplus is less than four million five hundred thousand dollars ($4,500,000).~~

~~In addition, an alien insurer qualifies under this subdivision if it complies with the capital and surplus requirements of this subdivision and maintains in the United States an irrevocable trust fund in either a national bank or a member of the Federal Reserve System, in an amount not less than five million four hundred thousand dollars ($5,400,000) for the protection of all of its policyholders in the United States, and the trust fund consists of cash, securities, letters of credit, or of investment of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers authorized to write like kinds of insurance in this State. The trust fund, which shall be included in any calculation of capital and surplus or its equivalent, shall have an expiration date which at no time shall be less than five years; or~~The requirements of this sub-subdivision may be satisfied by an insurer's possessing less than the minimum capital and surplus upon an affirmative finding of acceptability by the Commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability, and company record and reputation within the industry. In no event shall the Commissioner make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than four million five hundred thousand dollars ($4,500,000).

b. In the case of any Lloyd's plans or other similar group of insurers, which consists of unincorporated individual insurers, or a combination of both unincorporated and incorporated insurers,

maintains a trust fund in an amount of not less than one hundred million dollars ($100,000,000) as security to the full amount thereof for all policyholders and creditors in the United States of each member of the group, and the trust shall likewise comply with the terms and conditions established in subdivision (2)a. of this section for alien ~~insurers; and~~insurers.

c. In the case of an "insurance exchange" created by the laws of individual states, maintain capital and surplus, or the substantial equivalent thereof, of not less than seventy-five million dollars ($75,000,000) in the aggregate. For insurance exchanges which maintain funds in an amount of not less than fifteen million dollars ($15,000,000) for the protection of all insurance exchange policyholders, each individual syndicate shall maintain minimum capital and surplus, or the substantial equivalent thereof, of not less than five million dollars ($5,000,000). If the insurance exchange does not maintain funds in an amount of not less than fifteen million dollars ($15,000,000) for the protection of all insurance exchange policyholders, each individual syndicate shall meet the minimum capital and surplus requirements of subdivision (2)a. of this section.

d. In the case of a group of incorporated insurers under common administration, which has continuously transacted an insurance business outside the United States for at least three years immediately before this time, and which submits to this State's authority to examine its books and records and bears the expense of the examination, and maintains an aggregate policyholders' surplus of not less than ten billion dollars ($10,000,000,000), and maintains in trust a surplus of not less than one hundred million dollars ($100,000,000) for the benefit of United States surplus lines policyholders of any member of the group, and each insurer maintains capital and surplus of not less than twenty-five million dollars ($25,000,000) per company.

(3) Has caused to be provided to the Commissioner a copy of its current annual statement certified by such insurer; such statement to be provided no more than two months, and for alien insurers six months, after the close of the period reported upon and that is either:

a. Filed with and approved by the regulatory authority in the domicile of the nonadmitted insurer; or

b. Certified by an accounting or auditing firm licensed in the jurisdiction of the insurer's domicile; or

c. In the case of an insurance exchange, the statement may be an aggregate combined statement of all underwriting syndicates operating during the period reported."

SECTION 7. G.S. 58-21-35(a) reads as rewritten:

"**§ 58-21-35. Duty to file and retain reports.**

(a) Within 30 days after the placing of any surplus lines insurance, the surplus lines licensee shall file with the Commissioner a report in a format prescribed by the Commissioner regarding the insurance and including the following information:

(1) The name of the insured.

(2) The identity of the insurer or insurers.

(3) A description of the subject and location of the risk.

(4) The amount of premium charged for the insurance.

(5) The amount of premium tax for the insurance.
(6) The policy period.
(7) The policy number.
(7a) An acknowledged statement that the surplus lines licensee has complied with ~~G.S. 58-21-15.~~G.S: 58-21-15 or G.S. 58-21-16, whichever is applicable.
(8) The name, address, telephone number, facsimile telephone number, and electronic mail address of the licensee, as applicable.
(9) Any other relevant information the Commissioner may reasonably require.

(b) The licensee shall complete and retain a copy of the report in paper or electronic form as required by the Commissioner. The report required by this section and the quarterly report required by G.S. 58-21-80 shall be completed on a standardized form or forms prescribed by the Commissioner and are not public records under G.S. 132-1 or G.S. 58-2-100."

SECTION 8. G.S. 58-21-65(a) reads as rewritten:

"(a) ~~No~~ For insureds whose home state is this State, no agent or broker licensed by the Commissioner shall procure any contract of surplus lines insurance with any nonadmitted insurer, unless he possesses a current surplus lines insurance license issued by the Commissioner."

SECTION 9. G.S. 58-22-10(10) reads as rewritten:

"(10) "Risk retention group" means any corporation or other limited liability association:
a. Whose primary activity consists of assuming and spreading all or any portion of the liability exposure of its group members;
b. That is organized for the primary purpose of conducting the activity described under sub-subdivision a. of this subdivision;
c. That
(i) Is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or
(ii) Before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before that date, had certified to the insurance regulator of at least one state that it satisfied the capitalization requirements of such state; except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since that date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability, as such terms were defined in the Product Liability Risk Retention Act of 1981 before the effective date of the Risk Retention Act of 1986;
d. That does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such person;
e. That
~~(i) Has as its members only persons who have an ownership interest in the group and that has as its owners only persons who are members who are provided insurance by the risk retention group; or~~

~~(ii) Has as its sole member and sole owner an organization that is owned by persons who are provided insurance by the risk retention group;~~

(i) Has as it owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group; or

(ii) Has as its sole owner an organization that meets all of the following:

(I) Its members are only persons who comprise the membership of the risk retention group; and

(II) Its owners are only persons who comprise the membership of the risk retention group and who are provided insurance by such group;

f. Whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar, or common business trade, product, services, premises, or operations;

g. Whose activities do not include the provision of insurance other than:

(i) Liability insurance for assuming and spreading all or any portion of the similar or related liability exposure of its group members; and

(ii) Reinsurance with respect to the similar or related liability exposure of any other risk retention group, or any ~~members~~ member of such other group, that is engaged in businesses or activities so that such group or member meets the requirement described in sub-subdivision f. of this subdivision from membership in the risk retention group that provides such reinsurance; and

h. The name of which includes the phrase "Risk Retention Group"."

SECTION 10. This act becomes effective June 1, 2011.

HOUSE BILL 299:
Surplus Lines/Premium Tax.-AB

2011-2012 General Assembly

Committee:	House Insurance, if favorable, Finance	**Date:**	April 24, 2011
Introduced by:	Rep. Dockham	**Prepared by:**	Tim Hovis Committee Counsel
Analysis of:	PCS to First Edition H299-CSRG-9		

SUMMARY: House Bill 299 makes changes to the law governing surplus lines insurers to conform to the federal Nonadmitted and Reinsurance Reform Act of 2010 and to authorize the Commissioner of Insurance to enter into interstate agreements and compacts to prevent the loss of state tax revenue resulting from the federal Act.

[As introduced, this bill was identical to S321, as introduced by Sen. Apodaca, which is currently in Senate Finance.]

BACKGROUND: Surplus lines insurance coverage is coverage that is not available from insurers licensed in the State, referred to as admitted insurers. This coverage must instead be purchased from insurers who are not licensed in this State, referred to as nonadmitted insurers.

The Nonadmitted and Reinsurance Reform Act (NRRA) was enacted by Congress as part of the Dodd-Frank Wall Street Reform and Protection Act, signed into law in July of 2010. The federal NRRA supersedes aspects of state law regulating surplus lines insurers, requiring the State to make changes to conform to the federal law.

Most notably, the NRRA provides that only the home state of the insured, i.e. the insured's principal place of business, is authorized to tax surplus lines transactions. This change could result in the loss of significant revenue to many states. The NRRA does allow states to enter into interstate compacts for the allocation of tax revenue to prevent this loss. The N.C. Department of Insurance estimates that N.C. may lose $10 to $12 million unless authority is given to the Commissioner to enter into such an agreement.

BILL ANALYSIS: **Section 1.1** of the bill authorizes the Commissioner of Insurance to enter into a cooperative or interstate agreement or compact to establish alternative nationwide eligibility requirements for nonadmitted insurers domiciled in other states and to facilitate the collection, allocation and disbursement of premium taxes among states. This section also gives the Commissioner the express authority to enter into an interstate compact or agreement for the purpose of carrying out the NRRA.

Section 1.1 also adds a new section authorizing the Commissioner to participate in a national insurance producer database for the licensing of surplus lines insurers and to contract with nongovernmental entities to collect the appropriate licensing fees and surplus lines premium taxes.

Section 1.2 directs the Revenue Laws Study Committee, in cooperation with the Commissioner of Insurance, to study the potential impact that would result from the State's entrance into a nonadmitted insurance interstate agreement to determine which compact or agreement would result in the most retention of surplus lines tax revenue for the State. The Committee will report its findings to the 2012 Session of the 2011 General Assembly.

Section 2 adds definitions to conform state law to the federal NRRA.

Section 3 adds a new section defining "home state" as the principal place of business or principal residence of the insured, as required by the NRRA.

Section 4 amends current law to provide that a surplus lines insurer only be required to obta authorization to write insurance in its domiciliary state, as provided in the NRRA.

Section 5 provides a streamlined process by which a surplus lines licensee, i.e. a broker or agent, may place surplus lines coverage for certain exempt commercial purchasers without conducting a search to determine whether the insurance can be obtained from admitted insurers. To comply with the new procedure, the licensee must satisfy the following: (1) the licensee must disclose to the purchaser that the insurance may or may not be available from the admitted market; and (2) the exempt commercial purchaser must subsequently request in writing that the licensee place the insurance with a non-admitted insurer. This section also defines an "exempt commercial purchaser" for the purposes of the new statutory procedure.

Section 5 also provides that nothing prohibits a licensee from procuring surplus lines insurance from a nonadmitted insurer outside of the United States, known as an "alien" insurer, listed on the NAIC Listing of Alien Insurers.

Section 6 conforms State eligibility criteria for surplus lines insurers to the NAIC Nonadmitted Insurance Model Act, as required by the federal NRRA.

Section 7 makes conforming changes.

Section 8 provides that a NC surplus lines license is required only for those agents or brokers doing business with insureds whose home state is NC. (Under NRRA, only an insured's home state may require a surplus lines broker to be licensed.)

Section 9 revises the definition of risk retention group to conform to the definition in federal law.

EFFECTIVE DATE: House Bill 299 becomes effective June 1, 2011.

H299-SMRG-13(CSRG-9) v2

HOUSE BILL 299

Short Title:	Surplus Lines/Premium Tax.-AB	(Public)
Sponsors:	Representative Dockham (Primary Sponsor). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Insurance, if favorable, Finance.	

March 10, 2011

A BILL TO BE ENTITLED

AN ACT TO CONFORM PROVISIONS OF NORTH CAROLINA SURPLUS LINES INSURANCE LAWS TO THE FEDERAL NONADMITTED AND REINSURANCE REFORM ACT OF 2010, TO STREAMLINE APPLICATIONS FOR COMMERCIAL PURCHASERS, AND TO PREVENT ANY LOSS OF PREMIUM TAX REVENUE TO THE STATE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 21 of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-21-3. Cooperative or interstate agreements.**

The Commissioner is authorized to enter into a cooperative agreement or interstate agreement or compact to establish additional and alternative nationwide uniform eligibility requirements that shall be applicable to nonadmitted insurers domiciled in another state or territory of the United States.

"**§ 58-21-4. Nonadmitted and Reinsurance Reform Act duties.**

(a) For the purposes of carrying out the provisions of the Nonadmitted and Reinsurance Reform Act of 2010, the Commissioner is authorized to utilize the national insurance producer database of the NAIC, or any other equivalent uniform national database, for the licensure of an individual or an entity as a surplus lines producer and for renewal of such license.

(b) In order to assist in the performance of the Commissioner's duties, under the Nonadmitted and Reinsurance Reform Act of 2010, the Commissioner may contract with nongovernmental entities, including the NAIC or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions, including the collection of fees, related to producer licensing that the Commissioner and the nongovernmental entity may deem to be appropriate."

SECTION 2. G.S. 58-21-10 reads as rewritten:

"**§ 58-21-10. Definitions.**

As used in this Article:

(1) "Admitted insurer" means an insurer licensed to ~~do an insurance business~~ engage in the business of insurance in this State.

(1a) "Affiliate" means, with respect to an insured, any entity that controls, is controlled by, or is under common control with the insured.

(1b) "Affiliated group" means any group of entities that are all affiliated.

(2) "Capital", as used in the financial requirements of G.S. 58-21-20, means funds paid in for stock or other evidence of ownership.

(2a) "Control" means an entity that has "control" over another entity if either of the following occurs:
  a. The entity directly or indirectly or acting through one or more other persons owns, controls, or has the power to vote twenty-five percent (25%) or more of any class of voting securities of the other entity.
  b. The entity controls in any manner the election of a majority of the directors or trustees of the other entity.

(3) "Eligible surplus lines insurer" means a nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance under G.S. 58-21-20.

(4) "Export" means to place surplus lines insurance with a nonadmitted insurer.

(5) "Nonadmitted insurer" means an insurer not licensed to do an insurance business in this State. ~~This definition~~ "Nonadmitted insurer" includes insurance exchanges authorized under the laws of various states. "Nonadmitted insurer" does not include a risk retention group, as defined in G.S. 58-22-10(10).

(6) "Producing broker" means an agent or broker licensed under Article 33 of this Chapter who deals directly with the party seeking insurance and who may also be a surplus lines licensee.

(6a) "Reciprocal state" means a state that has enacted provisions substantially similar to the following:
  a. G.S. 58-21-85, 58-21-95(5), 58-21-75(10), 58-21-35(7b), and 58-28-5(b).
  b. The allocation schedule and reporting form contained in G.S. 58-21-85.

(7) "Surplus", as used in the financial requirements of G.S. 58-21-20, means funds over and above liabilities and capital of the company for the protection of policyholders.

(8) "Surplus lines insurance" means any insurance in this State of risks resident, located, or to be performed in this State, permitted to be placed through a surplus lines licensee with a nonadmitted insurer eligible to accept such insurance, other than reinsurance, commercial aircraft insurance, wet marine and transportation insurance, insurance independently procured pursuant to G.S. 58-28-5, life and accident or health insurance, and annuities.

(9) "Surplus lines licensee" means a person licensed under G.S. 58-21-65 to place insurance on risks resident, located, or to be performed in this State with nonadmitted insurers eligible to accept such insurance.

(10) "Wet marine and transportation insurance" means:
  a. Insurance upon vessels, crafts, hulls and of interests therein or with relation thereto;
  b. Insurance of marine builder's risks, marine war risks and contracts of marine protection and indemnity insurance;
  c. Insurance of freights and disbursements pertaining to a subject of insurance coming within this subsection; and
  d. Insurance of personal property and interests therein, in the course of exportation from or importation into any country, or in the course of transportation coastwise or on inland waters including transportation by land, water, or air from point of origin to final destination, in connection with any and all risks or perils of navigation, transit or transportation, and while being prepared for and while awaiting

shipment, and during any delays, transshipment, or reshipment incident thereto."

SECTION 3. Article 21 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-21-11. Home state.**

(a) Except as provided in subsection (b) of this section, the term "home state" means, with respect to an insured, either of the following:

(1) The state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence.

(2) If one hundred percent (100%) of the insured risk is located out of the state referred to in subdivision (1) of this subsection, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(b) Affiliated Groups. – If two or more insureds from an affiliated group are named insureds on a single nonadmitted insurance contract, the term "home state" means the home state, as determined pursuant to subsection (a) of this section, of the member of the affiliated group that has the largest percentage of premium attributed to it under that insurance contract."

SECTION 4. G.S. 58-21-15 reads as rewritten:

"**§ 58-21-15. Placement of surplus lines insurance.**

~~Insurance may be procured through a surplus lines licensee from nonadmitted insurers if:~~Surplus lines may be placed by a surplus lines licensee if all of the following apply:

(1) Each insurer is an eligible surplus lines ~~insurer;~~insurer.

(1a) Each insurer is authorized to write the kind of insurance in its domiciliary jurisdiction.

(2) The full amount or kind of insurance cannot be obtained from insurers who are admitted to do business in this State. Such full amount or kind of insurance may be procured from eligible surplus lines insurers, provided that a diligent search is made among the insurers who are admitted to transact and are actually writing the particular kind and class of insurance in this ~~State; and~~State.

(3) All other requirements of this Article are met."

SECTION 5. Article 21 of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-21-16. Streamlined application for commercial purchasers.**

(a) A surplus lines licensee seeking to procure or place nonadmitted insurance in this State for an exempt commercial purchaser shall not be required to satisfy any requirement under G.S. 58-21-15 to make a due diligence search to determine whether the full amount or type of insurance sought by such exempt commercial purchaser can be obtained from admitted insurers if all of the following apply:

(1) The licensee procuring or placing the surplus lines insurance has disclosed to the exempt commercial purchaser that such insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight.

(2) The exempt commercial purchaser has subsequently requested in writing the licensee to procure or place such insurance from a nonadmitted insurer.

(b) As used in this section, the following definitions apply:

(1) "Exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement, meets all of the following requirements:

a. The person employs or retains a qualified risk manager to negotiate insurance coverage.

b. The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of one hundred thousand dollars ($100,000) in the immediately preceding 12 months.

c. The person meets at least one of the following criteria:

1. The person possesses a net worth in excess of twenty million dollars ($20,000,000), as such amount is adjusted pursuant to subsection (c) of this section.

2. The person generates annual revenues in excess of fifty million dollars ($50,000,000), as such amount is adjusted pursuant to subsection (c) of this section.

3. The person employs more than 500 full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than 1,000 employees in the aggregate.

4. The person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least thirty million dollars ($30,000,000), as such amount is adjusted pursuant to subsection (c) of this section.

5. The person is a municipality with a population in excess of 50,000 persons.

(2) "Qualified risk manager" means, with respect to a policyholder of commercial insurance, a person who meets all of the following requirements:

a. Is an employee of, or third party consultant retained by, the commercial policyholder.

b. Provides skilled services in loss prevention, loss reduction, or risk and insurance coverage analysis, and purchase of insurance.

c. Has one of the following:

1. A bachelor's degree or higher from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by the Commissioner to demonstrate minimum competence in risk management and one of the following:

I. Three years of experience in risk financing, claims, administration, loss prevention, risk and insurance analysis, or purchasing commercial lines of insurance.

II. One of the following designations:

A. Chartered Property and Casualty Underwriter (CPCU) issued by the American Institute for CPCU/Insurance Institute of America.

B. Associate in Risk Management (ARM) issued by the American Institute for CPCU/Insurance Institute of America.

C. Certified Risk Manager (CRM) issued by the National Alliance for Insurance Education & Research.

D. RIMS Fellow (RF) issued by the Global Risk Management Institute.

E. A designation, certification, or license determined by the Commissioner to

demonstrate minimum competency in risk management.

2. Seven years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; and has any one of the designations specified in sub-sub-sub-sub-subdivisions A. through E. of sub-sub-sub-subdivision II. of this sub-subdivision.

3. Ten years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance.

4. A graduate degree from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by the Commissioner to demonstrate minimum competence in risk management.

(c) Effective on the fifth January 1 occurring after the date of the enactment of this section and each fifth January 1 occurring thereafter, the dollar amounts in sub-sub-subdivisions (b)(1)c.1. 2, 3, and 4 of this section shall be adjusted to reflect the percentage change for such five-year period in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the U.S. Department of Labor.

"**§ 58-21-17. Placement with alien insurers.**

Nothing in this Article prohibits a surplus lines licensee from placing surplus lines insurance with, or procuring surplus lines insurance from, a nonadmitted insurer domiciled outside the United States that is listed on the Quarterly Listing of Alien Insurers maintained by the International Insurers Department of the NAIC."

SECTION 6. G.S. 58-21-20(a) reads as rewritten:

"(a) ~~No surplus lines licensee shall place any coverage with a nonadmitted insurer, unless at the time of placement, such nonadmitted insurer:~~A surplus lines licensee shall not place coverage with a nonadmitted insurer unless, at the time of placement, the surplus lines licensee has determined that the nonadmitted insurer satisfies the following:

(1) Has established satisfactory evidence of good repute and financial ~~integrity; and~~integrity.

(2) Qualifies under one of the following subdivisions:

a. Has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction, which equals the greater of either:

1. This State's minimum capital and surplus requirements under ~~G.S. 58-7-75, or~~G.S. 58-7-75.

2. Fifteen million dollars ~~($15,000,000),~~($15,000,000). ~~whichever is greater, except that nonadmitted insurers already qualified under this Article must have ten million dollars ($10,000,000) by December 31, 1991, twelve million five hundred thousand dollars ($12,500,000) by December 31, 1992, and fifteen million dollars ($15,000,000) by December 31, 1993. The requirements of this sub-subdivision may be satisfied by an insurer possessing less than the commitment capital and surplus upon an affirmative finding of acceptability by the Commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, and the insurer's record and reputation within the industry. In no event shall the Commissioner~~

~~make an affirmative finding of acceptability when the insurer's capital and surplus is less than four million five hundred thousand dollars ($4,500,000).~~

~~In addition, an alien insurer qualifies under this subdivision if it complies with the capital and surplus requirements of this subdivision and maintains in the United States an irrevocable trust fund in either a national bank or a member of the Federal Reserve System, in an amount not less than five million four hundred thousand dollars ($5,400,000) for the protection of all of its policyholders in the United States, and the trust fund consists of cash, securities, letters of credit, or of investment of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers authorized to write like kinds of insurance in this State. The trust fund, which shall be included in any calculation of capital and surplus or its equivalent, shall have an expiration date which at no time shall be less than five years; or~~The requirements of this sub-subdivision may be satisfied by an insurer's possessing less than the minimum capital and surplus upon an affirmative finding of acceptability by the Commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability, and company record and reputation within the industry. In no event shall the Commissioner make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than four million five hundred thousand dollars ($4,500,000).

b. In the case of any Lloyd's plans or other similar group of insurers, which consists of unincorporated individual insurers, or a combination of both unincorporated and incorporated insurers, maintains a trust fund in an amount of not less than one hundred million dollars ($100,000,000) as security to the full amount thereof for all policyholders and creditors in the United States of each member of the group, and the trust shall likewise comply with the terms and conditions established in subdivision (2)a. of this section for alien ~~insurers; and~~insurers.

c. In the case of an "insurance exchange" created by the laws of individual states, maintain capital and surplus, or the substantial equivalent thereof, of not less than seventy-five million dollars ($75,000,000) in the aggregate. For insurance exchanges which maintain funds in an amount of not less than fifteen million dollars ($15,000,000) for the protection of all insurance exchange policyholders, each individual syndicate shall maintain minimum capital and surplus, or the substantial equivalent thereof, of not less than five million dollars ($5,000,000). If the insurance exchange does not maintain funds in an amount of not less than fifteen million dollars ($15,000,000) for the protection of all insurance exchange policyholders, each individual syndicate shall meet the minimum capital and surplus requirements of subdivision (2)a. of this section.

d. In the case of a group of incorporated insurers under common administration, which has continuously transacted an insurance business outside the United States for at least three years

immediately before this time, and which submits to this State's authority to examine its books and records and bears the expense of the examination, and maintains an aggregate policyholders' surplus of not less than ten billion dollars ($10,000,000,000), and maintains in trust a surplus of not less than one hundred million dollars ($100,000,000) for the benefit of United States surplus lines policyholders of any member of the group, and each insurer maintains capital and surplus of not less than twenty-five million dollars ($25,000,000) per company.

(3) Has caused to be provided to the Commissioner a copy of its current annual statement certified by such insurer; such statement to be provided no more than two months, and for alien insurers six months, after the close of the period reported upon and that is either:

a. Filed with and approved by the regulatory authority in the domicile of the nonadmitted insurer; or

b. Certified by an accounting or auditing firm licensed in the jurisdiction of the insurer's domicile; or

c. In the case of an insurance exchange, the statement may be an aggregate combined statement of all underwriting syndicates operating during the period reported."

SECTION 7. G.S. 58-21-35(a) reads as rewritten:

"**§ 58-21-35. Duty to file and retain reports.**

(a) Within 30 days after the placing of any surplus lines insurance, the surplus lines licensee shall file with the Commissioner a report in a format prescribed by the Commissioner regarding the insurance and including the following information:

(1) The name of the insured.

(2) The identity of the insurer or insurers.

(3) A description of the subject and location of the risk.

(4) The amount of premium charged for the insurance.

(5) The amount of premium tax for the insurance.

(6) The policy period.

(7) The policy number.

(7a) An acknowledged statement that the surplus lines licensee has complied with ~~G.S. 58-21-15.~~G.S. 58-21-15 or G.S. 58-21-16, whichever is applicable.

(8) The name, address, telephone number, facsimile telephone number, and electronic mail address of the licensee, as applicable.

(9) Any other relevant information the Commissioner may reasonably require.

(b) The licensee shall complete and retain a copy of the report in paper or electronic form as required by the Commissioner. The report required by this section and the quarterly report required by G.S. 58-21-80 shall be completed on a standardized form or forms prescribed by the Commissioner and are not public records under G.S. 132-1 or G.S. 58-2-100."

SECTION 8. G.S. 58-21-65(a) reads as rewritten:

"(a) ~~No~~ For insureds whose home state is this State, no agent or broker licensed by the Commissioner shall procure any contract of surplus lines insurance with any nonadmitted insurer, unless he possesses a current surplus lines insurance license issued by the Commissioner."

SECTION 9. G.S. 58-21-85 reads as rewritten:

"**§ 58-21-85. Surplus lines tax.**

(a) ~~Gross premiums charged, less any return premiums, for surplus lines insurance are subject to a premium receipts tax of five percent (5%), which shall be collected by the surplus~~

~~lines licensee as specified by the Commissioner, in addition to the full amount of the gross premium charged by the insurer for the insurance. The tax on any portion of the premium unearned at termination of insurance having been credited by the State to the licensee shall be returned to the policyholder directly by the surplus lines licensee or through the producing broker, if any. The surplus lines licensee is prohibited from absorbing such tax and from rebating for any reason, any part of such tax.~~ In addition to the full amount of gross premiums charged by the insurer for the insurance, every person licensed under this Article shall collect and pay to the Commissioner a sum equal to five percent (5%) of the gross premiums charged, less any return premiums, for surplus lines insurance provided by the licensee pursuant to the license. Where the insurance covers properties, risks, or exposures located or to be performed both in and out of this State, the sum payable shall be computed based on (i) an amount equal to five percent (5%) on that portion of the gross premiums allocated to this State pursuant to subsection (f) of this section, plus (ii) an amount equal to the portion of the premiums allocated to other states or territories on the basis of the tax rates and fees applicable to properties, risks, or exposures located or to be performed outside of this State pursuant to subsection (f) of this section, less (iii) the amount of gross premiums allocated to this State and returned to the insured. The tax on any portion of the premium unearned at termination of insurance having been credited by the State to the licensee shall be returned to the policyholder directly by the surplus lines licensee or through the producing broker, if any. The surplus lines licensee is prohibited from rebating, for any reason, any part of the tax. The Commissioner is authorized to participate in the clearinghouse established through the NAIC Nonadmitted Insurance Multi-State Agreement, or any successor agreement, for the purpose of collecting and disbursing to reciprocal states any funds collected pursuant to clause (ii) above applicable to properties, risks, or exposures located or to be performed outside of this State. To the extent that other states where portions of the properties, risks, or exposures reside have failed to enter into a compact or reciprocal allocation procedure with this State, the net premium tax collected shall be retained by this State.

(b) At the same time that he files his quarterly report as set forth in G.S. 58-21-80, each surplus lines licensee shall pay the premium receipts tax due for the period covered by the report.

(c) This section does not apply to risks of State government agencies nor to risks of local government risk pools created and operating under Article 23 of this Chapter.

(d) The surplus lines licensee placing the insurance and claiming the exemption in subsection (c) of this section shall affirmatively show in writing to the Commissioner that the risk qualifies for the exemption.

(e) If a surplus lines policy procured through a surplus lines licensee covers properties, risks, or exposures only partially located or to be performed in this State, the tax due shall be computed on the portions of the premiums that are attributable to the properties, risks, or exposures located or to be performed in this State. In determining the amount of premiums taxable in this State, all premiums written, procured, or received in this State shall be considered written on properties, risks, or exposures located or to be performed in this State, except premiums that are properly allocated or apportioned and reported as taxable premiums of a reciprocal state. In no event shall the tax payable to this State be less than the tax due pursuant to subsection (f) of this section; provided, however, if the amount of tax due under this provision is less than fifty dollars ($50.00) in any jurisdiction, it shall be payable in the jurisdiction in which the statement required in G.S. 58-21-35(a)(7a) is filed.

The Commissioner shall, at least annually, furnish to the insurance regulator of a reciprocal state a copy of all filings reporting an allocation of taxes as required by this subsection.

(f) In determining the amount of gross premiums taxable in this State for a placement of surplus lines insurance covering properties, risks, or exposures only partially located or to be performed in this State, the tax due shall be computed on the portions of the premiums that are

attributable to properties, risks, or exposures located or to be performed in this State and that relates to the kinds of insurance being placed as determined by reference to an allocation schedule, which shall be adopted by the Commissioner in a rule.

(g) If a policy covers more than one of the following classifications:

(1) For any portion of the coverage identified by a classification on the allocation schedule, the tax shall be computed by using the allocation schedule for the corresponding portion of the premium.

(2) For any portion of the coverage not identified by a classification on the allocation schedule, the tax shall be computed by using an alternative equitable method of allocation for the property or risk.

(3) For any portion of the coverage where the premium is indivisible, the tax shall be computed by using the method of allocation that pertains to the classification describing the predominant coverage.

(h) If the information provided by the surplus lines licensee is insufficient to substantiate the method of allocation used by the surplus lines licensee, or if the Commissioner determines that the licensee's method is incorrect, the Commissioner shall determine the equitable and appropriate amount of tax due to this State as follows:

(1) By the use of the allocation schedule where the risk is appropriately identified in the schedule.

(2) Where the allocation schedule does not identify a classification appropriate to the coverage, the Commissioner may give significant weight to documented evidence of the underwriting bases and other criteria used by the insurer. The Commissioner may also consider other available information to the extent sufficient and relevant, including the percentage of the insured's physical assets in this State, the percentage of the insured's sales in this State, the percentage of income or resources derived from this State, and the amount of premium tax paid to another jurisdiction for the policy.

(i) For the purposes of carrying out the Nonadmitted and Reinsurance Reform Act of 2010, the Commissioner is authorized to enter the NAIC Nonadmitted Insurance Multi-State Agreement in order to facilitate the collection, allocation, and disbursement of premium taxes attributable to the placement of nonadmitted insurance; provide for uniform methods of allocation and reporting among nonadmitted insurance risk classifications; and share information among states relating to nonadmitted insurance premium taxes."

SECTION 10. G.S. 58-28-5(b) reads as rewritten:

"(b) Any person in this State may directly procure or directly renew insurance with an eligible surplus lines insurer, as defined in G.S. 58-21-10(3), without the involvement of an agent, broker, or surplus lines licensee, on a risk located or to be performed, in whole or in part, in this State. The person shall, within 30 days after the date the insurance is procured or renewed, file a written report with the Commissioner on forms prescribed by the Commissioner. The report must contain the name and address of the insured; name and address of the insurer; the subject of insurance; a general description of the coverage; the amount of premium currently charged; and any additional information requested by the Commissioner. The report must also contain an affidavit of the insured that states that the full amount or kind of insurance cannot be obtained from insurers that are licensed to do business in this State; and that the insured has made a diligent search among the insurers that are licensed to transact and are actually writing the particular kind and class of insurance in this State. Gross premiums charged for the insurance, less any return premiums, are subject to a tax at the rate of five percent (5%). At the time of filing the report required by this subsection, the insured shall pay the tax to the Commissioner. All of the provisions in Article 21 of this Chapter relating to apportionment of premium taxes when there are multistate risks apply to the payment of the

premium tax in this subsection. The Commissioner has the powers specified in G.S. 58-21-90 with respect to the tax levied by this subsection."

SECTION 11. This act becomes effective June 1, 2011.

Talking Point - HB 299

This bill has two main purposes: (1) To conform our law to the new federal law (Frank-Dodd Act). We always do that. It makes it easier for folks doing business here to have our law conform to the federal law. There is no opposition. (2) To try to save the state from losing any revenue on surplus lines premium tax. The new federal law says that now 100% of the tax due is paid to the Insured's home state...that means NC could lose a lot of revenue. Exactly how much we don't know. Folks here think it could be in the millions. We can get some of that revenue back if we join a compact or agreement with other states that set an agreement for how it should be shared. The issue is...it is still early and not many states have joined either of the two compacts proposed...NC should get the best deal possible and that means joining a compact that has the most states in it...particularly the most states who will pay the most to NC. A handful of lobbyists have been hired to lean on the GA to go with one of the compacts over the other...they agree it is too early to tell which is the best deal for NC...So...the bill would allow the Commissioner the authority to make the choice for now, but will order a study commission to study it further and report back to the short session. The Commissioner really doesn't have a dog in the fight...the revenue goes to the General Fund, not to the DOI. The statute just puts the responsibility on DOI to collect the tax and turn it over to the General Fund.

HB 299 SB 321 Surplus Lines bill

"Surplus Lines" insurance is a line of insurance provided by insurers not licensed in the state. These non-admitted insurers write insurance on risks who cannot obtain coverage from admitted insurers...(they usually write insurance on risks other insurance companies are not willing to insure...for example...a dynamite factory...or, more common:...nursing homes...)(These companies are not admitted to do business in the states, but they are authorized to do so).

The Dodd-Frank Financial Reform Act is a major financial reform law passed by Congress. It included surplus lines insurance reforms that attempt to make the regulation of the surplus lines market in the various states more efficient and more uniform on a national basis.

The new law is expected to increase the level of efficiency in purchasing surplus lines insurance for all those involved in the surplus lines transaction..from the insurance company to the consumers.

That is a good intention but, unfortunately, the law included a provision that says that beginning on July 21, 2011, the surplus lines brokers are to pay the state of the "insured's principal place of business" AKA, the "Home State" all of the surplus lines tax from all the business that surplus lines company does all around the country. This was done to make it easier for surplus lines brokers who were having to figure out where to pay the tax. As the law is now, North Carolina collects 5% of about 500 million, or about $25 million dollars per year.

The federal law left it up to the states to work out amongst them how the tax will be divided up among the states. One purpose of this bill is to get the state involved in a plan to keep our share of this revenue.

We anticipate NC may lose a significant amount of revenue beginning in July 2011, unless a state fix is made in time. It would be good if NC were able to maintain the status quo in what we collect.

The proposed bill also makes conforming changes to our state law to reflect the changes made by the federal law and it gives the Commissioner the

authorization to enter into an agreement with other states to try to resolve the tax revenue issue...whether this will be through a clearinghouse operated by the NAIC or compact among states. The federal law takes effect July 21, 2011, but many states have not acted yet to determine which compact or agreement, if any, they will enter. North Carolina would benefit most from being in the compact or agreement that the most states, particularly the states from which we receive the most money, join. We will not know that until more time passes.

DETAILED SUMMARY OF HB 299/SB 321

Section 1.

58-21-3 Cooperative or interstate agreements. This section authorizes the Commissioner to enter into a cooperative or interstate agreement or compact to establish alternative nationwide eligibility requirements for nonadmitted insurers domiciled in other states and to facilitate the collection, allocation and disbursement of premium taxes among states. This section also gives the Commissioner authority to enter into an interstate compact or agreement.

58-21-4 Nonadmitted and Reinsurance Reform Act duties The federal law (Sec 523) prohibits a state from collecting any fees relating to licensing of an individual or entity as a surplus lines broker unless the State has in effect laws that provide for participation by the State in the national insurance producer database of the NAIC for the licensure of surplus lines brokers and the renewal of those licenses. (the purpose of the law is to make things easier for the brokers and more uniform between the states—instead of each state having different laws and requirements.)

SECTION 1.2 Directs the Revenue laws Study Committee, in cooperation with the Commissioner of Insurance, to study the potential impact that would result from the State's entrance into a nonadmitted insurance interstate agreement and report its findings next year.

Section 2.

58-21-10 Definitions Adds definitions used in the federal law to our statutes.

Section 3.

58-21-11 Home State Adds the definition of "Home State" as it is set out in federal law. Home state refers to the principal place of business of the INSURED...so...if a New York based business does some business in North Carolina, all of the tax will now be paid by the surplus lines broker to New York...it will be up to the agreement reached among the states to figure out how the money from the insurance of the business in North Carolina goes back to North Carolina.

Section 4.

58-21-15 Placement of Surplus Lines Insurance The new federal law provides that the surplus lines insurer only has to be authorized to write the insurance in its domiciliary state. This section reflects that change.

Section 5.

58-21-16 Streamlined application for commercial purchasers The new federal law provides that if a commercial purchaser meets certain conditions, it does not have to comply with state requirements to make a due diligence search to see if the full amount or type of insurance can be obtained from admitted insurers. This section sets out the new exemption and streamlines applications for commercial purchasers. (the broker doesn't have to conduct five diligent searches to see if the policy covers risks in five states, for example)

58-21-17 Placement with alien insurers (In the insurance world "foreign" insurers are insurers from other states. "Alien" insurers are insurers from other countries)

This section of the bill reflects that part of the federal act which says a state can't prohibit a surplus lines broker from placing nonadmitted insurance with or getting it from a nonadmitted insurer domiciled outside the US as long as the company is listed on the NAIC list of Alien Insurers.

Section 6.

58-21-20(a) The federal Act provides that the states can only use eligibility criteria that is set forth in the NAIC Nonadmitted Insurance Model Act (Sections 5A(2) and 5C(2)(a) for US surplus lines insurers.

The changes to this section reflect this new federal requirement by striking our current standards and establishing that the greater of the state's minimum capitalization requirements for surplus lines eligibility or $15 million are the capitalization standards for surplus lines insurer eligibility. The bill allows the Commissioner to allow a lesser amount of capitalization under certain circumstances, but no less than 4.5 million.

Section 7.

58-21-35 Conforming changes to reflect the changes caused by the new law

Section 8.

58-21-65(a) This change reflects the change in the federal law that declares that only an insured's home state may require a surplus lines broker to be licensed to conduct non-admitted business with respect to such insured.

Section 9. Revise definition of "Risk Retention Group" based on the definition in the US Code.

ATTACHMENT V

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. PCS

H. B. No. 299 DATE 4/26/11

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

COMMITTEE SUBSTITUTE _____

(Rep.) Dockham
Sen.)

moves to amend the bill on page 2, line 12

( ) WHICH CHANGES THE TITLE

by deleting the word "State." and substituting the following "State and the most cost-efficient method of administering the collection and distribution of tax revenues."

SIGNED Jerry Dockham

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

2011 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

By Representative Dockham (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 578 A BILL TO BE ENTITLED AN ACT TO EXEMPT HEALTH CARE SHARING ORGANIZATIONS FROM THE HEALTH INSURANCE REGULATORY LAWS.

☒ 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.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 578*
PROPOSED COMMITTEE SUBSTITUTE H578-PCS70190-RG-10

Short Title: Health Care Sharing Organizations. (Public)

Sponsors:

Referred to:

April 4, 2011

A BILL TO BE ENTITLED

AN ACT TO EXEMPT HEALTH CARE SHARING ORGANIZATIONS FROM THE HEALTH INSURANCE REGULATORY LAWS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 49 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-49-12. Exceptions to jurisdiction; health care sharing organizations.**

A health care sharing organization shall not be subject to the jurisdiction of the Commissioner and shall not be considered to be engaging in the business of providing health care benefits, as long as the health care sharing organization does the following:

(1) Maintains nonprofit entity status under the Internal Revenue Code.

(2) Limits its participants to those who share similar interests as defined by the organization.

(3) Provides for the financial or medical needs of a participant through contributions from one participant to another in accordance with criteria established by the health care sharing organization.

(4) Provides amounts that participants may contribute with no assumption of risk or promise to pay among the participants and no assumption of risk or promise to pay by the health care sharing organization to the participants.

(5) Publishes a written monthly statement to all participants that lists the total dollar amount of qualified needs submitted to the health care sharing organization, as well as the amount published or assigned to participants for their contribution.

(6) Provides a written disclaimer on or accompanying all applications and guideline materials distributed by or on behalf of the organization that reads, in substance, as follows:

'NOTICE: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be voluntary. No other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for

medical expenses or whether this organization continues to operate, you are always personally liable for the payment of your own medical bills.'"

SECTION 2. This act becomes effective October 1, 2011.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 578*
PROPOSED COMMITTEE SUBSTITUTE H578-CSRG-10 [v.1]

4/24/2011 3:22:56 PM

Short Title: Health Care Sharing Organizations. (Public)

Sponsors:

Referred to:

April 4, 2011

A BILL TO BE ENTITLED

AN ACT TO EXEMPT HEALTH CARE SHARING ORGANIZATIONS FROM THE HEALTH INSURANCE REGULATORY LAWS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 49 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-49-12. Exceptions to jurisdiction; health care sharing organizations.**

A health care sharing organization shall not be subject to the jurisdiction of the Commissioner and shall not be considered to be engaging in the business of providing health care benefits, as long as the health care sharing organization does the following:

(1) Maintains nonprofit entity status under the Internal Revenue Code.

(2) Limits its participants to those who share similar interests as defined by the organization.

(3) Provides for the financial or medical needs of a participant through contributions from one participant to another in accordance with criteria established by the health care sharing organization.

(4) Provides amounts that participants may contribute with no assumption of risk or promise to pay among the participants and no assumption of risk or promise to pay by the health care sharing organization to the participants.

(5) Publishes a written monthly statement to all participants that lists the total dollar amount of qualified needs submitted to the health care sharing organization, as well as the amount published or assigned to participants for their contribution.

(6) Provides a written disclaimer on or accompanying all applications and guideline materials distributed by or on behalf of the organization that reads, in substance, as follows:

"NOTICE: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be voluntary. No other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for

medical expenses or whether this organization continues to operate, you are always personally liable for the payment of your own medical bills.'"

SECTION 2. This act becomes effective October 1, 2011.

HOUSE BILL 578:
Health Care Sharing Organizations

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	April 25, 2011
Introduced by:	Reps. Murry, Dockham, Barnhart	**Prepared by:**	Tim Hovis
Analysis of:	PCS to First Edition H578-CSRG-10		Committee Counsel

SUMMARY: House Bill 578 adds a new section to Chapter 58 of the General Statutes governing insurance to exempt health care sharing organizations from the jurisdiction of the Commissioner of Insurance. To qualify as a heath care sharing organization, an organization must satisfy the following requirements:

- Maintain nonprofit entity status
- Limit its participants to persons sharing similar interests
- Provide for the financial or medical needs of its participants through participant contributions
- Provide amounts that participants may contribute with no assumption of risk or promise to pay among the participants
- Assume no risk or promise to pay to its participants
- Publish a written monthly statement to all participants listing the total dollar amount of qualified needs and the amount assigned to its participants for their contribution
- Provide a written disclaimer on or accompanying all applications and guideline materials that reads, in substance, as follows:

> NOTICE: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be voluntary. No other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally liable for the payment of your own medical bills.

The Proposed Committee Substitute makes a technical correction to the statutory number of the new section.

EFFECTIVE DATE: House Bill 578 becomes effective October 1, 2011.

H578-SMRG-14(CSRG-10) v2

HOUSE BILL 578*

Short Title:	Health Care Sharing Organizations.	(Public)
Sponsors:	Representatives Murry, Dockham, and Barnhart (Primary Sponsors). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Insurance.	

April 4, 2011

A BILL TO BE ENTITLED

AN ACT TO EXEMPT HEALTH CARE SHARING ORGANIZATIONS FROM THE HEALTH INSURANCE REGULATORY LAWS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 49 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 55-49-12. Exceptions to jurisdiction; health care sharing organizations.**

A health care sharing organization shall not be subject to the jurisdiction of the Commissioner and shall not be considered to be engaging in the business of providing health care benefits, as long as the health care sharing organization does the following:

(1) Maintains nonprofit entity status under the Internal Revenue Code.

(2) Limits its participants to those who share similar interests as defined by the organization.

(3) Provides for the financial or medical needs of a participant through contributions from one participant to another in accordance with criteria established by the health care sharing organization.

(4) Provides amounts that participants may contribute with no assumption of risk or promise to pay among the participants and no assumption of risk or promise to pay by the health care sharing organization to the participants.

(5) Publishes a written monthly statement to all participants that lists the total dollar amount of qualified needs submitted to the health care sharing organization, as well as the amount published or assigned to participants for their contribution.

(6) Provides a written disclaimer on or accompanying all applications and guideline materials distributed by or on behalf of the organization that reads, in substance, as follows:

'NOTICE: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be voluntary. No other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate,

you are always personally liable for the payment of your own medical bills.'"

SECTION 2. This act becomes effective October 1, 2011.

Prepared Testimony
for
House Insurance Committee
and
Senate Health Care Committee
of
the North Carolina General Assembly

Mr. Chairman. Committee Members. My name is Joe Guarino, and I handle government affairs for the Alliance of Health Care Sharing Ministries. We thank you for considering the bill before you today.

Participants in health care sharing organizations financially assist other participants with large medical expenses providing a result usually provided by health insurance. Due to their voluntary and ministerial nature, these organizations should be recognized in the insurance code as health care sharing organizations and not as health insurance companies.

A health care sharing organization is a health care cost-sharing arrangement among persons of similar and sincerely held beliefs, administered by a not-for-profit religious organization. The cost sharing is accomplished through participants' monthly gifts directed to families in financial distress and not to an insurance reserve fund. In addition to addressing the financial needs of those facing health challenges, these health care sharing organizations also seek to help meet spiritual and emotional needs as a part of the sense of community which exists among participants.

Nationally, health care sharing organizations serve more than 110,000 individuals in all 50 states. In North Carolina, approximately 3,800 individuals participate.

This bill is before you today because overzealous insurance regulators occasionally attempt to subject health care sharing organizations to the same requirements as insurance companies. It is impossible to meet such standards without destroying the voluntary, ministerial nature of these organizations. Fighting the regulators in court is extremely expensive and strains the finances of the health care sharing organizations' participants who are already a financially stressed segment of the population. The uncertainty created by such litigation can also harm the functioning of the organizations.

In terms of consumer protection, health care sharing organizations are under the oversight and general regulation of both the Internal Revenue Service and the State's Attorney General's offices since they are 501(c)(3) charities. The bill would require that all applicants be provided an explicit written warning that health care sharing organizations are not insurance and that there are no guarantees, which is in addition to similar wording that all major health care sharing organizations already include in their application forms and materials.

Health care sharing organizations should not be subject to the additional requirements of the state insurance code, which should specifically recognize them as charitable organizations and not insurance since they engage in voluntary sharing and not a contractual transfer of risk. The public good would be served by explicitly acknowledging this through a specific exemption in the state's insurance code to avoid uncertainty and unnecessary waste of legal expenses.

Vote for HB 578: Health Care Sharing Organizations Should be Exempt from Health Insurance Regulatory Laws

HEALTH CARE SHARING ORGANIZATIONS DEFINED: Health care sharing organizations are non-profit organizations that facilitate sharing the medical needs of their participants through contributions from one participant to another. They involve no assumption of risk or promise to pay among the participants, and no assumption of risk or promise to pay by the health care sharing organization to the participants. Their participants engage in voluntary sharing arrangements without a contractual transfer of risk. They do not constitute insurance.

TREATMENT IN NORTH CAROLINA: Health Care Sharing Organizations have had participants in North Carolina since the mid 1980's, and participating households number approximately 1,215 today. They have never been regulated by the Commissioner of Insurance.

THE PROBLEM: In some states, regulators have taken the position that health care sharing constitutes insurance, even though there is no assumption of risk, there is no guarantee of payment for medical expenses incurred by participants, and there is no pooling of assets.

THE PURPOSE OF HB 578: HB 578 will allow health care sharing organizations to continue serving participants in North Carolina without being regulated by the State as insurance. Health care sharing organizations provide a free-market alternative to consumers who do not wish to be forced to purchase insurance and do not wish to receive government assistance in the form of state Medicaid benefits or high-risk insurance pools. Many of the families participating in health care sharing are eligible to receive Medicaid benefits, but they are relieving taxpayers of that burden through participation in this low-cost solution.

WHAT HB 578 DOES: HB 578 codifies health care sharing organizations and exempts them from the jurisdiction of the Commissioner of Insurance. Under the bill, health care sharing organizations will publish a written monthly statement to all participants that lists the total dollar amount of qualified needs submitted to the health care sharing organization, as well as the amount published or assigned to participants for their contribution. The bill also requires health care sharing organizations to provide a written disclaimer to participants that the organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor its plan of operation is an insurance policy.

HEALTH CARE SHARING IN OTHER STATES: Eleven states have already exempted health care sharing organizations from their insurance codes: Florida, Iowa, Kansas, Kentucky, Maryland, Missouri, Oklahoma, Pennsylvania, Utah, Virginia, and Wisconsin. A 1998 Iowa State Supreme Court decision affirmed that health care sharing is not insurance. The Patient Protection and Affordable Care Act of 2010 ("Obamacare") allows two exemptions from the federal mandate to purchase health insurance; one of those two exemptions is for participants in health care sharing organizations.

For more information please contact Tami Fitzgerald, tamilfitzgerald@gmail.com, (919) 349-3655.

ALLIANCE OF HEALTH CARE SHARING MINISTRIES

...because faith, liberty, and charity are essential to effective health care

HEALTHCARESHARING.ORG

MINUTES

HOUSE COMMITTEE ON INSURANCE

May 10, 2011

The House Committee on Insurance met in Room 1228 of the Legislative Building on May 10, 2011, at 1:00 pm. The following members were present: Representatives Dockham, Chair, Brown, Brubaker, Bryant, Burr, Collins, Crawford, Current, Faison, Floyd, Folwell, Glazier, Hamilton, Howard, Hurley, Insko, Johnson, McElraft, Mills, Murry, Setzer, Shepard, Steen, Stevens, Wainwright, Warren, Wilkins, and Wray. Tim Hovis, Bill Patterson, Kory Goldsmith, and Amy Jo Johnson, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes. (Attachment I)

Representative Dockham, Chair, called the meeting to order at 1:00 pm. He introduced the pages and the Sergeant of Arms staff. (Attachment II)

Representative Dockham requested, since he is the primary sponsor of HB 453 and HB 115 under consideration, Representative Brubaker preside over the meeting.

HB 453, entitled, A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE PLACEMENT AND ISSUANCE OF SALARY PROTECTION INSURANCE UNDER THE SURPLUS LINES ACT. Representative Dockham, the bill sponsor, was recognized to explain the bill. (ATTACHMENT III) Representative Faison moved for a favorable report and recommendation that the bill be re-referred to the Committee on Finance. The motion passed.

HB 115, entitled, A BILL TO BE ENTITLED AN ACT TO PRESERVE STATE-BASED AUTHORITY TO REGULATE THE NORTH CAROLINA HEALTH INSURANCE MARKET AND TO PREVENT FEDERAL ENCROACHMENT ON STATE AUTHORITY BY ESTABLISHING THE NORTH CAROLINA BENEFIT EXCHANGE. Representative Dockham, bill sponsor, presented a proposed committee substitute. Representative Brown moved for adoption of the committee substitute for discussion. The motion passed. Amy Jo Johnson, Staff Counsel, was recognized to explain the differences in the proposed committee substitute and the original bill. (Attachment III) Representative Dockham was recognized to explain the new proposed committee substitute and a discussion of the bill followed. (Attachment IV)

Representative Insko was recognized to send forth a perfecting amendment (H115-ATK-46 (v.3). (Attachment V) After a brief explanation of the amendment and discussion, Rep. Insko moved to adopt the perfecting amendment and with the majority being in favor, the perfecting amendment was adopted. Rep. Dockham moved to adopt the amendment as perfected, and with the majority being in favor, the amendment was adopted.

Representative Bryant sent forth and amendment H115-ATK-47 (v.6). (Attachment VI) After a brief explanation and discussion of the amendment, Rep. Bryant moved for the adoption of the amendment, and with the majority being in favor, the amendment was adopted.

Representative Insko sent forth and amendment H115-ATK-49 (v.5). (Attachment VII) After a brief explanation and discussion of the amendment, Rep. Insko moved to adopt the amendment. Representative Dockham spoke in opposition of the amendment and asked that members do not support the amendment. With division having been called, the amendment failed.

Representative Murry sent forth and amendment H115-ATK-51 (v.3). (Attachment VIII) After a brief explanation and discussion of the amendment, Rep. Murry moved for the adoption of the amendment, and with the majority being in favor, the amendment was adopted.

Representative Stevens sent forth and amendment H115-ARG-7 (v.3). (Attachment IX) After a brief explanation and discussion of the amendment, Rep. Stevens moved for the adoption of the amendment, and with the majority being in favor, the amendment was adopted.

After a brief statement by Rep. Insko in opposition of HB 115, Representative Dockham moved to roll the amendments into a committee substitute, 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. At the request of Representative Insko a roll call vote was taken. (Attachment X) The motion passed.

There being no further business, the Chair adjourned the meeting at 1:45 pm.

Respectfully submitted,

Jerry C. Dockham

Representative Jerry C. Dockham, Chair

Regina Irwin

Regina Irwin, Committee Assistant

Attachments

AGENDA

HOUSE COMMITTEE ON INSURANCE

May 10, 2011

Room 1228

1:00 pm

OPENING REMARKS

Representative Jerry Dockham, Chairman
Insurance Committee

AGENDA ITEMS

HB 453	**Allow Salary Protection Insurance.**	**Representative Dockham**
HB 115	**North Carolina Health Benefit Exchange.**	**Representative Dockham** **Representative Brubaker** **Representative Wray** **Representative Murry**

ADJOURNMENT

ATTACHMENT I

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

MAY 10, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	Smith Anderson
Amy Whited	NC Med Society
Kevin Rogers	Action NC
Rose Williams	NCDOI
Ben Popken	NCDOI
Julia Lerche	NCDOI
Carla Obiol	NCDOI
Allen Feezor	NCDHHS
Sherman McCoy	Nation Wide
Dean Plunkett	PS
Sarah Lesesne	NCCHCA

VISITOR REGISTRATION SHEET

INSURANCE — MAY 10, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tammy Roberson	TWC
Tony Nichols	Medco
BJ Miller	Moses Cone
Sarah Sanders	NCAA
Lenda Bridges	Capital Health
[illegible]	[illegible]
[illegible]	NFIB
Gary [illegible]	[illegible]
Tara Steinmetz	NCAAN
Lisa Hazuga	NCAAN
Sarah Preston	ACLU/NC

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

MAY 10, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ed Lyons	Citizen Raleigh, NC
Hanna Lyons	citizen Raleigh NC
Ken Melton	K. M. A.
Mike Gunn	NC State AFCEO
JGoodman	NC CHAMBER
Marty Bocock	AHIP
	BCBS
Kathryn Mullin	BLBSNC
K Wright	BCBSNC
	NMSS-NC
Holly Safi	DRNC

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

MAY 10, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Hardin	Manning Fulton
Jerri Bunce	MCC
Matt Gray	NCPC
John Minnick	CSC
Adam Linker	NC Justice Center
Thomas Hardaway	PhRMA
Joanne Stevens	NCNA / Stevens + Assoc.
John Costopoulos	Am. Heart Assoc
GEORGE McCOY	HEMOPHILIA OF NC
Matt Igelman	Hemophilia of NC
Bobbie Dew	AARP

VISITOR REGISTRATION SHEET

INSURANCE — MAY 10, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Annaliese Dolph	bRNC
Ashley Emanuelson	NMSS-NC
Sandy Orving	NC Council of Churches
Bill Phillips	TWC
Emily Grimm	mwc
Dana Sykes	SA

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

MAY 10, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rebecca Whitaker	NCCHCA
Tom Mayfield	AEF
Steve Cline	DHHS
Gus Meyers	small business owner/citizen
JOHN RHODES	CITIZENS WITHOUT A VOICE
Nicole Fisher	John Locke Foundation
Karen Duquette	Civitas
Jennifer Cohen	IFNC
Sara Fender	IFNC
Cynthia Barnett	Christian Science Com on Rel for NC
David Jagelman	Hearing Tech Center

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

MAY 10, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
TERI Gutierrez	NC Assoc. of Health Underwriters
Betsy Vetter	American Heart Assn
Christine Wilson	American Career Society
Steve Mitchell	Astellas
John Bowdish	Astra Zeneca
Barbara Canales	BSCBC
Sandra Stein	Citizen, 905 E Oak Dr, Durham
Lonna Harkrader	OFA, 1320 Shepherd St Durham 27707
Becki Gray	John Locke Foundation
Hubert Olson	NCAHP
Anthony Greco	John Locke Foundation

VISITOR REGISTRATION SHEET

INSURANCE — May 10, 2011

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chuck Stone	SENR
Mitch Lennard	SENR
DANIEL BLUM	TROUTMAN SANDERS

PLEASE PRINT

ATTACHMENT II

HOUSE PAGES

NAME OF COMMITTEE: INSURANCE DATE: May 10, 2011

1. NAME: Anthony Moore

County: Cumberland County

Sponsor: Thom Tillis

2. NAME: Reginald Everette

County: Wilson County

Sponsor: Thom Tillis

3. NAME:

County:

Sponsor:

4. NAME:

County:

Sponsor:

5. NAME:

County:

Sponsor:

SERGEANTS-AT-ARMS

1. Name: Billy Jones

2. Name: Garland Shepheard

3. Name:

4. Name:

5: Name:

2011 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

By Representative Dockham (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 453 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE PLACEMENT AND ISSUANCE OF SALARY PROTECTION INSURANCE UNDER THE SURPLUS LINES ACT.

☒ 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 _____.

HOUSE BILL 453

Short Title:	Allow Salary Protection Insurance.	(Public)
Sponsors:	Representative Dockham (Primary Sponsor). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Insurance.	

March 24, 2011

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE PLACEMENT AND ISSUANCE OF SALARY PROTECTION INSURANCE UNDER THE SURPLUS LINES ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-21-10 reads as rewritten:

"**§ 58-21-10. Definitions.**

As used in this Article:

(1) "Admitted insurer" means an insurer licensed to do an insurance business in this State.

(2) "Capital", as used in the financial requirements of G.S. 58-21-20, means funds paid in for stock or other evidence of ownership.

(3) "Eligible surplus lines insurer" means a nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance under G.S. 58-21-20.

(4) "Export" means to place surplus lines insurance with a nonadmitted insurer.

(5) "Nonadmitted insurer" means an insurer not licensed to do an insurance business in this State. This definition includes insurance exchanges authorized under the laws of various states.

(6) "Producing broker" means an agent or broker licensed under Article 33 of this Chapter who deals directly with the party seeking insurance and who may also be a surplus lines licensee.

(6a) "Salary protection insurance" means insurance against financial loss caused by the cessation of earned income because of disability from sickness, ailment, or bodily injury.

(7) "Surplus", as used in the financial requirements of G.S. 58-21-20, means funds over and above liabilities and capital of the company for the protection of policyholders.

(8) "Surplus lines insurance" means any insurance in this State of risks resident, located, or to be performed in this State, permitted to be placed through a surplus lines licensee with a nonadmitted insurer eligible to accept such insurance, ~~other than~~ including salary protection insurance. The term does not include reinsurance, commercial aircraft insurance, wet marine and transportation insurance, insurance independently procured pursuant to G.S. 58-28-5, life and accident or health insurance, and annuities.

(9) "Surplus lines licensee" means a person licensed under G.S. 58-21-65 to place insurance on risks resident, located, or to be performed in this State with nonadmitted insurers eligible to accept such insurance.

(10) "Wet marine and transportation insurance" means:

a. Insurance upon vessels, crafts, hulls and of interests therein or with relation thereto;

b. Insurance of marine builder's risks, marine war risks and contracts of marine protection and indemnity insurance;

c. Insurance of freights and disbursements pertaining to a subject of insurance coming within this subsection; and

d. Insurance of personal property and interests therein, in the course of exportation from or importation into any country, or in the course of transportation coastwise or on inland waters including transportation by land, water, or air from point of origin to final destination, in connection with any and all risks or perils of navigation, transit or transportation, and while being prepared for and while awaiting shipment, and during any delays, transshipment, or reshipment incident thereto."

SECTION 2. Article 21 of Chapter 58 is amended by adding a new section to read:

"**§ 58-21-22. Limitation on amount of salary protection insurance.**

When salary protection insurance benefits are payable to an individual or an individual's beneficiary, the amount of salary protection insurance plus the amount of any in-force disability income insurance, if the individual can obtain disability insurance from an admitted insurer, shall not exceed seventy-five percent (75%) of the individual's annual earned income. As used in this section, "disability income insurance" has the same meaning as "accident and health insurance" in G.S. 58-7-15(3)."

SECTION 3. This act becomes effective October 1, 2011.

HOUSE BILL 453:
Allow Salary Protection Insurance

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	April 24, 2011
Introduced by:	Rep. Dockham	**Prepared by:**	Kory Goldsmith Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***House Bill 453 would allow a new type of surplus lines insurance, called "salary protection insurance" to be offered in North Carolina. Salary protection insurance would insure against financial loss caused by cessation of earned income due to disability from sickness, ailment, or bodily injury. The amount of benefits available to a beneficiary from the salary protection insurance plus the amount of any disability insurance may not exceed seventy-five percent (75%) of the individual's annual earn income.***

Because the bill would create a new type of insurance subject to the premium receipts tax (G.S. 58-21-85), the bill must be re-referred to House Finance.

CURRENT LAW: Surplus lines insurance coverage is coverage that is not available from insurers licensed in the State, referred to as admitted insurers. This coverage must instead be purchased from insurers who are not licensed in this State, referred to as non-admitted insurers.

State law does not currently allow for the sale of salary protection insurance by non-admitted insurers. G.S. 58-51-130 governs the standards for disability income insurance policies offered by admitted insurers.

G.S. 58-21-85 provides that gross premiums charged for surplus lines insurance are subject to a premium receipts tax of five percent (5%),

BILL ANALYSIS:

Section 1 amends G.S. 58-21-10 (Definitions) to create "Salary protection insurance". It is defined as "insurance against financial loss caused by cessation of earned income because of disability from sickness, ailment, or bodily injury." Section 1 also makes conforming changes to other definitions.

Section 2 adds a new statutory section to Chapter 58 (G.S. 58-21-22) which limits the benefits payable to an individual who is the beneficiary a salary protection insurance policy. The total amount of benefits from the salary protection insurance, plus the total amount of benefits from any in-force disability income insurance policy obtained from an admitted insurer, could not exceed seventy-five percent (75%) of the insured's annual earned income. Disability income insurance from an admitted insurer is "insurance against death or personal injury by accident or by any specified kinds of accident and insurance against sickness, ailment or bodily injury."

EFFECTIVE DATE: The act becomes effective October 1, 2011.

H453-SMRC-19(e1) v3

ATTACHMENT III

TALKING POINTS - HOUSE BILL 453 - ALLOW SALARY PROTECTION INSURANCE

ADMITTED MARKET DISABILITY INSURANCE:

... THE ADMITTED INSURANCE MARKET, DISABILITY INSURANCE IS GENERALLY LIMITED TO 60% OF LOST INCOME (WITH A MAXIMUM BENEFIT OF $15,000/MONTH, REGARDLESS OF LOST INCOME). THIS LEAVES A DEVASTATING FINANCIAL GAP IF HIGH INCOME EARNER IS UNABLE TO WORK. MANY HIGH INCOME EARNERS ARE UNINSURABLE IN THE ADMITTED MARKET BECAUSE OF HIGH-RISK OCCUPATIONS.

SALARY PROTECTION INSURANCE:

THIS PRODUCT DOES NOT IMPACT ADMITTED MARKET DISABILITY INSURANCE. IT IS NOT DESIGNED TO COMPETE WITH ADMITTED MARKET BUT TO EITHER (I) SUPPLEMENT ADMITTED DISABILITY COVERAGE OR (II) PROVIDE SALARY PROTECTION FOR THOSE DEEMED UNINSURABLE BY THE ADMITTED MARKET. IT IS AN ADDITIONAL LAYER OF INSURANCE DESIGNED TO CLOSE THE GAP BETWEEN ACTUAL LOST INCOME AND BENEFITS PAID BY ADMITTED DISABILITY INSURANCE PRODUCTS.

CURRENTLY, PURCHASERS OF THIS COVERAGE ARE BUYING IT OUTSIDE OF NORTH CAROLINA AND THE PREMIUM TAX BENEFITS THE STATE WHERE IT IS WRITTEN. SURPLUS LINES INSURANCE WRITTEN IN NORTH CAROLINA IS TAXED AT 5% AND PREMIUM TAXES GO INTO THE GENERAL FUND.

WHY NOW IN NORTH CAROLINA?

- THE SPORTS LANDSCAPE IN NORTH CAROLINA HAS CHANGED DRASTICALLY OVER THE PAST TWO DECADES. WE NOW HAVE NASCAR, PROFESSIONAL HOCKEY, PROFESSIONAL FOOTBALL, PROFESSIONAL BASKETBALL AND PROFESSIONAL SOCCER IN OUR STATE. WE HAVE SEVERAL MINOR LEAGUE BASEBALL TEAMS SENDING PLAYERS INTO THE MAJOR LEAGUES. MANY OF THESE PLAYERS ARE SIGNING MULTI-MILLION DOLLAR CONTRACTS. NORTH CAROLINA'S PUBLIC AND PRIVATE COLLEGES AND UNIVERSITIES ALSO PRODUCE MANY ATHLETES WHO GO ON TO HIGH-INCOME CAREERS IN THE SPORTS MENTIONED ABOVE, PLUS GOLF, SWIMMING, AND TENNIS.

- NORTH CAROLINA'S BUSINESS CLIMATE HAS CHANGED. OUR STATE IS HOME TO MANY HIGHLY COMPENSATED EXECUTIVES AND HIGH INCOME EARNERS WHO ARE UNABLE TO OBTAIN THE COVERAGE NEEDED TO REPLACE INCOME IN THE EVENT AN ACCIDENT LEAVES THEM UNABLE TO WORK.

- THE PROJECTED POPULATION GROWTH OF OUR STATE AND THE RESULTING INCREASE IN THE NUMBER OF HIGH INCOME EARNERS AND PROFESSIONAL SPORTS FRANCHISES CREATE A GROWING DEMAND FOR THIS PRODUCT.

EXAMPLE:

AN EXECUTIVE FOR A LARGE COMPANY IN CHARLOTTE EARNS $600,000 PER YEAR, OR $50,000 PER MONTH. AFTER YEARS OF EARNING AT THIS HIGH LEVEL, THE CASH NEEDS OF THIS EXECUTIVE'S FAMILY ARE COMMENSURATE WITH HIS OR HER INCOME. THE EXECUTIVE PURCHASES THE MAXIMUM AMOUNT OF DISABILITY COVERAGE AVAILABLE IN THE ADMITTED MARKET IN NORTH CAROLINA. THE EXECUTIVE IS INJURED IN AN AUTOMOBILE

ACCIDENT, THROUGH NO FAULT OF HIS OWN, AND IS UNABLE TO WORK. HIS DISABILITY INSURANCE REPLACES ONLY $15,000 PER MONTH.

STATISTICALLY, THE EXECUTIVE NEEDS 65% OF HIS INCOME REPLACED, $32,500 PER MONTH, IN ORDER TO MEET HIS FINANCIAL OBLIGATIONS. HIS CURRENT COVERAGE LEAVES A GAP OF $17,500 PER MONTH.

SALARY PROTECTION INSURANCE WOULD PROVIDE A LAYER OF COVERAGE IN ADDITION TO THE ADMITTED MARKET COVERAGE THAT WOULD ALLOW THE EXECUTIVE TO COVER UP TO 75% OF HIS LOST INCOME, OR $37,500 PER MONTH. OR, IN THE EVENT THE EXECUTIVE WAS UNABLE TO OBTAIN DISABILITY COVERAGE IN THE ADMITTED MARKET, SALARY PROTECTION INSURANCE WOULD COVER THE ENTIRE 75% OF LOST INCOME.

2011 COMMITTEE REPORT

HOUSE OF REPRESENTATIVES

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

By Representative Dockham (Chair) for the Committee on INSURANCE.

☒Committee Substitute # 1 for

HB 115 A BILL TO BE ENTITLED AN ACT TO PRESERVE STATE-BASED AUTHORITY TO REGULATE THE NORTH CAROLINA HEALTH INSURANCE MARKET AND TO PREVENT FEDERAL ENCROACHMENT ON STATE AUTHORITY BY ESTABLISHING THE NORTH CAROLINA BENEFIT EXCHANGE.

☒ 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.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 115
Committee Substitute Favorable 3/30/11
PROPOSED COMMITTEE SUBSTITUTE H115-CSTK-8 [v.9]

4/18/2011 4:37:32 PM

Short Title: North Carolina Health Benefit Exchange. (Public)

Sponsors:

Referred to:

February 17, 2011

A BILL TO BE ENTITLED

AN ACT TO PRESERVE STATE-BASED AUTHORITY TO REGULATE THE NORTH CAROLINA HEALTH INSURANCE MARKET AND TO PREVENT FEDERAL ENCROACHMENT ON STATE AUTHORITY BY ESTABLISHING THE NORTH CAROLINA BENEFIT EXCHANGE.

The General Assembly of North Carolina enacts:

SECTION 1. The purpose of this act is to provide for the establishment of the North Carolina Health Benefits Exchange Authority (Exchange Authority). The purpose of the Exchange Authority is to facilitate the purchase and sale of qualified health plans in the individual and small employer market by providing education, outreach, and technical assistance. The General Assembly believes it is in the best interest of the State, and thus the purpose of the Exchange Authority, to promote competition and choice in the health care marketplace and to facilitate innovation by offering products with variation in price and design. The Exchange Authority shall accomplish its purpose through a robust portal that provides meaningful guidance to health benefit plans that meet the needs of the health care marketplace of this State and not through the limitations of health benefit plan options to qualified individuals or qualified employers or by excluding health benefit plans who meet the premium and solvency requirements approved by the North Carolina Department of Insurance. In establishing the Exchange Authority, it is the intent of the General Assembly to reduce the number of uninsured individuals in this State, promote improved competition in the health care marketplace, reduce health care costs by, among other things, improving reimbursements to health care providers for uncompensated care, increasing consumer education, increasing transparency, and assisting individuals and employers in accessing health coverage, premium tax credits, and cost-sharing reductions.

SECTION 2. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 8. North Carolina Health Benefit Exchange Act.

"**§ 58-50-300. Definitions.**

The following definitions apply to this Part:

(1) Agent. – Defined in G.S. 58-33-10(1).

(2) Board. – The Board of Directors of the North Carolina Health Benefit Exchange Authority.

(3) Broker. – Defined in G.S. 58-33-10(3).

(4) Commissioner. – The Commissioner of Insurance of North Carolina or the Commissioner's authorized designee.

(5) Educated Health Care Consumer. – An individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical, and scientific matters.

(6) Essential Health Benefits. – Defined under section 1302(b) of the Federal Act.

(7) Exchange Authority. – The North Carolina Health Benefit Exchange Authority established pursuant to G.S. 58-50-310 and includes the Individual Exchange and the SHOP Exchange, unless otherwise specified.

(8) Executive Director. – The individual selected by a majority vote of the Board members and hired to serve as the Executive Director of the Exchange Authority.

(9) Federal Act. – The federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as further amended, as well as any regulations or guidance issued under those acts.

(10) Grandfathered Health Plan Coverage or Grandfathered Health Plan. – Defined in 45 C.F.R. Part 147.140(a).

(11) Health Benefit Plan. – Defined in G.S. 58-3-167(a)(1).

(12) Health Care Provider. – Defined in G.S. 58-50-270(3a).

(13) Health Insurer or Insurer. – Defined in G.S. 58-68-25(a)(6) and, for the purposes of this act, the terms also include qualified nonprofit health insurance issuers (CO-OP Insurers) as provided in section 1322 of the Federal Act, and multistate Qualified Health Plans as provided in section 1334 of the Federal Act.

(14) Individual Exchange. – The Exchange through which Qualified Individuals may purchase coverage established pursuant to this Part.

(15) Navigator. – An individual who is either an employee of or has been licensed by the North Carolina Department of Insurance Consumer Assistance Program in accordance with the standards set forth by the Secretary, as provided in section 1311(i) of the Federal Act; and G.S. 58-50-340(18).

(16) Plan of Operation. – The articles, bylaws, and operating rules and procedures adopted by the Board in accordance with this Part.

(17) Qualified Dental Plan. – A limited scope dental plan that has been certified in accordance with G.S. 58-50-350.

(18) Qualified Employer. – A Small Employer that elects to make its full-time employees eligible for one or more Qualified Health Plans offered through the SHOP Exchange, and at the option of the employer, some or all of its part-time employees.

(19) Qualified Health Plan. – A Health Benefit Plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and G.S. 58-50-350.

(20) Qualified Individual. – An individual, including a minor, who meets all of the following requirements:

a. Is seeking to enroll in a Qualified Health Plan offered to individuals through the Individual Exchange.

b. Resides in this State pursuant to G.S. 58-50-175(18).

c. At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges.

d. Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

(21) Secretary. – The Secretary of the federal Department of Health and Human Services.

(22) SHOP Exchange. – The Small Business Health Options Program established in G.S. 58-50-34(13) that is designed to assist Qualified Employers in the State who are Small Employers in facilitating the enrollment of their employees in Qualified Health Plans offered in the small group market in the State.

(23) Small Employer. – An employer as such term is defined in G.S. 58-50-110(22), subject to the requirements of the Federal Act and the Public Health Service Act (PHSA).

"**§ 58-50-310. Exchange established; Board of Directors; Plan of Operation.**

(a) There is hereby created a nonprofit entity to be known as the North Carolina Health Benefit Exchange Authority, which is subject to the supervision of the Commissioner. Notwithstanding that the Exchange Authority may be supported in whole or in part from State or federal funds, the Exchange Authority is not an instrumentality of the State or federal government and shall be operated by the Board. The purpose of the Exchange Authority is to do the following:

(1) Create and administer an Individual Exchange and a SHOP Exchange which shall be operated as two separate health benefit exchanges and shall not be operated as one health benefit exchange.

(2) Facilitate the purchase and sale of Qualified Health Plans to Qualified Individuals and Qualified Employers.

(3) Assist Qualified Individuals in enrollment in Qualified Health Plans and assist Qualified Employers in facilitating the enrollment of their employees in Qualified Health Plans.

(b) There is established the North Carolina Health Benefit Exchange Authority Board. The Board shall have the duties and powers as established by this section.

(1) The North Carolina Health Benefit Exchange Authority Board shall consist of the Commissioner of Insurance, the Director of the Division of Medical Assistance, who shall both serve as ex officio nonvoting members of the Board, and 11 additional members appointed as follows:

a. Four members appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, as follows:

1. One member who represents the medical provider community, as recommended by the North Carolina Medical Society.

2. One member who represents an insurer, and is not a licensed health insurance agent, as recommended by the North Carolina Association of Health Plans.

3. One member who represents business, who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider, as recommended by the North Carolina Chamber.

4. One member who represents the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider and shall reasonably be expected to qualify for coverage in the

Individual Exchange or SHOP Exchange. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member.

b. Four members appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, as follows:

1. One member who represents the medical provider community, as recommended by the North Carolina Hospital Association.
2. One member who represents the insurance industry and is not a licensed health insurance agent.
3. One member who represents small business, who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider, as recommended by the National Federation of Independent Business.
4. One member who represents the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider and shall reasonably be expected to qualify for coverage in the Individual Exchange or SHOP Exchange. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member.

c. Three members appointed by the Governor, who do not represent the categories listed in sub-subdivision a. and sub-subdivision b. of this subdivision, as follows:

1. One member, who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider, who has expertise and experience in the development and operation of State-scale information technology systems capable of conducting electronic funds transfers, secure data transfers, and other electronic functions relating to the creation and ongoing operations of the Exchange Authority.
2. One member, who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider, who has expertise and experience in rural health policy, rural health economics, or rural health care finance as recommended by the North Carolina Rural Economic Development Center.
3. One member who has experience and expertise as a licensed health insurance agent in the State of North Carolina, as recommended by the North Carolina Association of Health Underwriters, the National Association of Insurance and Financial Advisors – North Carolina, and the Independent Insurance Agents of North Carolina.

(2) The initial appointments by the General Assembly upon the recommendation of the Speaker of the House of Representatives and the President Pro Tempore of the Senate shall be made no later than 30 days after enactment

of this Part and shall serve a term of three years. The initial appointments by the Governor shall be made no later than 30 days after enactment of this Part and shall be for a term of two years. All succeeding appointments shall be for terms of three years. Members shall not serve for more than two successive terms. A Board member's term shall continue until the member's successor is appointed by the original appointing authority. Vacancies shall be filled by the appointing authority for the unexpired portion of the term in which they occur. A Board member may be removed by the member's appointing authority or by the Commissioner for cause. The Board shall meet at least quarterly upon the call of the chair. A majority of the total membership of the Commission shall constitute a quorum. The Commissioner shall appoint a chair to serve for the initial two years of the Exchange Authority's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms. Board members shall receive travel allowances under G.S. 138-5 when traveling to and from meetings of the Board but shall not receive any subsistence allowance or per diem under subdivision (a)(1) of that section.

(3) The Board shall employ or fix compensation of the Executive Director.

(4) The Board shall appoint appropriate legal, actuarial, and other persons, entities, or committees as necessary to provide technical assistance in the operation, policy, contractual design, and other functions of the Exchange Authority.

(5) The Board shall adopt bylaws, policies, and procedures as may be necessary or convenient.

(6) Each member of the Board shall comply with the conflict of interest rules and recusal procedures set forth in the Plan of Operation.

(7) No member of the Board or staff shall make, participate in making, or in any way attempt to use his or her official position to influence the making of any decision that he or she knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally or on all members of a profession, occupation, industry, or general class, on him or her or a member of his or her immediate family, or which will have reasonably foreseeable material effect on any business entity in which the member or his or her immediate family is director, officer, partner, trustee, employee, or holds any position of management.

(8) Each member of the Board shall have the responsibility and duty to meet the requirements of this Part, the Federal Act, and all applicable State and federal laws, rules, and regulations to serve the public interest of the individuals and employers seeking health care coverage through the Exchange Authority, and to ensure the operational well-being and fiscal solvency of the Exchange Authority.

(c) The Board shall submit to the Commissioner a Plan of Operation for the Exchange Authority and any amendments.

(1) The Commissioner shall review and approve or disapprove the Plan of Operation within 90 days after its submission or resubmission. If the Commissioner fails to act within 90 days of submission, the Plan of Operation shall be deemed approved. If the Commissioner disapproves any part of the Plan of Operation, the Commissioner shall provide specific reasons for the disapproval and provide the Board an opportunity to revise and resubmit the Plan of Operation. The Plan of Operation shall become effective upon approval in writing by the Commissioner. If the Board fails to

submit a Plan of Operation within 180 days after the appointment of the Board that is approved by the Commissioner, or at any time thereafter fails to submit amendments as required by statute or federal law to the Plan of Operation, the Commissioner shall adopt temporary rules necessary to effectuate the provisions of this section. The rules shall continue in force until modified by the Commissioner or superseded by a Plan of Operation submitted by the Board and approved by the Commissioner.

(2) The Plan of Operation shall establish policies and procedures for operation of the Exchange Authority, including, but not limited to, the following:

a. Process by which the Board sets policies and conducts business, including bylaws.

b. Process for certifying Qualified Health Plans.

c. Plans for determining the need for and selection of eligible entities with whom to contract for performance of Exchange Authority functions or operations.

d. Fiscal operations of the Exchange Authority, addressing the collection, handling, disbursing, accounting, and auditing of assets and monies of the Exchange Authority and any eligible entity with whom the Exchange Authority contracts.

e. Statement acknowledging the fiduciary duty owed by the Exchange Authority to persons receiving Qualified Health Plan coverage through the Exchange Authority.

f. Process for evaluating the effectiveness of the Executive Director and the overall operations of the Exchange Authority.

g. Provide for conflict of interest rules and recusal procedures that require a Board member to recuse himself or herself from an official matter whenever that matter will have a reasonably foreseeable material effect, distinguishable from its effect on the public generally or on all members of a profession, occupation, industry, or general class, on any Board member, or his or her immediate family member or on any business entity in which the member or his or her immediate family is a direct, officer, partner, trustee, employee, or holds any position of management.

h. Identify an approach for coordinating efforts with the Department of Health and Human Services to fairly allocate administrative costs for eligibility determinations in the Exchange Authority and Medicaid.

i. Provide for other matters as may be necessary or proper for the execution of the Executive Director's powers, duties, and obligations under this act.

j. Appeals processes authorized by this Part, including appeals of tax credit eligibility, cost-sharing subsidy, mandate waiver determination, affordability determinations pursuant to G.S. 58-50-340 and appeals of Insurer noncertification or decertification pursuant to G.S. 58-50-350.

"**§ 58-50-320. Exchange Authority general powers.**

(a) The Exchange Authority shall have the general powers and authority granted under the laws of this State and the specific authority to do all of the following:

(1) Contract with an eligible entity for any of its functions described in this act. For the purposes of this act, an eligible entity has the same meaning as section 1311(f)(3)(B) of the Federal Act.

(2) Take legal action as necessary.

(3) Enter into information-sharing agreements with federal and State agencies and other state exchanges to carry out its responsibilities under this act provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all State and federal laws and regulations.

"**§ 58-50-330. General requirements.**

(a) The Exchange Authority shall make Qualified Health Plans available to Qualified Individuals and Qualified Employers beginning with effective dates on or after January 1, 2014.

(b) The Exchange Authority shall not make available any Health Benefit Plan that is not a Qualified Health Plan. The Exchange Authority shall allow a Health Insurer to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange Authority, either separately or in conjunction with a Qualified Health Plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

(c) The Exchange Authority, or any Insurer offering Qualified Health Plans through the Exchange Authority, shall not impose any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986 without regard to paragraph (1)(C) or (D) thereof) or such coverage has become affordable within the meaning of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

(d) The Exchange Authority may make a Qualified Health Plan available notwithstanding any provision of law that may require benefits other than the Essential Health Benefits specified under section 1302(b) of the Federal Act.

(1) Nothing in this section shall preclude a Qualified Health Plan from including benefits in addition to Essential Health Benefits, including wellness programs.

(2) To the extent that State law or regulation requires that a Qualified Health Plan include benefits in addition to the Essential Health Benefits, the State shall make payments to defray the cost of any additional benefits directly to an individual enrolled in a Qualified Health Plan or on behalf of an individual directly to the Health Insurer in whose Qualified Health Plan such individual is enrolled.

(3) To the extent that funding to defray the cost for such additional benefits is not provided, notwithstanding any requirements in Chapter 58 of the General Statutes, a Health Insurer is not required to include such additional benefits in a Qualified Health Plan, may discontinue such benefits at the time such funding is no longer available, and shall provide written or electronic notice of discontinuation of such benefits to insureds and contracted Health Care Providers as soon as is reasonably practicable. The Exchange Authority shall not require that a Qualified Health Plan provide such additional benefits when funding to defray the cost for such additional benefits is not provided.

(e) Nothing in this Part, and no action taken by the Exchange Authority pursuant to the Part, shall be construed to conflict with, preempt, limit, or supersede any applicable health insurance laws of this State or regulations adopted and orders issued by the Commissioner. Nothing in this Part shall be construed to conflict with, limit, or supersede the statutory or regulatory authority vested with the North Carolina Department of Insurance. Except as expressly provided to the contrary by federal law, Insurers and any other entities or persons participating in the Exchange Authority in this State shall comply fully with all applicable provisions of Chapter 58 of the General Statutes and all related regulations adopted and orders issued by the Commissioner. Participation in the Exchange Authority in any way, including

payment or receipt of payment in relation to a Qualified Health Benefits Plan, does not exempt any Insurer, entity, or person from complying fully with Chapter 58 of the General Statutes and all related regulations adopted and orders issued by the Commissioner.

(f) The Executive Director shall make an annual report to the Governor, Speaker of the House of Representatives, the President Pro Tempore of the Senate, and the Commissioner by March 1 of each year. The report shall summarize the activities of the Exchange Authority in the preceding calendar year, including information about the number and types of plans offered; number of Insurers; summary information about premiums, enrollment levels and enrollment/disenrollment activity, duration of coverage; and cost of operating the Exchange Authority.

(g) Neither the Board nor the employees of the Exchange Authority are liable for any obligations of the Exchange Authority. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the Exchange Authority or its agents or employees, the Board, the Executive Director, or the Commissioner or the Commissioner's representatives for any action taken by them in good faith in the performance of their powers and duties under this Part.

(h) The Exchange Authority, including the Board and its employees, is subject to the provisions of Article 33C of Chapter 143 of the General Statutes.

(i) The Executive Director, with the approval of the Board, shall operate the Exchange Authority in a manner so that the estimated cost of operating the Exchange Authority during any calendar year is not anticipated to exceed the total income the Exchange Authority expects to receive from any revenue available to the Exchange Authority.

(j) The Board shall provide for other matters as may be necessary and proper for the execution of the Executive Director's powers, duties, and obligations under this Part.

(k) All documents, papers, letters, maps, books, photographs, films, sound recordings, magnetic or other tapes, electronic data-processing records, artifacts, or other documentary material, regardless of physical form or characteristics within the possession of the Exchange Authority, including its employees and the Board, are subject to the provisions of Chapter 132 of the General Statutes except to the extent that these public records are protected under State or federal law, or are confidential or proprietary property of a person as defined in G.S. 66-152.

(l) The members of the Board and the Executive Director are public servants under G.S. 138A-3(30) and are subject to the provisions of Chapter 138A of the General Statutes.

"**§ 58-50-340. General duties.**

The Exchange Authority shall do the following:

(1) Facilitate the purchase and sale of Qualified Health Plans.

(2) Assist qualified individuals in this State with enrollment in Qualified Health Plans.

(3) Assist qualified employers in this State with enrollment of their employees in Qualified Health Plans.

(4) Implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and this Part, of health benefit plans as Qualified Health Plans.

(5) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance in a manner that is accessible to individuals with different communication needs and that effectively communicates information in a manner that is appropriate to the needs of the population being served by the Exchange Authority.

(6) Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act.

(7) Maintain an Internet Web site through which enrollees and prospective enrollees of Qualified Health Plans and individuals eligible for Medicaid or North Carolina Health Choice may obtain standardized comparative information on such plans.

(8) Assign a rating to each Qualified Health Plan offered through the Exchange Authority in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act, and determine each Qualified Health Plan's level of coverage in accordance with regulations issued by the Secretary under section 1302(d)(2)(A) of the Federal Act.

(9) Use a standardized format for presenting health benefit options in the Exchange Authority, including the use of the uniform outline of coverage established under section 2715 of the PHSA that supports consumer choice by making comprehensive information about health plans available in an objective, easy-to-understand format.

(10) In accordance with section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act, or any applicable State or local public program and if, through screening of the application by the Exchange Authority, the Exchange Authority determines that any individual is eligible for any such program, enroll that individual in that program.

(11) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act.

(12) Establish an Individual Exchange, through which Qualified Individuals may enroll in any qualified plan offered through the Individual Exchange for which they are eligible.

(13) Establish a SHOP Exchange through which Qualified Employers may make its employees eligible for one or more Qualified Health Plans offered through the SHOP Exchange or through which Qualified Employers may specify a level of coverage so that any of its employees may enroll in any Qualified Health Plan offered through the SHOP Exchange at the specified level of coverage.

(14) Subject to section 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because of either of the following:

a. There is no affordable Qualified Health Plan available through the Exchange Authority, or the individual's employer, covering the individual.

b. The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty.

(15) Transfer to the federal Secretary of the Treasury the following:

a. A list of the individuals who are issued a certification under subdivision (14) of this subsection, including the name and taxpayer identification number of each individual.

b. The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be

eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because of either of the following:

1. The employer did not provide minimum essential coverage.
2. The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code of 1986 to either be unaffordable to the employee or not provide the required minimum actuarial value.

c. The name and taxpayer identification number of the following:

1. Each individual who notifies the Exchange Authority under section 1411(b)(4) of the Federal Act that he or she has changed employers.
2. Each individual who ceases coverage under a Qualified Health Plan during a plan year and the effective date of that cessation.

(16) Provide to each employer the name of each employee of the employer described in sub-sub-subdivision b.2. of subdivision (15) of this subsection who ceases coverage under a Qualified Health Plan during a plan year and the effective date of the cessation.

(17) Perform duties required of the Exchange Authority by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions.

(18) Select Navigators and award grants to enable Navigators to do the following:

a. Conduct public education activities to raise awareness of the availability of Qualified Health Plans.
b. Distribute fair and impartial information concerning enrollment in Qualified Health Plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act.
c. Facilitate enrollment in Qualified Health Plans.
d. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHSA, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their Health Benefit Plan, coverage, or a determination under that plan or coverage.
e. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange Authority.

(19) Take into account any excess of premium growth outside of the Exchange Authority as compared to the rate of such growth inside the Exchange Authority when determining under section 1302(f)(2)(B) of the Federal Act whether to recommend to the General Assembly that Qualified Health Plans be offered in the large group market through the SHOP Exchange.

(20) Consult with stakeholders relevant to carrying out the activities required under this act, including, but not limited to, the following:

a. Educated health care consumers who are enrollees in Qualified Health Plans.
b. Individuals and entities with experience in facilitating enrollment in Qualified Health Plans.

c. Representatives of small businesses and self-employed individuals.
d. Representatives of Health Insurers that offer Qualified Health Plans through the Exchange Authority.
e. Representatives of Health Insurers that are not offering qualified plans through the Exchange Authority.
f. Representatives of Health Care Providers.
g. The Division of Medical Assistance.
h. The North Carolina Department of Insurance.
i. Advocates for enrolling hard to reach populations.

(21) Meet all of the following financial integrity requirements:
a. Keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the Secretary, the Governor, the Commissioner, and the General Assembly a report concerning such accountings.
b. Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Federal Act and allow the Secretary, in coordination with the Inspector General of the U.S. Department of Health and Human Services, to do all of the following:
1. Investigate the affairs of the Exchange Authority.
2. Examine the properties and records of the Exchange Authority.
3. Require periodic reports in relation to the activities undertaken by the Exchange Authority.
c. In carrying out its activities under this act, not use any funds intended for the administrative and operational expenses of the Exchange Authority for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or State legislative and regulatory modifications.

(22) Meet the following fiduciary duties and liability:
a. Any person who acts on behalf of an Exchange Authority shall act as a fiduciary. Such person shall ensure that the Exchange Authority is operated (i) solely in the interests of individuals participating in qualified health plans offered through the Exchange Authority and (ii) for the exclusive purpose of facilitating the purchase of Qualified Health Plans.
b. Any person who acts as a fiduciary on behalf of the Exchange Authority who breaches any of their responsibilities, obligations, or duties imposed by this section shall be liable to make good to the Exchange Authority, the Qualified Health Plans offered through the Exchange Authority, or participants of Qualified Health Plans offered through the Exchange Authority any losses resulting from each breach and shall be subject to such other legal or equitable relief as the court may deem appropriate, including removal of such fiduciary.

(23) With respect to eligibility determinations, provide for (i) review of enrollee appeals of Exchange Authority premium tax credit and cost-sharing reductions and mandate exemption determinations and establish procedures for identifying and confirming income levels of applicants for Exchange Authority coverage and eligibility for receipt of premiums and tax credits

and (ii) employer appeals of employer-sponsored plan availability or affordability determinations.

(24) Conduct a review of the costs and benefits of collecting and distributing premiums for small businesses. No later than January 1, 2015, the Exchange Authority shall report the results of the review, including analysis of the financial impact of such collection and distribution, and its recommendations to the North Carolina General Assembly. The Exchange Authority may implement and carry out a process for collecting and distributing premiums if it has sufficient funding to implement the initiative and upon approval by vote by both chambers of the North Carolina General Assembly.

(25) In conjunction with North Carolina Department of Health and Human Services, study the feasibility of offering a Basic Health Plan pursuant to section 1331 of the Federal Act and make a recommendation to the 2013 Regular Session of the 2013 General Assembly.

(26) Provide for publicity and outreach campaigns to raise awareness of the existence of the Exchange Authority and disseminate information regarding eligibility criteria, enrollment procedures, availability of premium tax credits and cost-sharing reductions, small employer tax credits, and other relevant information.

(27) Consider the extent to and the circumstances under which benefits for spiritual care services that are deductible under Section 213(d) of the Internal Revenue Code of 1986 as of January 1, 2011, will be made available under the Exchange Authority in accordance with Section 1311(d)(3)(B) of the Affordable Care Act.

"**§ 58-50-350. Health Benefit Plan certification.**

(a) The Exchange Authority shall certify a Health Benefit Plan as a Qualified Health Plan if the Department of Insurance determines that it satisfies the requirements set forth in subdivisions (1) through (6) of this subsection unless the Exchange Authority determines that making the plan available through the Exchange Authority is not in the interest of Qualified Individuals and Qualified Employers in this State.

(1) The plan provides the Essential Health Benefits package described in section 1302(a) of the Federal Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of Qualified Dental Plans, as provided in subsection (e) of this section, if both of the following occur:

a. The Exchange Authority has determined that at least one Qualified Dental Plan is available to supplement the plan's coverage.

b. The Insurer makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange Authority, that the plan does not provide the full range of essential pediatric benefits, and that Qualified Dental Plans providing those benefits and other dental benefits not covered by the plan are offered through the Exchange Authority.

(2) The premium rates and insurance policy forms, certifications, applications and riders have been approved by the Commissioner.

(3) The plan provides at least a bronze level of coverage, unless the plan is certified as a qualified catastrophic plan, meets the requirements of section 1302(e) of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage.

(4) The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the Federal Act, and if the plan is offered

through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act.

(5) The Health Insurer offering the plan meets the following requirements:

a. Is licensed and in good standing to offer health insurance coverage in this State.

b. Offers at least one Qualified Health Plan in the silver level and at least one plan in the gold level through each component of the Exchange Authority in which the Insurer participates, where "component" refers to the SHOP Exchange and the Individual Exchange.

c. Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange Authority and without regard to whether the plan is offered directly from the Insurer or through an insurance producer.

d. Does not charge any cancellation fees or penalties in violation of G.S. 58-50-330(c).

e. Complies with the regulations developed by the Secretary under section 1311(d) of the Federal Act and such other requirements as the Exchange Authority may establish.

(6) The plan meets the requirements of certification as promulgated by regulation pursuant to this section and by the Secretary under section 1311(c) of the Federal Act.

(b) The Exchange Authority shall not exclude a health plan through the imposition of premium price controls nor shall it exclude a health plan based on the following:

(1) That the plan is a fee-for-service plan.

(2) That the Health Benefit Plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange Authority determines are inappropriate or too costly.

(c) The Exchange Authority shall require each Health Insurer seeking certification of a plan as a Qualified Health Plan to do the following:

(1) Submit a justification for any premium increase before implementation of that increase. The Insurer shall prominently post such information on its Internet Web site. The Exchange Authority shall take this information, along with the information and the recommendations provided to the Exchange Authority by the Commissioner under section 2794(b) of the PHSA, relating to patterns or practices of excessive or unjustified premium increases, into consideration when determining whether to continue to allow the Insurer to make plans available through the Exchange Authority. In no case shall an Exchange Authority impose any premium price controls or restrict premiums that otherwise meet the requirements of State law.

(2) Make available to the public and submit to the Exchange Authority, the Secretary, and the Commissioner, accurate and timely disclosure of the following:

a. Claims payment policies and practices.

b. Periodic financial disclosures.

c. Data on enrollment.

d. Data on disenrollment.

e. Data on the number of claims that are denied.

f. Data on rating practices.

g. Information on cost-sharing and payments with respect to any out-of-network coverage.

h. Information on enrollee and participant rights under title I of the Federal Act.

i. Other information as determined appropriate by the Secretary.

The information shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act.

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, co-payments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet Web site and through other means for individuals without access to the Internet.

(d) The Exchange Authority shall establish and publish a transparent, objective process for denying certification or decertifying Qualified Health Plans.

(1) The Exchange Authority shall give each Health Insurer the opportunity to appeal a decertification decision or the denial of certification as a Qualified Health Plan.

(2) The Exchange Authority shall give each Health Insurer that appeals a decertification decision or the denial of certification the opportunity for the following:

a. The submission and consideration of facts, arguments, or proposals of adjustment of the health plan or plans at issue.

b. A hearing and a decision on the record, to the extent that the Exchange Authority and the Health Insurer are unable to reach agreement following the submission of the information in sub-subdivision a. of this subdivision.

(3) Any hearing held pursuant to subdivision (2) of this subsection shall be conducted by an impartial party agreed to by the Exchange Authority and the Health Insurer. If the Exchange Authority and the Health Insurer cannot agree on an impartial party, then the hearing must be held by an administrative law judge.

(4) The hearing decision may be appealed to the North Carolina Court of Appeals by the aggrieved party.

(e) The Exchange Authority shall not exempt any Health Insurer seeking certification of a Qualified Health Plan, regardless of the type or size of the Insurer, from State licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among Health Insurers participating in the Exchange Authority.

(1) The provisions of this act that are applicable to Qualified Health Plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of subdivisions (2), (3), and (4) of this subsection or by regulations adopted by the Commissioner.

(2) The Insurer shall be licensed to offer dental coverage but need not be licensed to offer other health benefits.

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by Health Benefit Plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to section 1302(b)(1)(J) of the Federal Act and such other dental benefits as the Exchange Authority or the Secretary may specify by regulation.

(4) Insurers may jointly offer a comprehensive plan through the Exchange Authority in which the dental benefits are provided by an Insurer through a

Qualified Dental Plan and the other benefits are provided by an Insurer through a Qualified Health Plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

"§ 58-50-360. Choice.

(a) In accordance with section 1312(f)(2)(A) of the Federal Act, a Qualified Employer may either designate one or more Qualified Health Plans from which its employees may choose or designate any level of coverage to be made available to employees through the SHOP Exchange.

(b) In accordance with section 1312(b) of the Federal Act, a Qualified Individual enrolled in any Qualified Health Plan may pay any applicable premium owed by such individual to the Health Insurer issuing such Qualified Health Plan.

(c) In accordance with section 1312(c) of the Federal Act, the following risk pools are established:

(1) Individual Market. – A Health Insurer shall consider all enrollees in all health plans other than Grandfathered Health Plans offered by such Insurer in the individual market, including those enrollees who do not enroll in such plans through the Individual Exchange, to be members of a single risk pool.

(2) Small Group Market. – A Health Insurer shall consider all enrollees in all health plans other than Grandfathered Health Plans offered by such Insurer in the small group market, including those enrollees who do not enroll in such plans through the SHOP Exchange, to be members of a single risk pool.

(d) In accordance with section 1312(d) of the Federal Act, this section shall not prohibit either of the following:

(1) A Health Insurer from offering outside of the Individual Exchange or the SHOP Exchange a health plan to a Qualified Individual or a Qualified Employer.

(2) A Qualified Individual from enrolling in, or a Qualified Employer from selecting for its employees, a health plan offered outside of the Exchange Authority.

(e) This section shall not limit the operation of any requirement under State law or regulation with respect to any policy or plan that is offered outside of the Exchange Authority with respect to any requirement to offer benefits.

(f) Nothing in this section shall restrict the choice of a Qualified Individual to enroll or not to enroll in a Qualified Health Plan or to participate in the Individual Exchange.

(g) Nothing in this section shall compel an individual to enroll in a Qualified Health Plan or to participate in the Exchange Authority.

(h) A Qualified Individual may enroll in any Qualified Health Plan, except that in the case of a catastrophic plan described in section 1302(e) of the Federal Act, a Qualified Individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1312(e)(2) of the Federal Act.

(i) Nothing in this act or the Federal Act shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any Health Benefit Plan that is offered outside of the Exchange Authority.

(j) In accordance with section 1312(e) of the Federal Act, the Exchange Authority shall allow Agents or Brokers to do the following:

(1) To enroll Qualified Individuals and Qualified Employers in any Qualified Health Plan offered through the Exchange Authority for which the individual or employer is eligible.

(2) To assist Qualified Individuals in applying for premium tax credits and cost-sharing reductions for any Qualified Health Plan purchased through the Individual Exchange.

(k) Any compensation to Agents and Brokers paid under this Part shall be determined by the insurer.

"**§ 58-50-370. Funding; publication of costs.**

(a) Beginning in 2014, the funding stream that supports the North Carolina Health Insurance Risk Pool shall be utilized to support the operations of the Exchange Authority. Beginning in 2015, the funding stream that supports the North Carolina Health Insurance Risk Pool shall be utilized to support the operations of the Exchange Authority that serve those individuals with incomes less than or equal to four hundred percent (400%) of the federal poverty level and Qualified Employers receiving a tax credit for the purchase of insurance pursuant to the Federal Act. The proportional cost associated with serving individuals with incomes over four hundred percent (400%) of the federal poverty level and the Qualified Employers not receiving a tax credit pursuant to the Federal Act shall be funded by an annual user fee paid by the individual or the employer to the Exchange Authority. The user fee assessed by the Exchange Authority shall be no greater than the anticipated expenses for serving this market for the applicable fiscal year and must be approved by the Commissioner. Additionally, the Exchange Authority is authorized to utilize grant funding for operations, including, but not limited to, grant funding from the Federal Department of Health and Human Services. The Exchange Authority is also authorized to collect and use advertising fees to help support operations of the Exchange Authority.

(b) Prior to the commencement of the 2013 Regular Session of the 2013 General Assembly, the Exchange Authority shall examine its potential operational costs and propose to the General Assembly any additional changes to the funding stream necessary to ensure its solvency. Proposals submitted by the Exchange Authority to ensure the Exchange Authority's solvency shall not include appropriations from the General Fund.

(c) As required by section 1311(d)(5)(A) of the Federal Act, the Exchange Authority shall be self-sustaining by January 1, 2015. A budget for the Exchange Authority shall be prepared by the Exchange Authority and submitted to the Commissioner annually for approval at least 120 days before the beginning of the next fiscal year.

(d) Services performed by the Exchange Authority on behalf of other State or federal programs shall be paid for by those State or federal programs.

(e) Any unspent funding by the Exchange Authority shall be used for future operation of the Exchange Authority or reducing future user fees.

(f) The Exchange Authority shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange Authority, and the administrative costs of the Exchange Authority, on an Internet Web site to educate consumers on such costs. This information shall include information on monies lost to waste, fraud, and abuse.

(g) The Exchange Authority is exempt from any and all State taxes.

"**§ 58-50-380. Audit.**

An audit of the Exchange Authority shall be conducted annually under the oversight of the State Auditor. The cost of the audit shall be reimbursed to the State Auditor from Exchange Authority funds.

SECTION 3. Nothing in this Act shall be construed to interfere with payments to federally qualified health centers. If any item or service covered by a qualified health plan is provided by a federally qualified health center, as defined in section 1905(1)(2)(B) under the Social Security Act 42 U.S.C. 1396d(1)(2)(B), to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or services an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Social Security Act for such item or service.

SECTION 4. Severability. – If any provision of this act is held invalid by a court of competent jurisdiction, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, is repealed. If section 1311 of the federal Patient Protection and Affordable Care Act or the federal Patient Protection and Affordable Care Act in its entirety is repealed or held invalid by a court of competent jurisdiction, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, is repealed. If funding is not provided as set forth in the federal Patient Protection and Affordable Care Act, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, shall not be enforceable.

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

HOUSE BILL 115:
North Carolina Health Benefit Exchange

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	April 18, 2011
Introduced by:	Reps. Dockham, Brubaker, Wray, Murry	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	PCS to Second Edition H115-CSTK-8		

SUMMARY: ***The PCS to House Bill 115 adds a new Part to Article 50 of Chapter 58 of the General Statutes creating the North Carolina Health Benefit Exchange.***

CURRENT LAW: The federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, P.L. 111-152, (hereafter "The ACA") directs that States may set up Health Benefit Exchanges for individuals and small businesses to purchase health insurance. An Exchange for small businesses is known as the Small Business Health Options Program or "SHOP" Exchange. A state is not required to create its own Exchange. If a state does not create its own exchange, the federal government will create one for the state. If the state chooses to create its own Exchange, the Exchange(s) must be functional by 2014, at the time when citizens and legal immigrants will be required to pay a penalty if they do not have qualified health insurance unless they meet specific exemptions. A state's Health Benefit Exchange must ensure that it is nancially self-sufficient beginning January 1, 2015. Section 1311(d) of the ACA outlines certain xchange requirements and functions.

BILL ANALYSIS:

§58-50-300. Definitions. This definition section applies only to the newly created Part 8 of Article 50 of Chapter 58 of the General Statutes.

- A "qualified employer" is a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the SHOP Exchange.
- A "qualified individual" is to be defined as an individual, including a minor, who meets all of the following requirements: is seeking to enroll in a qualified health plan offered to individuals through the Exchange, resides in this State, is not incarcerated at the time of enrollment, other than incarceration pending the disposition of charges, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.
- A "Small employer" is any individual actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than 50 eligible employees, the majority of whom are employed within this State, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists.

8-50-310. Exchange established; board of directors; plan of operation. The Exchange Authority y be supported in whole or in part by State funds but is not an instrumentality of the State. The Exchange Authority is subject to the supervision of the Commissioner of Insurance. This section of the

bill also directs that the Exchange Authority will be operated by the Board of Directors. The Exchange Authority will create two separate Exchanges: the Individual Exchange and the SHOP Exchange.

The Board consists of the following 13 members:

- The Commissioner of Insurance, serving as an ex officio, nonvoting member.
- The Director of the Division of Medical Assistance, serving as an ex officio, nonvoting member.
- Four members appointed by the President Pro Tempore of the Senate:
  - One member who represents the medical provider community, recommended by the North Carolina Medical Society.
  - One member who represents an insurer, and is not a licensed health insurance agent, as recommended by the North Carolina Association of Health Plans.
  - One member who represents business, who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, as recommended by the North Carolina Chamber.
  - One member of the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, who can reasonably be expected to qualify for coverage in the Exchanges.
- Four members appointed by the Speaker of the House of Representatives:
  - One member who represents the medical provider community, as recommended by the North Carolina Hospital Association.
  - One member who represents the insurance industry and is not a licensed health insurance agent.
  - One member who represents small business, who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, as recommended by the National Federation of Independent Business.
  - One member of the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, who can reasonably be expected to qualify for coverage in the Exchanges.
- Three members appointed by the Governor:
  - One member, who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, who has expertise and experience in the development and operation of State-scale information technology systems.
  - One member, who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, who has expertise and experience in rural health policy, rural health economics, or rural health care finance as recommended by the North Carolina Rural Economic Development Center.
  - One member who has expertise and experience as a licensed health insurance agent in this State, as recommended by the North Carolina Association of Health Underwriters, the National Association of Insurance and Financial Advisors – North Carolina, and the Independent Insurance Agents of North Carolina.

Initial appointments are staggered, after which all succeeding appointments will be for three years. Members are not allowed to serve for more than two consecutive terms. A Board member may not influence any decision that might have a material financial effect on him or her or a member of his or her immediate family.

The Board is required to submit to the Commissioner a Plan of Operation for the Exchange. The Plan of Operation will be effective upon written approval of the Commissioner. The Plan of Operation must

nclude policies and procedures for fiscal operations of the Exchange Authority, a statement acknowledging the fiduciary duty owed by the Exchange Authority to persons it services, and an approach to coordinate with DHHS to fairly allocate administrative costs for eligibility determinations in the Exchange Authority and Medicaid.

§ 58-50-320. Exchange Authority general powers. The Exchange Authority has the power and authority to enter into contracts, to take legal action, and to enter into information-sharing agreements with federal and State agencies and other state exchanges.

§ 58-50-330. General requirements. The Exchange Authority will make qualified health plans available January 1, 2014. The Exchange Authority cannot charge a fee if an individual enrolls in another type of minimum essential coverage if that individual has become newly eligible or insurance has become affordable through their employer. A qualified health plan may include benefits above and beyond the essential benefits, and if a state law or regulation requires doing so, the state will make payment to defray the cost. If payments to defray the costs are not made, the insurer is not required to include those additional benefits in their health plans. Nothing in this Part is meant to conflict with or limit any state insurance laws or regulations adopted by the Commissioner. The Exchange Authority is subject to the Public Meetings laws and Public Records laws. Additionally, the members of the Board and the Executive Director are public servants for purposes of the State Ethics Act.

§ 58-50-340. General duties. Among its duties, the Exchange Authority will facilitate the purchase and ıle of qualified health plans, operate a toll-free telephone hotline and an internet web-site, rate qualified ealth plans, inform individuals of eligibility requirements under Medicaid and CHIP and enroll ıdividuals qualifying for those plans, provide pertinent information to the federal Secretary of the Treasury including information regarding exempted individuals and individuals receiving premium tax credits, take into account any excess of premium growth when recommending to the General Assembly whether or not to open the SHOP Exchange to the large group market, and meet financial integrity requirements and fiduciary duty requirements. Additionally, the Exchange Authority shall also conduct a review of costs and benefits of collecting and distributing premiums for small business, as well as study the feasibility of offering a Basic Health Plan and make recommendations on both issues to the General Assembly.

§ 58-50-350. Health Benefit Plan certification. The conditions under which the Exchange Authority will certify a health benefit plan as a qualified health plan include approval of the Commissioner of specific requirements unless the Exchange Authority determines that making the plan available is not in the interest of qualified individuals and employers. Additionally, the Exchange Authority will require each insurer to submit a justification for any premium increases. There are limits as to why the Exchange Authority may exclude a plan. The Exchange Authority is not allowed to impose premium price controls. The Exchange Authority must establish a process for certifying and decertifying claims, including an appeals process.

§ 58-50-360. Choice. There will be two risk pools: one for the Individual Exchange and one for the SHOP Exchange. Both risk pools will consist of all enrollees within that market, including those not rchased on the Exchange. Agents and brokers will be allowed to enroll on the Exchange Authority.

ş 58-50-370. Funding; Publication of costs. The Exchange Authority utilizes the funding stream which currently supports the North Carolina Health Insurance Risk Pool for the operations of the Exchange beginning in 2014. In 2015, that funding stream will support operation of the Exchange

Authority that serves individuals with incomes less than 400% of the federal poverty level as well as qualified employers receiving a tax credit. All other users shall pay an annual user fee to the Exchange Authority, which must be approved by the Commissioner. Services performed by the Exchange Authority on behalf of other state or federal programs shall be paid for by those state or federal programs. The Exchange is exempt from all State taxes.

§ 58-50-380. Audit. There will be an annual audit of the Exchange Authority by the State Auditor.

Nothing in the Act will be construed to interfere with payments to Federally-qualified health centers.

The bill contains a severability clause. If the any portion of the act is found invalid, then the whole act is repealed. If the ACA is repealed or found invalid, then this act is repealed. If the ACA is not funded, the this act is unenforceable.

EFFECTIVE DATE: This act is effective when it becomes law.

H115-SMTK-18(CSTK-8) v1

HOUSE BILL 115
Committee Substitute Favorable 3/30/11

Short Title: North Carolina Health Benefit Exchange. (Public)

Sponsors:

Referred to:

February 17, 2011

A BILL TO BE ENTITLED

AN ACT TO PRESERVE STATE-BASED AUTHORITY TO REGULATE THE NORTH CAROLINA HEALTH INSURANCE MARKET AND TO PREVENT FEDERAL ENCROACHMENT ON STATE AUTHORITY BY ESTABLISHING THE NORTH CAROLINA BENEFIT EXCHANGE.

The General Assembly of North Carolina enacts:

SECTION 1. The purpose of this act is to provide for the establishment of the North Carolina Health Benefits Exchange Authority (Exchange Authority). The purpose of the Exchange Authority is to facilitate the purchase and role of qualified health plans in the individual and small employer market by providing education, outreach, and technical assistance. The General Assembly believes it is in the best interest of the State, and thus the purpose of the Exchange Authority, to promote competition and choice in the health care marketplace and to facilitate innovation by offering products with variation in price and design. The Exchange Authority shall accomplish its purpose through a robust portal that provides meaningful guidance to health benefit plans that meet the needs of the health care marketplace of this State and not through the limitations of health benefit plan options to qualified individuals or qualified employers or by excluding health benefit plans who meet the premium and solvency requirements approved by the North Carolina Department of Insurance. In establishing the Exchange Authority, it is the intent of the General Assembly to reduce the number of uninsured individuals in this State, promote improved competition in the health care marketplace, reduce health care costs by, among other things, improving reimbursements to health care providers for uncompensated care, increasing consumer education, increasing transparency, and assisting individuals and employers in accessing health coverage, premium tax credits, and cost-sharing reductions.

SECTION 2. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 8. North Carolina Health Benefit Exchange Act.

"**§ 58-50-300. Definitions.**

The following definitions apply to this Part:

(1) Agent. – Defined in G.S. 58-33-10(1).

(2) Board. – The Board of Directors of the North Carolina Health Benefit Exchange Authority.

(3) Broker. – Defined in G.S. 58-33-10(3).

(4) Commissioner. – The Commissioner of Insurance of North Carolina or the Commissioner's authorized designee.

(5) Educated Health Care Consumer. – An individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical, and scientific matters.

(6) Essential Health Benefits. – Defined under section 1302(b) of the Federal Act.

(7) Exchange Authority. – The North Carolina Health Benefit Exchange Authority established pursuant to G.S. 58-50-310 and includes the Individual Exchange and the SHOP Exchange, unless otherwise specified.

(8) Executive Director. – The individual selected by a majority vote of the Board members and hired to serve as the Executive Director of the Exchange Authority.

(9) Federal Act. – The federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as further amended, as well as any regulations or guidance issued under those acts.

(10) Grandfathered Health Plan Coverage or Grandfathered Health Plan. – Defined in 45 C.F.R. Part 147.140(a).

(11) Health Benefit Plan. – Defined in G.S. 58-3-167(a)(1).

(12) Health Care Provider. – Defined in G.S. 58-50-270(3a).

(13) Health Insurer or Insurer. – Defined in G.S. 58-68-25(a)(6) and, for the purposes of this act, the terms also include qualified nonprofit health insurance issuers (CO-OP Insurers) as provided in section 1322 of the Federal Act, and multistate Qualified Health Plans as provided in section 1334 of the Federal Act.

(14) Individual Exchange. – The Exchange through which Qualified Individuals may purchase coverage established pursuant to this Part.

(15) Plan of Operation. – The articles, bylaws, and operating rules and procedures adopted by the Board in accordance with this Part.

(16) Qualified Dental Plan. – A limited scope dental plan that has been certified in accordance with G.S. 58-50-350.

(17) Qualified Employer. – A Small Employer that elects to make its full-time employees eligible for one or more Qualified Health Plans offered through the SHOP Exchange, and at the option of the employer, some or all of its part-time employees.

(18) Qualified Health Plan. – A Health Benefit Plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and G.S. 58-50-350.

(19) Qualified Individual. – An individual, including a minor, who meets all of the following requirements:

a. Is seeking to enroll in a Qualified Health Plan offered to individuals through the Individual Exchange.

b. Resides in this State pursuant to G.S. 58-50-175(18).

c. At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges.

d. Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

(20) Secretary. – The Secretary of the federal Department of Health and Human Services.

(21) SHOP Exchange. – The Small Business Health Options Program established in G.S. 58-50-340(a)(13) that is designed to assist Qualified Employers in

the State who are Small Employers in facilitating the enrollment of their employees in Qualified Health Plans offered in the small group market in the State.

(22) Small Employer. – An employer as such term is defined in G.S. 58-50-110(22), subject to the requirements of the Federal Act and the Public Health Service Act (PHSA).

"**§ 58-50-310. Exchange established; Board of Directors; Plan of Operation.**

(a) There is hereby created a nonprofit entity to be known as the North Carolina Health Benefit Exchange Authority, which is subject to the supervision of the Commissioner. Notwithstanding that the Exchange Authority may be supported in whole or in part from State or federal funds, the Exchange Authority is not an instrumentality of the State or federal government and shall be operated by the Board. The purpose of the Exchange Authority is to do the following:

(1) Create and administer an Individual Exchange and a SHOP Exchange which shall be operated as two separate health benefit exchanges and shall not be operated as one health benefit exchange.

(2) Facilitate the purchase and sale of Qualified Health Plans to Qualified Individuals and Qualified Employers.

(3) Assist Qualified Individuals in enrollment in Qualified Health Plans and assist Qualified Employers in facilitating the enrollment of their employees in Qualified Health Plans.

(b) There is established the North Carolina Health Benefit Exchange Authority Board. The Board shall have the duties and powers as established by this section.

(1) The North Carolina Health Benefit Exchange Authority Board shall consist of the Commissioner of Insurance, the Director of the Division of Medical Assistance, who shall both serve as ex officio nonvoting members of the Board, and 11 additional members appointed as follows:

a. Four members appointed by the President Pro Tempore of the Senate as follows:

1. One member who represents the medical provider community, as recommended by the North Carolina Medical Society.

2. One member who represents an insurer, as recommended by the North Carolina Association of Health Plans.

3. One member who represents business, as recommended by the North Carolina Chamber.

4. One member who represents the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider and shall reasonably be expected to qualify for coverage in the Individual Exchange or SHOP Exchange. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member.

b. Four members appointed by the Speaker of the House of Representatives as follows:

1. One member who represents the medical provider community, as recommended by the North Carolina Hospital Association.

2. One member who represents the insurance industry.

3. One member who represents small business, as recommended by the National Federation of Independent Business.

4. One member who represents the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider and shall reasonably be expected to qualify for coverage in the Individual Exchange or SHOP Exchange. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member.

c. Three members appointed by the Governor who do not represent the categories listed in sub-subdivision a. and sub-subdivision b. of this subdivision and have expertise and experience in one or more of the subject area groupings: development and operation of State-scale information technology systems capable of conducting electronic funds transfers, secure data transfers, and other electronic functions relating to the creation and ongoing operations of the Exchange Authority; health economics or health care finance; actuarial science or risk management; health policy analysis or health law; or as a health insurance agent.

(2) The initial appointments by the General Assembly upon the recommendation of the Speaker of the House of Representatives and the President Pro Tempore of the Senate shall be made no later than 30 days after enactment of this Part and shall serve a term of three years. The initial appointments by the Governor shall be made no later than 30 days after enactment of this Part and shall be for a term of two years. All succeeding appointments shall be for terms of three years. Members shall not serve for more than two successive terms. A Board member's term shall continue until the member's successor is appointed by the original appointing authority. Vacancies shall be filled by the appointing authority for the unexpired portion of the term in which they occur. A Board member may be removed by the member's appointing authority or by the Commissioner for cause. The Board shall meet at least quarterly upon the call of the chair. A majority of the total membership of the Commission shall constitute a quorum. The Commissioner shall appoint a chair to serve for the initial two years of the Exchange Authority's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms. Board members shall receive travel allowances under G.S. 138-5 when traveling to and from meetings of the Board but shall not receive any subsistence allowance or per diem under subdivision (a)(1) of that section.

(3) The Board shall employ or fix compensation of the Executive Director.

(4) The Board shall appoint appropriate legal, actuarial, and other persons, entities, or committees as necessary to provide technical assistance in the operation, policy, contractual design, and other functions of the Exchange Authority.

(5) The Board shall adopt bylaws, policies, and procedures as may be necessary or convenient.

(6) Each member of the Board shall comply with the conflict of interest rules and recusal procedures set forth in the Plan of Operation.

(7) No member of the Board or staff shall make, participate in making, or in any way attempt to use his or her official position to influence the making of any

decision that he or she knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on him or her or a member of his or her immediate family, or which will have reasonable foreseeable material effect on any business entity in which the member or his or her immediate family is director, officer, partner, trustee, employee, or holds any position of management.

(8) Each member of the Board shall have the responsibility and duty to meet the requirements of this Part, the Federal Act, and all applicable State and federal laws, rules, and regulations to serve the public interest of the individuals and employers seeking health care coverage through the Exchange Authority, and to ensure the operational well-being and fiscal solvency of the Exchange Authority.

(c) The Board shall submit to the Commissioner a Plan of Operation for the Exchange Authority and any amendments.

(1) The Commissioner shall review and approve or disapprove the Plan of Operation within 90 days after its submission or resubmission. If the Commissioner fails to act within 90 days of submission, the Plan of Operation shall be deemed approved. If the Commissioner disapproves any part of the Plan of Operation, the Commissioner shall provide specific reasons for the disapproval and provide the Board an opportunity to revise and resubmit the Plan of Operation. The Plan of Operation shall become effective upon approval in writing by the Commissioner. If the Board fails to submit a Plan of Operation within 180 days after the appointment of the Board that is approved by the Commissioner, or at any time thereafter fails to submit amendments as required by statute or federal law to the Plan of Operation, the Commissioner shall adopt temporary rules necessary to effectuate the provisions of this section. The rules shall continue in force until modified by the Commissioner or superseded by a Plan of Operation submitted by the Board and approved by the Commissioner.

(2) The Plan of Operation shall establish policies and procedures for operation of the Exchange Authority, including, but not limited to, the following:

a. Process by which the Board sets policies and conducts business, including bylaws.

b. Process for certifying Qualified Health Plans.

c. Plans for determining the need for and selection of eligible entities with whom to contract for performance of Exchange Authority functions or operations.

d. Fiscal operations of the Exchange Authority, addressing the collection, handling, disbursing, accounting, and auditing of assets and monies of the Exchange Authority and any eligible entity with whom the Exchange Authority contracts.

e. Statement acknowledging the fiduciary duty owed by the Exchange Authority to persons receiving Qualified Health Plan coverage through the Exchange Authority.

f. Process for evaluating the effectiveness of the Executive Director and the overall operations of the Exchange Authority.

g. Provide for conflict of interest rules and recusal procedures that require a Board member to recuse himself or herself from an official matter, whenever the Board member or his or her immediate family has any financial involvement or interest in that matter.

h. Identify an approach for coordinating efforts with the Department of Health and Human Services to fairly allocate administrative costs for eligibility determinations in the Exchange Authority and Medicaid.

i. Provide for other matters as may be necessary or proper for the execution of the Executive Director's powers, duties, and obligations under this act.

j. Appeals processes authorized by this Part, including appeals of tax credit eligibility, cost-sharing subsidy, mandate waiver determination, affordability determinations pursuant to G.S. 58-50-340 and appeals of Insurer noncertification or decertification pursuant to G.S. 58-50-350.

"**§ 58-50-320. Exchange Authority general powers.**

(a) The Exchange Authority shall have the general powers and authority granted under the laws of this State and the specific authority to do all of the following:

(1) Contract with an eligible entity for any of its functions described in this act. For the purposes of this act, an eligible entity has the same meaning as section 1311(f)(3)(B) of the Federal Act.

(2) Take legal action as necessary.

(3) Enter into information-sharing agreements with federal and State agencies and other state exchanges to carry out its responsibilities under this act provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all State and federal laws and regulations.

"**§ 58-50-330. General requirements.**

(a) The Exchange Authority shall make Qualified Health Plans available to Qualified Individuals and Qualified Employers beginning with effective dates on or after January 1, 2014.

(b) The Exchange Authority shall not make available any Health Benefit Plan that is not a Qualified Health Plan. The Exchange Authority shall allow a Health Insurer to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange Authority, either separately or in conjunction with a Qualified Health Plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

(c) Neither the Exchange Authority nor an Insurer offering Qualified Health Plans through the Exchange Authority may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

(d) The Exchange Authority may make a Qualified Health Plan available notwithstanding any provision of law that may require benefits other than the Essential Health Benefits specified under section 1302(b) of the Federal Act.

(1) Nothing in this section shall preclude a Qualified Health Plan from including benefits in addition to Essential Health Benefits, including wellness programs.

(2) To the extent that State law or regulation requires that a Qualified Health Plan include benefits in addition to the Essential Health Benefits, the State shall make payments to defray the cost of any additional benefits directly to an individual enrolled in a Qualified Health Plan or on behalf of an individual directly to the Health Insurer in whose Qualified Health Plan such individual is enrolled.

(3) To the extent that funding to defray the cost for such additional benefits is not provided, notwithstanding any requirements in Chapter 58 of the General Statutes, a Health Insurer is not required to include such additional benefits in a Qualified Health Plan, may discontinue such benefits at the time such funding is no longer available, and shall provide written or electronic notice of discontinuation of such benefits to insureds and contracted Health Care Providers as soon as is reasonably practicable. The Exchange Authority shall not require that a Qualified Health Plan provide such additional benefits when funding to defray the cost for such additional benefits is not provided.

(e) Nothing in this Part, and no action taken by the Exchange Authority pursuant to the Part, shall be construed to conflict with, preempt, limit, or supersede any applicable health insurance laws of this State or regulations adopted and orders issued by the Commissioner. Nothing in this Part shall be construed to conflict with, limit, or supersede the statutory or regulatory authority vested with the North Carolina Department of Insurance. Except as expressly provided to the contrary by federal law, Insurers and any other entities or persons participating in the Exchange Authority in this State shall comply fully with all applicable provisions of Chapter 58 of the General Statutes and all related regulations adopted and orders issued by the Commissioner. Participation in the Exchange Authority in any way, including payment or receipt of payment in relation to a Qualified Health Benefits Plan, does not exempt any Insurer, entity, or person from complying fully with Chapter 58 of the General Statutes and all related regulations adopted and orders issued by the Commissioner.

(f) The Executive Director shall make an annual report to the Governor, Speaker of the House of Representatives, the President Pro Tempore of the Senate, and the Commissioner by March 1 of each year. The report shall summarize the activities of the Exchange Authority in the preceding calendar year, including information about the number and types of plans offered; number of Insurers; summary information about premiums, enrollment levels and enrollment/disenrollment activity, duration of coverage; and cost of operating the Exchange Authority.

(g) Neither the Board nor the employees of the Exchange Authority are liable for any obligations of the Exchange Authority. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the Exchange Authority or its agents or employees, the Board, the Executive Director, or the Commissioner or the Commissioner's representatives for any action taken by them in good faith in the performance of their powers and duties under this Part.

(h) The Exchange Authority, including the Board and its employees, is subject to the provisions of Article 33C of Chapter 143 of the General Statutes.

(i) The Executive Director, with the approval of the Board, shall operate the Exchange Authority in a manner so that the estimated cost of operating the Exchange Authority during any calendar year is not anticipated to exceed the total income the Exchange Authority expects to receive from any revenue available to the Exchange Authority.

(j) The Board shall provide for other matters as may be necessary and proper for the execution of the Executive Director's powers, duties, and obligations under this Part.

(k) All documents, papers, letters, maps, books, photographs, films, sound recordings, magnetic or other tapes, electronic data-processing records, artifacts, or other documentary material, regardless of physical form or characteristics within the possession of the Exchange Authority, including its employees and the Board, are subject to the provisions of Chapter 132 of the General Statutes except to the extent that these public records are protected under State or federal law, or are confidential or proprietary property of a person as defined in G.S. 66-152.

(l) The members of the Board and the Executive Director are public servants under G.S. 138A-3(30) and are subject to the provisions of Chapter 138A of the General Statutes.

"**§ 58-50-340. General duties.**

(a) The Exchange Authority shall do the following:

(1) Facilitate the purchase and sale of Qualified Health Plans.

(2) Assist qualified individuals in this State with enrollment in Qualified Health Plans.

(3) Assist qualified employers in this State with enrollment of their employees in Qualified Health Plans.

(4) Implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and this Part, of health benefit plans as Qualified Health Plans.

(5) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance in a manner that is accessible to individuals with different communication needs and that effectively communicates information in a manner that is appropriate to the needs of the population being served by the Exchange Authority.

(6) Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act.

(7) Maintain an Internet Web site through which enrollees and prospective enrollees of Qualified Health Plans and individuals eligible for Medicaid or North Carolina Health Choice may obtain standardized comparative information on such plans.

(8) Assign a rating to each Qualified Health Plan offered through the Exchange Authority in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act, and determine each Qualified Health Plan's level of coverage in accordance with regulations issued by the Secretary under section 1302(d)(2)(A) of the Federal Act.

(9) Use a standardized format for presenting health benefit options in the Exchange Authority, including the use of the uniform outline of coverage established under section 2715 of the PHSA that supports consumer choice by making comprehensive information about health plans available in an objective, easy-to-understand format.

(10) In accordance with section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act, or any applicable State or local public program and if, through screening of the application by the Exchange Authority, the Exchange Authority determines that any individual is eligible for any such program, enroll that individual in that program.

(11) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act.

(12) Establish an Individual Exchange, through which Qualified Individuals may enroll in any qualified plan offered through the Individual Exchange for which they are eligible.

(13) Establish a SHOP Exchange through which Qualified Employers may make its employees eligible for one or more Qualified Health Plans offered through the SHOP Exchange or through which Qualified Employers may specify a level of coverage so that any of its employees may enroll in any Qualified Health Plan offered through the SHOP Exchange at the specified level of coverage.

(14) Subject to section 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because of either of the following:

a. There is no affordable Qualified Health Plan available through the Exchange Authority, or the individual's employer, covering the individual.

b. The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty.

(15) Transfer to the federal Secretary of the Treasury the following:

a. A list of the individuals who are issued a certification under subdivision (14) of this subsection, including the name and taxpayer identification number of each individual.

b. The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because of either of the following:

1. The employer did not provide minimum essential coverage.

2. The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code of 1986 to either be unaffordable to the employee or not provide the required minimum actuarial value.

c. The name and taxpayer identification number of the following:

1. Each individual who notifies the Exchange Authority under section 1411(b)(4) of the Federal Act that he or she has changed employers.

2. Each individual who ceases coverage under a Qualified Health Plan during a plan year and the effective date of that cessation.

(16) Provide to each employer the name of each employee of the employer described in sub-sub-subdivision b.2. of subdivision (15) of this subsection who ceases coverage under a Qualified Health Plan during a plan year and the effective date of the cessation.

(17) Perform duties required of the Exchange Authority by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions.

(18) Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act, and standards developed by the Secretary, and award grants to enable Navigators who are certified and trained by the North Carolina Department of Insurance to do the following:

a. Conduct public education activities to raise awareness of the availability of Qualified Health Plans.

b. Distribute fair and impartial information concerning enrollment in Qualified Health Plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act.

c. Facilitate enrollment in Qualified Health Plans.

d. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHSA, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their Health Benefit Plan, coverage, or a determination under that plan or coverage.

e. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange Authority.

(19) Take into account any excess of premium growth outside of the Exchange Authority as compared to the rate of such growth inside the Exchange Authority when determining under section 1302(f)(2)(B) of the Federal Act whether to recommend to the General Assembly that Qualified Health Plans be offered in the large group market through the SHOP Exchange.

(20) Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, and collect the amount credited from the offering employer and remit the amount of the free choice voucher to the appropriate health carrier.

(21) Consult with stakeholders relevant to carrying out the activities required under this act, including, but not limited to, the following:

a. Educated health care consumers who are enrollees in Qualified Health Plans.

b. Individuals and entities with experience in facilitating enrollment in Qualified Health Plans.

c. Representatives of small businesses and self-employed individuals.

d. Representatives of Health Insurers that offer Qualified Health Plans through the Exchange Authority.

e. Representatives of Health Insurers that are not offering qualified plans through the Exchange Authority.

f. Representatives of Health Care Providers.

g. The Division of Medical Assistance.

h. The North Carolina Department of Insurance.

i. Advocates for enrolling hard to reach populations.

(22) Meet all of the following financial integrity requirements:

a. Keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the Secretary, the Governor, the Commissioner, and the General Assembly a report concerning such accountings.

b. Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Federal Act and allow the Secretary, in coordination with the Inspector General of the U.S. Department of Health and Human Services, to do all of the following:

1. Investigate the affairs of the Exchange Authority.

2. Examine the properties and records of the Exchange Authority.

3. Require periodic reports in relation to the activities undertaken by the Exchange Authority.

c. In carrying out its activities under this act, not use any funds intended for the administrative and operational expenses of the Exchange

Authority for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or State legislative and regulatory modifications.

(23) Meet the following fiduciary duties and liability:

a. Any person who acts on behalf of an Exchange Authority shall act as a fiduciary. Such person shall ensure that the Exchange Authority is operated (i) solely in the interests of individuals participating in qualified health plans offered through the Exchange Authority and (ii) for the exclusive purpose of facilitating the purchase of Qualified Health Plans.

b. Any person who acts as a fiduciary on behalf of the Exchange Authority who breaches any of their responsibilities, obligations, or duties imposed by this section shall be liable to make good to the Exchange Authority, the Qualified Health Plans offered through the Exchange Authority, or participants of Qualified Health Plans offered through the Exchange Authority any losses resulting from each breach and shall be subject to such other legal or equitable relief as the court may deem appropriate, including removal of such fiduciary.

(24) With respect to eligibility determinations, provide for (i) review of enrollee appeals of Exchange Authority premium tax credit and cost-sharing reductions and mandate exemption determinations and establish procedures for identifying and confirming income levels of applicants for Exchange Authority coverage and eligibility for receipt of premiums and tax credits and (ii) employer appeals of employer-sponsored plan availability or affordability determinations.

(25) Conduct a review of the costs and benefits of collecting and distributing premiums for small businesses. No later than January 1, 2015, the Exchange Authority shall report the results of the review, including analysis of the financial impact of such collection and distribution, and its recommendations to the North Carolina General Assembly. The Exchange Authority may implement and carry out a process for collecting and distributing premiums if it has sufficient funding to implement the initiative and upon approval by vote by both chambers of the North Carolina General Assembly.

(26) Study the feasibility of offering a Basic Health Plan pursuant to section 1331 of the Federal Act and make a recommendation to the 2013 Regular Session of the 2013 General Assembly.

(27) Provide for publicity and outreach campaigns to raise awareness of the existence of the Exchange Authority and disseminate information regarding eligibility criteria, enrollment procedures, availability of premium tax credits and cost-sharing reductions, small employer tax credits, and other relevant information.

"**§ 58-50-350. Health Benefit Plan certification.**

(a) The Exchange Authority shall certify a Health Benefit Plan as a Qualified Health Plan if the Department of Insurance determines that it satisfies the requirements set forth in subdivisions (1) through (6) of this subsection unless the Exchange Authority determines that making the plan available through the Exchange Authority is not in the interest of Qualified Individuals and Qualified Employers in this State.

(1) The plan provides the Essential Health Benefits package described in section 1302(a) of the Federal Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of Qualified Dental

Plans, as provided in subsection (e) of this section, if both of the following occur:

a. The Exchange Authority has determined that at least one Qualified Dental Plan is available to supplement the plan's coverage.

b. The Insurer makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange Authority, that the plan does not provide the full range of essential pediatric benefits, and that Qualified Dental Plans providing those benefits and other dental benefits not covered by the plan are offered through the Exchange Authority.

(2) The premium rates and contract language have been approved by the Commissioner.

(3) The plan provides at least a bronze level of coverage, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage.

(4) The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the Federal Act, and if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act.

(5) The Health Insurer offering the plan meets the following requirements:

a. Is licensed and in good standing to offer health insurance coverage in this State.

b. Offers at least one Qualified Health Plan in the silver level and at least one plan in the gold level through each component of the Exchange Authority in which the Insurer participates, where "component" refers to the SHOP Exchange and the Individual Exchange.

c. Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange Authority and without regard to whether the plan is offered directly from the Insurer or through an insurance producer.

d. Does not charge any cancellation fees or penalties in violation of G.S. 58-50-330(c).

e. Complies with the regulations developed by the Secretary under section 1311(d) of the Federal Act and such other requirements as the Exchange Authority may establish.

(6) The plan meets the requirements of certification as promulgated by regulation pursuant to this section and by the Secretary under section 1311(c) of the Federal Act.

(b) The Exchange Authority shall not exclude a health plan through the imposition of premium price controls nor shall it exclude a health plan based on the following:

(1) That the plan is a fee-for-service plan.

(2) That the Health Benefit Plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange Authority determines are inappropriate or too costly.

(c) The Exchange Authority shall require each Health Insurer seeking certification of a plan as a Qualified Health Plan to do the following:

(1) Submit a justification for any premium increase before implementation of that increase. The Insurer shall prominently post such information on its Internet Web site. The Exchange Authority shall take this information, along

with the information and the recommendations provided to the Exchange Authority by the Commissioner under section 2794(b) of the PHSA, relating to patterns or practices of excessive or unjustified premium increases, into consideration when determining whether to continue to allow the Insurer to make plans available through the Exchange Authority. In no case shall an Exchange Authority impose any premium price controls or restrict premiums that otherwise meet the requirements of State law.

(2) Make available to the public and submit to the Exchange Authority, the Secretary, and the Commissioner, accurate and timely disclosure of the following:

a. Claims payment policies and practices.
b. Periodic financial disclosures.
c. Data on enrollment.
d. Data on disenrollment.
e. Data on the number of claims that are denied.
f. Data on rating practices.
g. Information on cost-sharing and payments with respect to any out-of-network coverage.
h. Information on enrollee and participant rights under title I of the Federal Act.
i. Other information as determined appropriate by the Secretary.

The information shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act.

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, co-payments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet Web site and through other means for individuals without access to the Internet.

(d) The Exchange Authority shall establish and publish a transparent, objective process for denying certification or decertifying Qualified Health Plans.

(1) The Exchange Authority shall give each Health Insurer the opportunity to appeal a decertification decision or the denial of certification as a Qualified Health Plan.

(2) The Exchange Authority shall give each Health Insurer that appeals a decertification decision or the denial of certification the opportunity for the following:

a. The submission and consideration of facts, arguments, or proposals of adjustment of the health plan or plans at issue.
b. A hearing and a decision on the record, to the extent that the Exchange Authority and the Health Insurer are unable to reach agreement following the submission of the information in sub-subdivision a. of this subdivision.

(3) Any hearing held pursuant to subdivision (2) of this subsection shall be conducted by an impartial party agreed to by the Exchange Authority and the Health Insurer. If the Exchange Authority and the Health Insurer cannot agree on an impartial party, then the hearing must be held by an administrative law judge.

(4) The hearing decision may be appealed to the North Carolina Court of Appeals by the aggrieved party.

(e) The Exchange Authority shall not exempt any Health Insurer seeking certification of a Qualified Health Plan, regardless of the type or size of the Insurer, from State licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among Health Insurers participating in the Exchange Authority.

(1) The provisions of this act that are applicable to Qualified Health Plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of subdivisions (2), (3), and (4) of this subsection or by regulations adopted by the Commissioner.

(2) The Insurer shall be licensed to offer dental coverage but need not be licensed to offer other health benefits.

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by Health Benefit Plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to section 1302(b)(1)(J) of the Federal Act and such other dental benefits as the Exchange Authority or the Secretary may specify by regulation.

(4) Insurers may jointly offer a comprehensive plan through the Exchange Authority in which the dental benefits are provided by an Insurer through a Qualified Dental Plan and the other benefits are provided by an Insurer through a Qualified Health Plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

"**§ 58-50-360. Choice.**

(a) In accordance with section 1312(f)(2)(A) of the Federal Act, a Qualified Employer may either designate one or more Qualified Health Plans from which its employees may choose or designate any level of coverage to be made available to employees through the SHOP Exchange.

(b) In accordance with section 1312(b) of the Federal Act, a Qualified Individual enrolled in any Qualified Health Plan may pay any applicable premium owed by such individual to the Health Insurer issuing such Qualified Health Plan.

(c) In accordance with section 1312(c) of the Federal Act, the following risk pools are established:

(1) Individual Exchange. – A Health Insurer shall consider all enrollees in all health plans other than Grandfathered Health Plans offered by such Insurer in the individual market, including those enrollees who do not enroll in such plans through the Individual Exchange, to be members of a single risk pool.

(2) SHOP Exchange. – A Health Insurer shall consider all enrollees in all health plans other than Grandfathered Health Plans offered by such Insurer in the small group market, including those enrollees who do not enroll in such plans through the SHOP Exchange, to be members of a single risk pool.

(d) In accordance with section 1312(d) of the Federal Act, this section shall not prohibit either of the following:

(1) A Health Insurer from offering outside of the Individual Exchange or the SHOP Exchange a health plan to a Qualified Individual or a Qualified Employer.

(2) A Qualified Individual from enrolling in, or a Qualified Employer from selecting for its employees, a health plan offered outside of the Exchange Authority.

(e) This section shall not limit the operation of any requirement under State law or regulation with respect to any policy or plan that is offered outside of the Exchange Authority with respect to any requirement to offer benefits.

(f) Nothing in this section shall restrict the choice of a Qualified Individual to enroll or not to enroll in a Qualified Health Plan or to participate in the Individual Exchange.

(g) Nothing in this section shall compel an individual to enroll in a Qualified Health Plan or to participate in the Exchange Authority.

(h) A Qualified Individual may enroll in any Qualified Health Plan, except that in the case of a catastrophic plan described in section 1302(e) of the Federal Act, a Qualified Individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1312(e)(2) of the Federal Act.

(i) Nothing in this act or the Federal Act shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any Health Benefit Plan that is offered outside of the Exchange Authority.

(j) In accordance with section 1312(e) of the Federal Act, the Exchange Authority shall allow Agents or Brokers to do the following:

(1) To enroll Qualified Individuals and Qualified Employers in any Qualified Health Plan offered through the Exchange Authority for which the individual or employer is eligible.

(2) To assist Qualified Individuals in applying for premium tax credits and cost-sharing reductions for any Qualified Health Plan purchased through the Individual Exchange.

(k) Any compensation to Agents and Brokers paid under this Part shall be determined by the insurer.

"**§ 58-50-370. Funding; publication of costs.**

(a) Beginning in 2014, the funding stream that supports the North Carolina Health Insurance Risk Pool shall be utilized to support the operations of the Exchange Authority. Beginning in 2015, the funding stream that supports the North Carolina Health Insurance Risk Pool shall be utilized to support the operations of the Exchange Authority that serve those individuals with incomes less than or equal to four hundred percent (400%) of the federal poverty level and Qualified Employers receiving a tax credit for the purchase of insurance pursuant to the Federal Act. The proportional cost associated with serving individuals with incomes over four hundred percent (400%) of the federal poverty level and the Qualified Employers not receiving a tax credit pursuant to the Federal Act shall be funded by an annual user fee paid by the individual or the employer to the Exchange Authority. The user fee assessed by the Exchange Authority shall be no greater than the anticipated expenses for serving this market for the applicable fiscal year and must be approved by the Commissioner. Additionally, the Exchange Authority is authorized to utilize grant funding for operations, including, but not limited to, grant funding from the Department of Health and Human Services. The Exchange Authority is also authorized to collect and use advertising fees to help support operations of the Exchange Authority.

(b) Prior to the commencement of the 2013 Regular Session of the 2013 General Assembly, the Exchange Authority shall examine its potential operational costs and propose to the General Assembly any additional changes to the funding stream necessary to ensure its solvency.

(c) As required by section 1311(d)(5)(A) of the Federal Act, the Exchange Authority shall be self-sustaining by January 1, 2015. A budget for the Exchange Authority shall be prepared by the Exchange Authority and submitted to the Commissioner annually for approval.

(d) Services performed by the Exchange Authority on behalf of other State or federal programs shall be paid for by those State or federal programs.

(e) Any unspent funding by the Exchange Authority shall be used for future operation of the Exchange Authority or reducing future user fees.

(f) The Exchange Authority shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange Authority, and the administrative costs

of the Exchange Authority, on an Internet Web site to educate consumers on such costs. This information shall include information on monies lost to waste, fraud, and abuse.

(g) The Exchange Authority is exempt from any and all State taxes.

"**§ 58-50-380. Regulations.**

The Commissioner shall promulgate regulations pursuant to Chapter 150B of the General Statutes, including temporary rules, to implement the provisions of this Part.

"**§ 58-50-390. Audit.**

An audit of the Exchange Authority shall be conducted annually under the oversight of the State Auditor. The cost of the audit shall be reimbursed to the State Auditor from Exchange Authority funds.

SECTION 3. Nothing in this Act shall be construed to interfere with payments to federally qualified health centers. If any item or service covered by a qualified health plan is provided by a federally qualified health center, as defined in section 1905(1)(2)(B) under the Social Security Act 42 U.S.C. 1396d(1)(2)(B), to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or services an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Social Security Act for such item or service.

SECTION 4. Severability. – If any provision of this act is held invalid by a court of competent jurisdiction, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, is repealed. If section 1311 of the federal Patient Protection and Affordable Care Act or the federal Patient Protection and Affordable Care Act in its entirety is repealed or held invalid by a court of competent jurisdiction, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, is repealed. If funding is not provided as set forth in the federal Patient Protection and Affordable Care Act, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, shall not be enforceable.

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

TALKING POINT FOR HB 115

HB 115, NORTH CAROLINA HEALTH BENEFIT EXCHANGE ACT

ANK YOU MR. CHAIRMAN.

THE PCS BEFORE YOU TODAY IS DRAMATICALLY DIFFERENT FROM THE ORIGINAL LEGISLATION WE INTRODUCED.

WE HAVE TAKEN SOME OF THE RECOMMENDATIONS MADE BY THE DEPARTMENT OF INSURANCE COMMISSIONER WAYNE GOODWIN FROM THE LAST MEETING AND INCORPORATED THEM IN THIS NEW VERSION OF THE BILL.

THIS LEGISLATION IS SUPPORTED BY:

- THE NORTH CAROLINA CHAMBER
- THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS – NFIB
- THE NORTH CAROLINA MEDICAL SOCIETY
- THE NORTH CAROLINA HOSPITAL ASSOCIATION
- GLAXOSMITHKLINE
- THE NORTH CAROLINA ACADEMY OF FAMILY PHYSICIANS
- THE NORTH CAROLINA SOCIETY OF ANESTHESIOLOGISTS
- AND BLUE CROSS BLUE SHIELD OF NORTH CAROLINA
- NORTH CAROLINA ASSOCIATION OF HEALTH PLANS
- NORTH CAROLINA FARM BUREAU FEDERATION

IN MANY WAYS THIS IS THE MOST IMPORTANT HEALTH CARE LEGISLATION WE WILL DEBATE THIS YEAR. MUCH OF THE LEGISLATION IS BASED ON THE "AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT" ADOPTED BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) ON 11/22/10. OVER 20 STATES ARE CURRENTLY CONSIDERING EXCHANGE LEGISLATION, THE MOST RECENT BEING SOUTH CAROLINA AND THEY INTRODUCED LEGISLATION VERY SIMILAR TO THIS BILL.

A HEALTH BENEFIT EXCHANGE IS AN ONLINE MARKETPLACE FOR INDIVIDUALS AND SMALL EMPLOYERS TO PURCHASE QUALIFIED HEALTH PLANS. IF YOU HAVE EVER USED TRAVELOCITY OR ORBITZ, THIS WILL BE SIMILAR. IT WILL BE A PLACE WHERE NORTH ROLINIANS WILL BE ABLE TO COMPARE HEALTH INSURANCE PRODUCTS AND MAKE CISIONS ON WHAT TO PURCHASE.

THE EXCHANGE IS REQUIRED BY THE FEDERAL HEALTH CARE REFORM LEGISLATION. STATES MUST CREATE AN EXCHANGE FOR INDIVIDUALS AND SMALL BUSINESSES BY JANUARY 1, 2014. THE KEY THING TO KNOW, WHETHER YOU LIKE THE FEDERAL HEALTH CARE REFORM OR NOT, IS THAT IF STATES DO NOT CREATE AN EXCHANGE, THE FEDERAL GOVERNMENT WILL.

I'LL REPEAT - IF STATES DO NOT CREATE AN EXCHANGE, THE FEDERAL GOVERNMENT WILL.

IF NORTH CAROLINA DOES NOT DEMONSTRATE SIGNIFICANT PROGRESS TO IMPLEMENT AN EXCHANGE BY JANUARY 1, 2013, THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES WILL ESTABLISH A FEDERAL EXCHANGE IN NORTH CAROLINA - AND I DO NOT BELIEVE THIS WOULD BE GOOD FOR NC. US HHS WILL HAVE THE ABILITY TO SET UP AN EXCHANGE DIRECTLY OR BY CONTRACTING WITH A NON-PROFIT. THIS WOULD GIVE THE FEDERAL GOVERNMENT UNPRECEDENTED CONTROL OVER THE STATE INSURANCE MARKET.

STATE IMPLEMENTATION RATHER THAN FEDERAL WILL BE CRITICAL TO ENSURE EFFECTIVE COORDINATION WITH THE NORTH CAROLINA DEPARTMENT OF INSURANCE, TO AVOID CONFLICTS BETWEEN FEDERAL AND STATE RULES, AND TO ENSURE THAT CHOICES AND SERVICES ARE RESPONSIVE TO LOCAL NEEDS. STATE LEVEL EXCHANGES CAN ALSO BE IMPLEMENTED FASTER AND AT A LOWER COST BY AVOIDING THE CREATION OF A NEW LEVEL OF BUREAUCRACY.

EXCHANGE:

ENROLLMENT IS LIMITED TO CITIZENS AND LAWFUL RESIDENTS WHO DO NOT HAVE ACCESS TO EMPLOYER-SPONSORED OR GOVERNMENT-SPONSORED HEALTH INSURANCE AND TO SMALL BUSINESSES WITH FEWER THAN 50 EMPLOYEES.

THIS LEGISLATION WILL CREATE AN EXCHANGE THAT WILL MAKE IT EASIER FOR INDIVIDUALS AND SMALL EMPLOYERS TO SHOP, COMPARE, AND ENROLL IN QUALIFIED HEALTH PLANS.

WHO WILL BE ABLE TO ENROLL IN AN EXCHANGE: INDIVIDUALS QUALIFYING FOR SUBSIDIES, SMALL BUSINESSES SEEKING TAX CREDIT, FOR TWO YEARS, AND INDIVIDUALS QUALIFYING FOR AN EMPLOYER VOUCHER. ALL THESE WILL BE REQUIRED TO GET INSURANCE THROUGH THE EXCHANGE. IN ADDITION, ANY OTHER LAWFUL RESIDENT OR EMPLOYER SIZE AS DETERMINED BY THE STATE MAY OBTAIN COVERAGE THROUGH THE EXCHANGE.

BOARD:

THE BOARD MAKEUP HAS BEEN CHANGED. WE NOW HAVE EQUAL NUMBERS APPOINTED BY THE SPEAKER AND PRESIDENT PRO TEM AS FOLLOWS:

2 MEMBERS FROM THE BUSINESS COMMUNITY – 1 RECOMMENDED BY THE NORTH CAROLINA CHAMBER AND 1 RECOMMENDED BY NFIB. 2 MEMBERS FROM THE MEDICAL COMMUNITY – 1 RECOMMENDED BY THE MEDICAL SOCIETY AND 1 RECOMMENDED BY THE HOSPITAL ASSOCIATION. 2 MEMBERS FROM THE GENERAL PUBLIC NOT AFFILIATED WITH AN INSURANCE COMPANY OR MEDICAL PROVIDER.

2 MEMBERS FROM THE HEALTH INSURANCE INDUSTRY. AND THEN 4 MEMBERS APPOINTED BY THE GOVERNOR: NONE CAN BE ASSOCIATED WITH THE OTHER APPOINTMENTS. THEY WILL NEED TO HAVE AN EXPERTISE IN HEALTH ECONOMICS, HEALTH CARE FINANCE, ACTUARIAL SCIENCE, HEALTH POLICY OR HEALTH LAW, AND/OR A HEALTH INSURANCE AGENT.

CONCLUSION:

THIS EXCHANGE, IF DONE CORRECTLY, WILL HELP PEOPLE TO COMPARE AND SHOP FOR PLANS, AND WILL BE THE ONLY AVENUE FOR THOSE ELIGIBLE FOR FEDERAL PREMIUM SUBSIDY TO PURCHASE COVERAGE. THE INSURANCE REFORMS MANDATED BY FEDERAL LAW WILL APPLY TO PLANS SOLD INSIDE AND OUTSIDE OF THE EXCHANGE, AND THESE REFORMS WILL BE OVERSEEN BY THE DEPARTMENT OF INSURANCE.

I BELIEVE IT IS IMPORTANT THAT THIS LEGISLATION CONTINUES TO GIVE THE NC DEPARTMENT OF INSURANCE THE REGULATORY AUTHORITY – NOT THE EXCHANGE. ALSO – THIS LEGISLATION ENSURES THAT THE EXCHANGE BE A MARKET-BASED APPROACH WITH A MECHANISM THAT CONTAINS COSTS AND MINIMIZES THE IMPACT ON THE MARKET OUTSIDE THE EXCHANGE.

I HOPE YOU WILL SUPPORT THIS IMPORTANT LEGISLATION.

ATTACHMENT V

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 115

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

H115-ATK-46 [v.3]

Comm. Sub. [YES]
Amends Title [NO]
Second Edition

Date _____,2011

Representative Insko

moves to amend the bill ~~on page 13, lines 19-20, by inserting the following between the lines~~:

~~"f. Offers identical qualified health plan products within the SHOP Exchange and the Individual Exchange as the health carrier offers in the private market."~~

~~and~~ on page 15, lines 4-5, by inserting between the lines:

"(f) Any Insurer offering only catastrophic plans ~~or bronze plans~~ outside of the Exchange Authority without offering any plans in the Exchange will be required to participate in the Exchange Authority and offer identical catastrophic plans ~~or bronze plans~~ inside of the Exchange Authority.".

SIGNED Verla Insko
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

ATTACHMENT VI

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 115

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

H115-ATK-47 [v.6]

Comm. Sub. [YES]
Amends Title [NO]
Second Edition

Date _____,2011

Representative Bryant

moves to amend the bill on page 3, lines 32-34, be rewriting the lines to read:

"of the Commissioner of Insurance, who shall serve as an ex officio nonvoting member, the Director of the Division of Medical Assistance, who shall serve as an ex officio member and shall vote only in the case of a tie, and 12 additional members appointed as follows:"

and further amend the bill on page 3, line 48, through page 4, line 4, by rewriting the lines to read:

"4. One member who has experience and expertise as a licensed health insurance agent in the State of North Carolina, as recommended by the North Carolina Association of Health Underwriters, the National Association of Insurance and Financial Advisors – North Carolina, and the Independent Insurance Agents of North Carolina.;

and further amend the bill on page 4, line 26, by deleting the word "Three" and substituting the word "Four";

and further amend the bill on page 4, lines 43-48, by rewriting the lines to read:

"3. One member who represents the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider and shall reasonably be expected to qualify for coverage in the Individual Exchange or SHOP Exchange. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member.

4. One member who has experience and expertise in one or more of the subject area groupings: health economics or health care finance; actuarial science or risk management; health policy analysis or health law; or as a health insurance agent."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

ATTACHMENT VII

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 115

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

H115-ATK-49 [v.5]

Comm. Sub. [YES]
Amends Title [NO]
Second Edition

Date _____,2011

Representative _____

moves to amend the bill on page on page 16, lines 9-22, by rewriting the lines to read:

"No individual or employer shall be assessed a user fee, a tax, or a penalty for enrolling in the Exchange Authority.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

ATTACHMENT VIII

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 115

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

H115-ATK-51 [v.3]

Comm. Sub. [YES]
Amends Title [NO]
Second Edition

Date _____,2011

Representative Murry

moves to amend the bill on page 4, line 8, by deleting the word "medical" and substituting the word" nursing".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

ATTACHMENT IX

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 115

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

H115-ARG-7 [v.3]

Comm. Sub. [YES]
Amends Title [NO]
Second Edition

Date _____,2011

Representative Stevens

moves to amend the bill on page 5, line18,
by rewriting the line to read:
"(3) The Board shall employ or fix compensation of the Executive Director. The annual salary for the Executive Director shall not exceed one hundred and fifty percent (150%) of the annual salary for members of the Council of State."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

Rep. Insko

ATTACHMENT X

ROLL CALL VOTE

23 YES 5 NO = 28 (TOTAL)

HB# 115
SB# ____

HOUSE STANDING COMMITTEE ON INSURANCE

House Subcommittee on _____

YES	NO	MEMBER (last name)	YES	NO	MEMBER (last name)
✓		DOCKHAM	✓		SETZER
		BLUST	✓		SHEPARD
✓		BROWN	✓		STEEN
✓		BRUBAKER	✓		STEVENS
	✓	BRYANT		✓	WAINWRIGHT
✓		BURR	✓		WARREN
✓		COLLINS	✓		WILKINS
✓		CRAWFORD	✓		WRAY
✓		CURRENT			
✓		FAISON			
✓		FLOYD			
✓		FOLWELL			
	✓	GLAZIER			
		GRAHAM			
	✓	HAMILTON			
✓		HOWARD			
✓		HURLEY			
	✓	INSKO			
		JACKSON			
✓		JOHNSON			
✓		MCELRAFT			
		MCGUIRT			
✓		MILLS			
✓		MURRY			
		PIERCE			

MINUTES

HOUSE COMMITTEE ON INSURANCE

May 17, 2011

The House Committee on Insurance met in Room 1228 of the Legislative Building on May 17, 2011, at 1:00 pm. The following members were present: Representatives Dockham, Chair, Blust, Brown, Burr, Collins, Crawford, Faison, Floyd, Glazier, Howard, Insko, Jackson, Johnson, McGuirt, Mills, Murry, Setzer, Shepard, Steen, Stevens, Warren, and Wilkins. Tim Hovis, Bill Patterson, and Amy Jo Johnson, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes. (Attachment I)

Representative Dockham, Chair, called the meeting to order at 1:00 pm. He introduced the pages and the Sergeant of Arms staff. (Attachment II) The following bills were considered:

SB 321, ENTITLED, AN ACT TO CONFORM PROVISIONS OF NORTH CAROLINA SURPLUS LINES INSURANCE LAWS TO THE FEDERAL NONADMITTED AND REINSURANCE REFORM ACT OF 2010, TO STREAMLINE APPLICATIONS FOR COMMERCIAL PURCHASERS, TO PREVENT ANY LOSS OF PREMIUM TAX REVENUE TO THE STATE, AND TO CONFORM THE DEFINITION OF RISK RETENTION GROUP TO FEDERAL LAW. Sen. Apodaca, bill sponsor, was not available to explain the bill. A proposed House committee substitute bill was presented. Representative Brown moved to adopt the proposed House committee substitute bill for consideration. The motion passed. The Chair recognized Ms. Rose Vaughn Williams, Legislative Counsel with the NC Department of Insurance, to explain the PCS. (Attachment III) After some discussion, Representative Glazier moved for a favorable report as to as to the House committee substitute bill, unfavorable as to Senate Committee Substitute Bill 2 and recommendation that the House committee substitute bill be re-referred to the Committee on FINANCE.

HB 501, entitled AN ACT TO PROVIDE FOR THE FORMATION AND OWNERSHIP OF INSURANCE COMPANIES BY CREDIT UNIONS. A proposed committee substitute bill was presented. Representative Steen moved to adopt the proposed committee substitute for consideration. The motion passed. The Chair recognized Rep. Glazier, bill sponsor, to explain the bill. This legislation has been requested by State Employees' Credit Union (SECU), which seeks to charter a North Carolina based life insurance company to solely serve its 1.6 million members. Under the General Statutes governing state-chartered credit unions, authority is granted for credit unions to offer insurance services. However, it is unclear under current law whether credit unions could offer these services to members through an insurance company owned by the credit union. HB 501 seeks to clarify this statutory authority. For more than 25 years, SECU has offered insurance products to members through arrangements with outside companies. With the passage of HB 501, members can benefit from the availability of life insurance and annuity products underwritten directly through an SECU-owned insurance company, subject to the approval of a new company filing with the North Carolina Department of Insurance. HB 501 is a bi-partisan bill supported by both regulatory agencies, the Department of Insurance and the Credit Union Division, and we are aware of no opposition.

The life insurance company SECU is looking to charter would join NC Mutual Life Insurance Company as the only other currently operating life insurance company domiciled in North Carolina. HB 501 is a win-win for the state, having potential to create jobs and provide tax revenue for North Carolina. After a brief discussion, Representative Setzer moved for 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 BANKING. The motion passed.

Representative Dockham requested, since he is the primary sponsor of HB 575 and HB 617 under consideration, Representative Collins preside over the remainder of the meeting.

HB 575, A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT IN LIEU OF CONTRACTUAL LIABILITY INSURANCE, A SERVICE CONTRACT PROVIDER MAY MAINTAIN A FUNDED RESERVE ACCOUNT FOR ITS OBLIGATIONS UNDER SERVICE CONTRACTS ISSUED AND OUTSTANDING IN THIS STATE. A proposed committee substitute was presented. Representative Jackson moved to adopt the proposed committee substitute for consideration. The motion passed. The Chair recognized Representative Dockham, bill sponsor, to explain the bill (Attachment IV), and Tim Hovis, Staff Counsel, to explain the proposed committee substitute (Attachment V). Ms. Rose Vaughn Williams, Legislative Counsel with the NC Department of Insurance spoke in support of the bill. After a brief discussion, Rep. Setzer moved for a favorable report as to the committee substitute bill, unfavorable as to the original bill. The motion passed.

HB 617, A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR THE REGULATION OF PORTABLE ELECTRONICS INSURANCE. A proposed committee substitute was presented. Representative Blust moved to adopt the proposed committee substitute for consideration. The motion passed. The Chair recognized Rep. Dockham, bill sponsor, to explain the bill (Attachment VI). After a brief discussion, Rep. Faison moved for 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. The motion passed.

There being no further business, the Chair adjourned the meeting at 1:30 pm.

Respectfully submitted,

Representative Jerry C. Dockham, Chair

Regina Irwin, Committee Assistant

Attachments

AGENDA

HOUSE COMMITTEE ON INSURANCE

May 17, 2011

Room 1228

1:00 pm

OPENING REMARKS

Representative Jerry Dockham, Chairman
Insurance Committee

AGENDA ITEMS

HB 501 **Credit Union Ownership of Stock Life Ins. Co.**
Representative Rick Glazier, Sponsor
Representative Jerry Dockham, Sponsor
Representative Susi Hamilton, Sponsor
Representative Mitchell Setzer, Sponsor

HB 575 **Service Agreements/Allow Reserve Account.**
Representative Jerry Dockham, Sponsor

HB 617 **Portable Electronics Insurance Coverage.**
Representative Jerry Dockham, Sponsor

SB 321 **Surplus Lines/Premium Tax.-AB**
Senator Tom Apodaca, Sponsor

ADJOURNMENT

ATTACHMENT I

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

MAY 17, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
BRUCE THOMPSON	PARKER POE
[illegible]	[illegible]
[illegible]	KITATES
Bryan Heckle	NCDOI
Sara Fender	IFNC
John Bardish	Astra Zeneca
Barbara Canales	BCA
[illegible]	MFAF
[illegible]	DSE
Michelle Frazier	MF+S
[illegible]	SA
JOEL MAYNARD	EPMS ASSOC.

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

MAY 17, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John T Bads	BCS
Katie Hallaway	Lowe's
Heather Robinson	NCRMA
Harry Dixon	SECU
Lauren Whaley	NCCUL
Jim BLANE	SECU
Jerrie K. Jay	NC Credit Union Division
[illegible]	NMRS
[illegible]	FCB
Paul Stock	NCBA
John Hazlin	MPS
Bill Rust	Ary

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

MAY 17, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Doug Miskew	PSG
Mike James	NCP
Dana Horne	SA.

ATTACHMENT II

House Committee Pages / Sergeants at Arms

NAME OF COMMITTEE INSURANCE

DATE: May 17, 2011 **Room:** 1228

*Name: Hannah Welborn

County: Lee

Sponsor: Mike Stone

*Name: Sarah Brooks

County: Cumberland

Sponsor: Rick Glazier

*Name: Danielle Damiani

County: Lee

Sponsor: Mike Stone

*Name:

County:

Sponsor:

*Name:

County:

Sponsor:

House Sgt-At Arms:

1. Name: Billy Jones
2. Name: Garland Shepeard
3. Name:
4. Name:
5. Name:
6. Name:

2011 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☒Committee Substitute # 2 for
SB 321 A BILL TO BE ENTITLED AN ACT TO CONFORM PROVISIONS OF NORTH CAROLINA SURPLUS LINES INSURANCE LAWS TO THE FEDERAL NONADMITTED AND REINSURANCE REFORM ACT OF 2010, TO STREAMLINE APPLICATIONS FOR COMMERCIAL PURCHASERS, TO PREVENT ANY LOSS OF PREMIUM TAX REVENUE TO THE STATE, AND TO CONFORM THE DEFINITION OF RISK RETENTION GROUP TO FEDERAL LAW.

☒ With a favorable report as to the House committee substitute bill, unfavorable as to Senate Committee Substitute Bill 2 and recommendation that the House committee substitute bill be re-referred to the Committee on FINANCE.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House/Senate) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S D

SENATE BILL 321
Insurance Committee Substitute Adopted 4/14/11
Finance Committee Substitute Adopted 5/3/11
PROPOSED HOUSE COMMITTEE SUBSTITUTE S321-CSRG-13 [v.2]

5/16/2011 9:55:47 AM

Short Title: Surplus Lines/Premium Tax.-AB (Public)

Sponsors:

Referred to:

March 14, 2011

A BILL TO BE ENTITLED

AN ACT TO CONFORM PROVISIONS OF NORTH CAROLINA SURPLUS LINES INSURANCE LAWS TO THE FEDERAL NONADMITTED AND REINSURANCE REFORM ACT OF 2010, TO STREAMLINE APPLICATIONS FOR COMMERCIAL PURCHASERS, TO PREVENT ANY LOSS OF PREMIUM TAX REVENUE TO THE STATE, AND TO CONFORM THE DEFINITION OF RISK RETENTION GROUP TO FEDERAL LAW.

The General Assembly of North Carolina enacts:

SECTION 1.1. Article 21 of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-21-4. Nonadmitted and Reinsurance Reform Act duties.**

(a) For the purposes of carrying out the provisions of the Nonadmitted and Reinsurance Reform Act of 2010, the Commissioner is authorized to utilize the national insurance producer database of the NAIC, or any other equivalent uniform national database, for the licensure of an individual or an entity as a surplus lines producer and for renewal of such license.

(b) In order to assist in the performance of the Commissioner's duties, under the Nonadmitted and Reinsurance Reform Act of 2010, the Commissioner may contract with nongovernmental entities, including the NAIC or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions that the Commissioner and the nongovernmental entity may deem to be appropriate, including (i) the collection of fees related to producer licensing and (ii) the collection of the premium tax under G.S. 58-21-85. The NAIC or other entity with whom the Commissioner contracts may charge a reasonable fee to the insurer, insured, or other appropriate person for the functions performed."

SECTION 1.2. The Revenue Laws Study Committee shall, in cooperation with the Commissioner of Insurance, study the potential impact that would result from the State's entrance into a nonadmitted insurance multistate agreement or other compact or interstate agreement for the purpose of carrying out the Nonadmitted and Reinsurance Reform Act of 2010 in order to prevent the State from losing revenue after July 21, 2011, the effective date of the Nonadmitted and Reinsurance Reform Act. The Committee shall determine if entering into a compact or agreement would result in retention of surplus lines tax revenue for the State and, if so, which compact or agreement would result in the most retention of surplus lines tax revenue for the State and the most cost-efficient method of administering the collection and

distribution of tax revenues. The Committee shall report its findings and recommendations, including any proposed legislation, to the 2012 Regular Session of the 2011 General Assembly.

SECTION 2. G.S. 58-21-10 reads as rewritten:

"**§ 58-21-10. Definitions.**

As used in this Article:

(1) "Admitted insurer" means an insurer licensed to ~~do an insurance business~~ engage in the business of insurance in this State.

(1a) "Affiliate" means, with respect to an insured, any entity that controls, is controlled by, or is under common control with the insured.

(1b) "Affiliated group" means any group of entities that are all affiliated.

(2) "Capital", as used in the financial requirements of G.S. 58-21-20, means funds paid in for stock or other evidence of ownership.

(2a) "Control" means an entity that has "control" over another entity if either of the following occurs:

a. The entity directly or indirectly or acting through one or more other persons owns, controls, or has the power to vote twenty-five percent (25%) or more of any class of voting securities of the other entity.

b. The entity controls in any manner the election of a majority of the directors or trustees of the other entity.

(3) "Eligible surplus lines insurer" means a nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance under G.S. 58-21-20.

(4) "Export" means to place surplus lines insurance with a nonadmitted insurer.

(5) "Nonadmitted insurer" means an insurer not licensed to do an insurance business in this State. ~~This definition~~ "Nonadmitted insurer" includes insurance exchanges authorized under the laws of various states. "Nonadmitted insurer" does not include a risk retention group, as defined in G.S. 58-22-10(10).

(6) "Producing broker" means an agent or broker licensed under Article 33 of this Chapter who deals directly with the party seeking insurance and who may also be a surplus lines licensee.

(7) "Surplus", as used in the financial requirements of G.S. 58-21-20, means funds over and above liabilities and capital of the company for the protection of policyholders.

(8) "Surplus lines insurance" means any insurance in this State of risks resident, located, or to be performed in this State, permitted to be placed through a surplus lines licensee with a nonadmitted insurer eligible to accept such insurance, other than reinsurance, commercial aircraft insurance, wet marine and transportation insurance, insurance independently procured pursuant to G.S. 58-28-5, life and accident or health insurance, and annuities.

(9) "Surplus lines licensee" means a person licensed under G.S. 58-21-65 to place insurance on risks resident, located, or to be performed in this State with nonadmitted insurers eligible to accept such insurance.

(10) "Wet marine and transportation insurance" means:

a. Insurance upon vessels, crafts, hulls and of interests therein or with relation thereto;

b. Insurance of marine builder's risks, marine war risks and contracts of marine protection and indemnity insurance;

c. Insurance of freights and disbursements pertaining to a subject of insurance coming within this subsection; and

d. Insurance of personal property and interests therein, in the course of exportation from or importation into any country, or in the course of transportation coastwise or on inland waters including transportation by land, water, or air from point of origin to final destination, in connection with any and all risks or perils of navigation, transit or transportation, and while being prepared for and while awaiting shipment, and during any delays, transshipment, or reshipment incident thereto."

SECTION 3. Article 21 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-21-11. Home state.**

(a) The provisions of this Article shall apply to those transactions in which North Carolina is the home state of the insured.

(b) Except as provided in subsection (c) of this section, the term "home state" means, with respect to an insured, either of the following:

(1) The state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence.

(2) If one hundred percent (100%) of the insured risk is located out of the state referred to in subdivision (1) of this subsection, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(c) Affiliated Groups. – If two or more insureds from an affiliated group are named insureds on a single nonadmitted insurance contract, the term "home state" means the home state, as determined pursuant to subsection (b) of this section, of the member of the affiliated group that has the largest percentage of premium attributed to it under that insurance contract."

SECTION 4. G.S. 58-21-15 reads as rewritten:

"**§ 58-21-15. Placement of surplus lines insurance.**

~~Insurance may be procured through a surplus lines licensee from nonadmitted insurers if:~~Surplus lines may be placed by a surplus lines licensee if all of the following apply:

(1) Each insurer is an eligible surplus lines ~~insurer;~~insurer.

(1a) Each insurer is authorized to write the kind of insurance in its domiciliary jurisdiction.

(2) The full amount or kind of insurance cannot be obtained from insurers who are admitted to do business in this State. Such full amount or kind of insurance may be procured from eligible surplus lines insurers, provided that a diligent search is made among the insurers who are admitted to transact and are actually writing the particular kind and class of insurance in this ~~State; and~~State.

(3) All other requirements of this Article are met."

SECTION 5. Article 21 of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-21-16. Streamlined application for commercial purchasers.**

(a) A surplus lines licensee seeking to procure or place nonadmitted insurance in this State for an exempt commercial purchaser shall not be required to satisfy any requirement under G.S. 58-21-15 to make a due diligence search to determine whether the full amount or type of insurance sought by such exempt commercial purchaser can be obtained from admitted insurers if all of the following apply:

(1) The licensee procuring or placing the surplus lines insurance has disclosed to the exempt commercial purchaser that such insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight.

(2) The exempt commercial purchaser has subsequently requested in writing the licensee to procure or place such insurance from a nonadmitted insurer.

(b) As used in this section, the following definitions apply:

(1) "Exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement, meets all of the following requirements:

a. The person employs or retains a qualified risk manager to negotiate insurance coverage.

b. The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of one hundred thousand dollars ($100,000) in the immediately preceding 12 months.

c. The person meets at least one of the following criteria:

1. The person possesses a net worth in excess of twenty million dollars ($20,000,000), as such amount is adjusted pursuant to subsection (c) of this section.

2. The person generates annual revenues in excess of fifty million dollars ($50,000,000), as such amount is adjusted pursuant to subsection (c) of this section.

3. The person employs more than 500 full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than 1,000 employees in the aggregate.

4. The person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least thirty million dollars ($30,000,000), as such amount is adjusted pursuant to subsection (c) of this section.

5. The person is a municipality with a population in excess of 50,000 persons.

(2) "Qualified risk manager" means, with respect to a policyholder of commercial insurance, a person who meets all of the following requirements:

a. Is an employee of, or third-party consultant retained by, the commercial policyholder.

b. Provides skilled services in loss prevention, loss reduction, or risk and insurance coverage analysis, and purchase of insurance.

c. Has one of the following:

1. A bachelor's degree or higher from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by the Commissioner to demonstrate minimum competence in risk management and one of the following:

I. Three years of experience in risk financing, claims, administration, loss prevention, risk and insurance analysis, or purchasing commercial lines of insurance.

II. One of the following designations:

A. Chartered Property and Casualty Underwriter (CPCU) issued by the American Institute for CPCU/Insurance Institute of America.

B. Associate in Risk Management (ARM) issued by the American Institute for CPCU/Insurance Institute of America.

C. Certified Risk Manager (CRM) issued by the National Alliance for Insurance Education & Research.

D. RIMS Fellow (RF) issued by the Global Risk Management Institute.

E. A designation, certification, or license determined by the Commissioner to demonstrate minimum competency in risk management.

2. Seven years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; and has any one of the designations specified in sub-sub-sub-sub-subdivisions A. through E. of sub-sub-sub-subdivision II. of this sub-subdivision.

3. Ten years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance.

4. A graduate degree from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by the Commissioner to demonstrate minimum competence in risk management.

(c) Effective on the fifth January 1 occurring after the date of the enactment of this section and each fifth January 1 occurring thereafter, the dollar amounts in sub-sub-subdivisions (b)(1)c.1. 2., 3., and 4. of this section shall be adjusted to reflect the percentage change for such five-year period in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the U.S. Department of Labor.

"**§ 58-21-17. Placement with alien insurers.**

Nothing in this Article prohibits a surplus lines licensee from placing surplus lines insurance with, or procuring surplus lines insurance from, a nonadmitted insurer domiciled outside the United States that is listed on the Quarterly Listing of Alien Insurers maintained by the International Insurers Department of the NAIC."

SECTION 6. G.S. 58-21-20(a) reads as rewritten:

"(a) ~~No surplus lines licensee shall place any coverage with a nonadmitted insurer, unless at the time of placement, such nonadmitted insurer:~~A surplus lines licensee shall not place coverage with a nonadmitted insurer unless, at the time of placement, the surplus lines licensee has determined that the nonadmitted insurer satisfies the following:

~~(1) Has established satisfactory evidence of good repute and financial integrity; and~~

(2) Qualifies under one of the following subdivisions:

a. Has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction, which equals the greater of either:

1. This State's minimum capital and surplus requirements under ~~G.S. 58-7-75, or~~G.S. 58-7-75.

2. Fifteen million dollars ~~($15,000,000),~~($15,000,000). ~~whichever is greater, except that nonadmitted insurers already qualified under this Article must have ten million dollars ($10,000,000) by December 31, 1991, twelve million five hundred thousand dollars ($12,500,000) by December 31, 1992, and fifteen million dollars ($15,000,000) by December 31, 1993. The~~

~~requirements of this sub-subdivision may be satisfied by an insurer possessing less than the commitment capital and surplus upon an affirmative finding of acceptability by the Commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, and the insurer's record and reputation within the industry. In no event shall the Commissioner make an affirmative finding of acceptability when the insurer's capital and surplus is less than four million five hundred thousand dollars ($4,500,000).~~

~~In addition, an alien insurer qualifies under this subdivision if it complies with the capital and surplus requirements of this subdivision and maintains in the United States an irrevocable trust fund in either a national bank or a member of the Federal Reserve System, in an amount not less than five million four hundred thousand dollars ($5,400,000) for the protection of all of its policyholders in the United States, and the trust fund consists of cash, securities, letters of credit, or of investment of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers authorized to write like kinds of insurance in this State. The trust fund, which shall be included in any calculation of capital and surplus or its equivalent, shall have an expiration date which at no time shall be less than five years; or~~The requirements of this sub-subdivision may be satisfied by an insurer's possessing less than the minimum capital and surplus upon an affirmative finding of acceptability by the Commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability, and company record and reputation within the industry. In no event shall the Commissioner make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than four million five hundred thousand dollars ($4,500,000).

b. In the case of any Lloyd's plans or other similar group of insurers, which consists of unincorporated individual insurers, or a combination of both unincorporated and incorporated insurers, maintains a trust fund in an amount of not less than one hundred million dollars ($100,000,000) as security to the full amount thereof for all policyholders and creditors in the United States of each member of the group, and the trust shall likewise comply with the terms and conditions established in subdivision (2)a. of this section for alien ~~insurers; and~~insurers.

c. In the case of an "insurance exchange" created by the laws of individual states, maintain capital and surplus, or the substantial equivalent thereof, of not less than seventy-five million dollars ($75,000,000) in the aggregate. For insurance exchanges which maintain funds in an amount of not less than fifteen million dollars ($15,000,000) for the protection of all insurance exchange policyholders, each individual syndicate shall maintain minimum capital and surplus, or the substantial equivalent thereof, of not less than five million dollars ($5,000,000). If the insurance exchange does

not maintain funds in an amount of not less than fifteen million dollars ($15,000,000) for the protection of all insurance exchange policyholders, each individual syndicate shall meet the minimum capital and surplus requirements of subdivision (2)a. of this section.

d. In the case of a group of incorporated insurers under common administration, which has continuously transacted an insurance business outside the United States for at least three years immediately before this time, and which submits to this State's authority to examine its books and records and bears the expense of the examination, and maintains an aggregate policyholders' surplus of not less than ten billion dollars ($10,000,000,000), and maintains in trust a surplus of not less than one hundred million dollars ($100,000,000) for the benefit of United States surplus lines policyholders of any member of the group, and each insurer maintains capital and surplus of not less than twenty-five million dollars ($25,000,000) per company.

(3) Has caused to be provided to the Commissioner a copy of its current annual statement certified by such insurer; such statement to be provided no more than two months, and for alien insurers six months, after the close of the period reported upon and that is either:

a. Filed with and approved by the regulatory authority in the domicile of the nonadmitted insurer; or

b. Certified by an accounting or auditing firm licensed in the jurisdiction of the insurer's domicile; or

c. In the case of an insurance exchange, the statement may be an aggregate combined statement of all underwriting syndicates operating during the period reported."

SECTION 7. G.S. 58-21-35(a) reads as rewritten:

"**§ 58-21-35. Duty to file and retain reports.**

(a) Within 30 days after the placing of any surplus lines insurance, the surplus lines licensee shall file with the Commissioner a report in a format prescribed by the Commissioner regarding the insurance and including the following information:

(1) The name of the insured.

(2) The identity of the insurer or insurers.

(3) A description of the subject and location of the risk.

(4) The amount of premium charged for the insurance.

(5) The amount of premium tax for the insurance.

(6) The policy period.

(7) The policy number.

(7a) An acknowledged statement that the surplus lines licensee has complied with ~~G.S. 58-21-15.~~G.S. 58-21-15 or G.S. 58-21-16, whichever is applicable.

(8) The name, address, telephone number, facsimile telephone number, and electronic mail address of the licensee, as applicable.

(9) Any other relevant information the Commissioner may reasonably require.

(b) The licensee shall complete and retain a copy of the report in paper or electronic form as required by the Commissioner. The report required by this section and the quarterly report required by G.S. 58-21-80 shall be completed on a standardized form or forms prescribed by the Commissioner and are not public records under G.S. 132-1 or G.S. 58-2-100."

SECTION 8. G.S. 58-21-65 reads as rewritten:

"**§ 58-21-65. Licensing of surplus lines licensee.**

(a) ~~No~~ For insureds whose home state is this State, no agent or broker licensed by the Commissioner shall procure any contract of surplus lines insurance with any nonadmitted insurer, unless he possesses a current surplus lines insurance license issued by the Commissioner.

(b) The Commissioner shall issue a surplus lines license to any qualified holder of a current property broker's or agent's license, but only when the broker or agent has:

(1) Remitted the fifty dollars ($50.00) annual fee to the Commissioner;

(2) Submitted a completed license application on a form supplied by the Commissioner, and the application has been approved by the Commissioner;

(3) Passed a qualifying examination approved by the Commissioner; except that all holders of a license prior to July 11, 1985 shall be deemed to have passed such an examination; and

(4) Repealed by Session Laws 2004-199, s. 20(c), effective August 17, 2004.

(c) Corporations shall be eligible to be resident surplus lines licensees, upon the following conditions:

(1) The corporate licensee shall list individuals within the corporation who have satisfied all requirements of this Article to become surplus lines licensees; and

(2) Only those individuals listed on the corporate license and who are surplus lines licensees shall transact surplus lines business.

(d) Each surplus lines license shall be issued on September 1 of each year and expire August 31 of the following year unless renewed. Application for renewal shall be made 30 days before the expiration date. The license shall be renewed upon payment of the annual license fee and compliance with the other applicable provisions of this section. Any person who places surplus lines insurance without a valid surplus lines license in effect shall pay a penalty of one thousand dollars ($1,000) and be subject to such other penalties as provided by law.

The clear proceeds of civil penalties provided for in this subsection shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2.

(e) Any person who does not renew a surplus lines license and applies for another surplus lines license more than two years after the expiration date of the previous license shall be required to satisfy every condition in this section, including the written exam, before the Commissioner issues another surplus lines license to that person.

~~(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 9. G.S. 58-21-85 reads as rewritten:

"**§ 58-21-85. Surplus lines tax.**

(a) Gross premiums charged, less any return premiums, for surplus lines insurance on insureds for whom North Carolina is the home state are subject to a premium receipts tax of five percent (5%), which shall be collected by the surplus lines licensee as specified by the Commissioner, in addition to the full amount of the gross premium charged by the insurer for the insurance. The tax on any portion of the premium unearned at termination of insurance having been credited by the State to the licensee shall be returned to the policyholder directly by the surplus lines licensee or through the producing broker, if any. The surplus lines licensee is prohibited from absorbing such tax and from rebating for any reason, any part of such tax. To the extent that other states in which portions of the properties, risks, or exposures reside have

failed to enter into a compact or reciprocal allocation procedure with this State, the premium tax collected shall be retained by this State.

(b) At the same time that he files his quarterly report as set forth in G.S. 58-21-80, each surplus lines licensee shall pay the premium receipts tax due for the period covered by the report.

(c) This section does not apply to risks of State government agencies nor to risks of local government risk pools created and operating under Article 23 of this Chapter.

(d) The surplus lines licensee placing the insurance and claiming the exemption in subsection (c) of this section shall affirmatively show in writing to the Commissioner that the risk qualifies for the exemption."

SECTION 10. G.S. 58-22-10(10) reads as rewritten:

"(10) "Risk retention group" means any corporation or other limited liability association:

a. Whose primary activity consists of assuming and spreading all or any portion of the liability exposure of its group members;

b. That is organized for the primary purpose of conducting the activity described under sub-subdivision a. of this subdivision;

c. That

(i) Is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

(ii) Before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before that date, had certified to the insurance regulator of at least one state that it satisfied the capitalization requirements of such state; except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since that date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability, as such terms were defined in the Product Liability Risk Retention Act of 1981 before the effective date of the Risk Retention Act of 1986;

d. That does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such person;

e. That

~~(i) Has as its members only persons who have an ownership interest in the group and that has as its owners only persons who are members who are provided insurance by the risk retention group; or~~

~~(ii) Has as its sole member and sole owner an organization that is owned by persons who are provided insurance by the risk retention group;~~

(i) Has as it owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group; or

(ii) Has as its sole owner an organization that meets all of the following:

(I) Its members are only persons who comprise the membership of the risk retention group; and

(II) Its owners are only persons who comprise the membership of the risk retention group and who are provided insurance by such group;

f. Whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar, or common business trade, product, services, premises, or operations;

g. Whose activities do not include the provision of insurance other than:

(i) Liability insurance for assuming and spreading all or any portion of the similar or related liability exposure of its group members; and

(ii) Reinsurance with respect to the similar or related liability exposure of any other risk retention group, or any ~~members~~ member of such other group, that is engaged in businesses or activities so that such group or member meets the requirement described in sub-subdivision f. of this subdivision from membership in the risk retention group that provides such reinsurance; and

h. The name of which includes the phrase "Risk Retention Group"."

SECTION 11. This act becomes effective June 1, 2011.

SENATE BILL 321:
Surplus Lines/Premium Tax.-AB

2011-2012 General Assembly

Committee:	House Insurance, Serial Referral to Finance	**Date:**	May 15, 2011
Introduced by:	Sen. Apodaca	**Prepared by:**	Tim Hovis
Analysis of:	PCS to Third Edition S321-CSRG-13		Committee Counsel

SUMMARY: ***Senate Bill 321 makes changes to the law governing surplus lines insurers to conform to the federal Nonadmitted and Reinsurance Reform Act of 2010 and to authorize the Commissioner of Insurance to enter into interstate agreements and compacts to prevent the loss of state tax revenue resulting from the federal Act.***

[As introduced, this bill was identical to H299, introduced by Rep. Dockham, which is currently in House Finance.]

PCS: The PCS for Senate Bill 321 deletes language authorizing the Commissioner of Insurance to enter into an interstate compact. Recommendations to enter into such an agreement and, if so, which agreement to enter into, shall be made to the 2012 Regular Session of the General Assembly by the Revenue laws Study Commission. The PCS also adds Section 9 concerning the retention of premium tax revenues for risks located in other states which have not entered into an agreement with NC (See Section 9 below) and makes other conforming changes.

BACKGROUND: Surplus lines insurance coverage is coverage that is not available from insurers licensed in the State, referred to as admitted insurers. This coverage must instead be purchased from insurers who are not licensed in this State, referred to as nonadmitted insurers.

The Nonadmitted and Reinsurance Reform Act (NRRA) was enacted by Congress as part of the Dodd-Frank Wall Street Reform and Protection Act, signed into law in July of 2010. The federal NRRA supersedes aspects of state law regulating surplus lines insurers, requiring the State to make changes to conform to the federal law.

Most notably, the NRRA provides that only the home state of the insured, i.e. the insured's principal place of business, is authorized to tax surplus lines transactions. This change could result in the loss of significant revenue to many states. The NRRA does allow states to enter into interstate compacts for the allocation of tax revenue to prevent this loss. The N.C. Department of Insurance estimates that N.C. may lose $10 to $12 million unless authority is given to the Commissioner to enter into such an agreement.

BILL ANALYSIS: **Section 1.1** adds a new section authorizing the Commissioner to participate in a national insurance producer database for the licensing of surplus lines insurers and to contract with nongovernmental entities to collect the appropriate licensing fees and surplus lines premium taxes.

Section 1.2 directs the Revenue Laws Study Committee, in cooperation with the Commissioner of Insurance, to study the potential impact that would result from the State's entrance into a nonadmitted insurance interstate agreement to determine which compact or agreement would result in the most retention of surplus lines tax revenue for the State. The Committee will report its findings to the 2012 Session of the 2011 General Assembly.

Section 2 adds definitions to conform state law to the federal NRRA.

Section 3 adds a new section defining "home state" as the principal place of business or principal residence of the insured, as required by the NRRA.

Section 4 amends current law to provide that a surplus lines insurer only be required to obtain authorization to write insurance in its domiciliary state, as provided in the NRRA.

Section 5 provides a streamlined process by which a surplus lines licensee, i.e. a broker or agent, may place surplus lines coverage for certain exempt commercial purchasers without conducting a search to determine whether the insurance can be obtained from admitted insurers. To comply with the new procedure, the licensee must satisfy the following: (1) the licensee must disclose to the purchaser that the insurance may or may not be available from the admitted market; and (2) the exempt commercial purchaser must subsequently request in writing that the licensee place the insurance with a non-admitted insurer. This section also defines an "exempt commercial purchaser" for the purposes of the new statutory procedure.

Section 5 also provides that nothing prohibits a licensee from procuring surplus lines insurance from a nonadmitted insurer outside of the United States, known as an "alien" insurer, listed on the NAIC Listing of Alien Insurers.

Section 6 conforms State eligibility criteria for surplus lines insurers to the NAIC Nonadmitted Insurance Model Act, as required by the federal NRRA.

Section 7 makes conforming changes.

Section 8 provides that a NC surplus lines license is required only for those agents or brokers doing business with insureds whose home state is NC. (Under NRRA, only an insured's home state may require a surplus lines broker to be licensed.)

Section 9 adds language to G.S. 58-21-85 governing the surplus lines premium tax providing that the tax is collected "on insureds for whom North Carolina is the home state" as required by the NRRA. This section also provides that, to the extent portions of an insured risk are located in another state that has failed to enter into a compact with NC, any tax collected shall be retained by the State.

Section 10 revises the definition of risk retention group to conform to the definition in federal law.

EFFECTIVE DATE: Senate Bill 321 becomes effective June 1, 2011.

S321-SMRG-19(CSRG-13) v2

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S 3

SENATE BILL 321
Insurance Committee Substitute Adopted 4/14/11
Finance Committee Substitute Adopted 5/3/11

Short Title: Surplus Lines/Premium Tax.-AB (Public)

Sponsors:

Referred to:

March 14, 2011

A BILL TO BE ENTITLED

AN ACT TO CONFORM PROVISIONS OF NORTH CAROLINA SURPLUS LINES INSURANCE LAWS TO THE FEDERAL NONADMITTED AND REINSURANCE REFORM ACT OF 2010, TO STREAMLINE APPLICATIONS FOR COMMERCIAL PURCHASERS, TO PREVENT ANY LOSS OF PREMIUM TAX REVENUE TO THE STATE, AND TO CONFORM THE DEFINITION OF RISK RETENTION GROUP TO FEDERAL LAW.

The General Assembly of North Carolina enacts:

SECTION 1.1. Article 21 of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-21-3. Cooperative or interstate agreements.**

(a) The Commissioner is authorized to enter into a cooperative agreement or interstate agreement or compact to do the following:

(1) Establish additional and alternative nationwide uniform eligibility requirements that shall be applicable to nonadmitted insurers domiciled in another state or territory of the United States.

(2) Facilitate the collection, allocation, and disbursement of premium taxes attributable to the placement of nonadmitted insurance, provide for uniform methods of allocation and reporting among nonadmitted insurance risk classifications, and share information among states relating to nonadmitted insurance premium taxes.

(b) The Commissioner is authorized to enter the NAIC Nonadmitted Insurance Multi-State Agreement or other compact or interstate agreement for the purpose of carrying out the Nonadmitted and Reinsurance Reform Act of 2010.

"**§ 58-21-4. Nonadmitted and Reinsurance Reform Act duties.**

(a) For the purposes of carrying out the provisions of the Nonadmitted and Reinsurance Reform Act of 2010, the Commissioner is authorized to utilize the national insurance producer database of the NAIC, or any other equivalent uniform national database, for the licensure of an individual or an entity as a surplus lines producer and for renewal of such license.

(b) In order to assist in the performance of the Commissioner's duties, under the Nonadmitted and Reinsurance Reform Act of 2010, the Commissioner may contract with nongovernmental entities, including the NAIC or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions that the Commissioner and the nongovernmental entity may deem to be appropriate, including (i) the collection of fees related to producer licensing and (ii) the collection of the premium tax under G.S. 58-21-85. The NAIC or other

entity with whom the Commissioner contracts may charge a reasonable fee to the insurer, insured, or other appropriate person for the functions performed."

SECTION 1.2. The Revenue Laws Study Committee shall, in cooperation with the Commissioner of Insurance, study the potential impact that would result from the State's entrance into a nonadmitted insurance multistate agreement or other compact or interstate agreement for the purpose of carrying out the Nonadmitted and Reinsurance Reform Act of 2010 in order to prevent the State from losing revenue after July 21, 2011, the effective date of the Nonadmitted and Reinsurance Reform Act. The Committee shall determine if entering into a compact or agreement would result in retention of surplus lines tax revenue for the State and, if so, which compact or agreement would result in the most retention of surplus lines tax revenue for the State and the most cost-efficient method of administering the collection and distribution of tax revenues. The Committee shall report its findings and recommendations, including any proposed legislation, to the 2012 Regular Session of the 2011 General Assembly.

SECTION 2. G.S. 58-21-10 reads as rewritten:

"**§ 58-21-10. Definitions.**

As used in this Article:

(1) "Admitted insurer" means an insurer licensed to ~~do an insurance business~~ engage in the business of insurance in this State.

(1a) "Affiliate" means, with respect to an insured, any entity that controls, is controlled by, or is under common control with the insured.

(1b) "Affiliated group" means any group of entities that are all affiliated.

(2) "Capital", as used in the financial requirements of G.S. 58-21-20, means funds paid in for stock or other evidence of ownership.

(2a) "Control" means an entity that has "control" over another entity if either of the following occurs:

a. The entity directly or indirectly or acting through one or more other persons owns, controls, or has the power to vote twenty-five percent (25%) or more of any class of voting securities of the other entity.

b. The entity controls in any manner the election of a majority of the directors or trustees of the other entity.

(3) "Eligible surplus lines insurer" means a nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance under G.S. 58-21-20.

(4) "Export" means to place surplus lines insurance with a nonadmitted insurer.

(5) "Nonadmitted insurer" means an insurer not licensed to do an insurance business in this State. ~~This definition~~ "Nonadmitted insurer" includes insurance exchanges authorized under the laws of various states. "Nonadmitted insurer" does not include a risk retention group, as defined in G.S. 58-22-10(10).

(6) "Producing broker" means an agent or broker licensed under Article 33 of this Chapter who deals directly with the party seeking insurance and who may also be a surplus lines licensee.

(6a) "Reciprocal state" means a state that has enacted provisions substantially similar to the following:

a. G.S. 58-21-85, 58-21-95(5), 58-21-75(10), 58-21-35(7b), and 58-28-5(b).

b. The allocation schedule and reporting form contained in G.S. 58-21-85.

(7) "Surplus", as used in the financial requirements of G.S. 58-21-20, means funds over and above liabilities and capital of the company for the protection of policyholders.

(8) "Surplus lines insurance" means any insurance in this State of risks resident, located, or to be performed in this State, permitted to be placed through a surplus lines licensee with a nonadmitted insurer eligible to accept such insurance, other than reinsurance, commercial aircraft insurance, wet marine and transportation insurance, insurance independently procured pursuant to G.S. 58-28-5, life and accident or health insurance, and annuities.

(9) "Surplus lines licensee" means a person licensed under G.S. 58-21-65 to place insurance on risks resident, located, or to be performed in this State with nonadmitted insurers eligible to accept such insurance.

(10) "Wet marine and transportation insurance" means:

a. Insurance upon vessels, crafts, hulls and of interests therein or with relation thereto;

b. Insurance of marine builder's risks, marine war risks and contracts of marine protection and indemnity insurance;

c. Insurance of freights and disbursements pertaining to a subject of insurance coming within this subsection; and

d. Insurance of personal property and interests therein, in the course of exportation from or importation into any country, or in the course of transportation coastwise or on inland waters including transportation by land, water, or air from point of origin to final destination, in connection with any and all risks or perils of navigation, transit or transportation, and while being prepared for and while awaiting shipment, and during any delays, transshipment, or reshipment incident thereto."

SECTION 3. Article 21 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-21-11. Home state.**

(a) Except as provided in subsection (b) of this section, the term "home state" means, with respect to an insured, either of the following:

(1) The state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence.

(2) If one hundred percent (100%) of the insured risk is located out of the state referred to in subdivision (1) of this subsection, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(b) Affiliated Groups. – If two or more insureds from an affiliated group are named insureds on a single nonadmitted insurance contract, the term "home state" means the home state, as determined pursuant to subsection (a) of this section, of the member of the affiliated group that has the largest percentage of premium attributed to it under that insurance contract."

SECTION 4. G.S. 58-21-15 reads as rewritten:

"**§ 58-21-15. Placement of surplus lines insurance.**

~~Insurance may be procured through a surplus lines licensee from nonadmitted insurers if:~~Surplus lines may be placed by a surplus lines licensee if all of the following apply:

(1) Each insurer is an eligible surplus lines ~~insurer;~~insurer.

(1a) Each insurer is authorized to write the kind of insurance in its domiciliary jurisdiction.

(2) The full amount or kind of insurance cannot be obtained from insurers who are admitted to do business in this State. Such full amount or kind of insurance may be procured from eligible surplus lines insurers, provided that a diligent search is made among the insurers who are admitted to transact

and are actually writing the particular kind and class of insurance in this ~~State; and~~State.

(3) All other requirements of this Article are met."

SECTION 5. Article 21 of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-21-16. Streamlined application for commercial purchasers.**

(a) A surplus lines licensee seeking to procure or place nonadmitted insurance in this State for an exempt commercial purchaser shall not be required to satisfy any requirement under G.S. 58-21-15 to make a due diligence search to determine whether the full amount or type of insurance sought by such exempt commercial purchaser can be obtained from admitted insurers if all of the following apply:

(1) The licensee procuring or placing the surplus lines insurance has disclosed to the exempt commercial purchaser that such insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight.

(2) The exempt commercial purchaser has subsequently requested in writing the licensee to procure or place such insurance from a nonadmitted insurer.

(b) As used in this section, the following definitions apply:

(1) "Exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement, meets all of the following requirements:

a. The person employs or retains a qualified risk manager to negotiate insurance coverage.

b. The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of one hundred thousand dollars ($100,000) in the immediately preceding 12 months.

c. The person meets at least one of the following criteria:

1. The person possesses a net worth in excess of twenty million dollars ($20,000,000), as such amount is adjusted pursuant to subsection (c) of this section.

2. The person generates annual revenues in excess of fifty million dollars ($50,000,000), as such amount is adjusted pursuant to subsection (c) of this section.

3. The person employs more than 500 full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than 1,000 employees in the aggregate.

4. The person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least thirty million dollars ($30,000,000), as such amount is adjusted pursuant to subsection (c) of this section.

5. The person is a municipality with a population in excess of 50,000 persons.

(2) "Qualified risk manager" means, with respect to a policyholder of commercial insurance, a person who meets all of the following requirements:

a. Is an employee of, or third-party consultant retained by, the commercial policyholder.

b. Provides skilled services in loss prevention, loss reduction, or risk and insurance coverage analysis, and purchase of insurance.

c. Has one of the following:

1. A bachelor's degree or higher from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by the Commissioner to demonstrate minimum competence in risk management and one of the following:
   I. Three years of experience in risk financing, claims, administration, loss prevention, risk and insurance analysis, or purchasing commercial lines of insurance.
   II. One of the following designations:
      A. Chartered Property and Casualty Underwriter (CPCU) issued by the American Institute for CPCU/Insurance Institute of America.
      B. Associate in Risk Management (ARM) issued by the American Institute for CPCU/Insurance Institute of America.
      C. Certified Risk Manager (CRM) issued by the National Alliance for Insurance Education & Research.
      D. RIMS Fellow (RF) issued by the Global Risk Management Institute.
      E. A designation, certification, or license determined by the Commissioner to demonstrate minimum competency in risk management.
2. Seven years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; and has any one of the designations specified in sub-sub-sub-sub-subdivisions A. through E. of sub-sub-sub-subdivision II. of this sub-subdivision.
3. Ten years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance.
4. A graduate degree from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by the Commissioner to demonstrate minimum competence in risk management.

(c) Effective on the fifth January 1 occurring after the date of the enactment of this section and each fifth January 1 occurring thereafter, the dollar amounts in sub-sub-subdivisions (b)(1)c.1. 2., 3., and 4. of this section shall be adjusted to reflect the percentage change for such five-year period in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the U.S. Department of Labor.

"**§ 58-21-17. Placement with alien insurers.**

Nothing in this Article prohibits a surplus lines licensee from placing surplus lines insurance with, or procuring surplus lines insurance from, a nonadmitted insurer domiciled outside the United States that is listed on the Quarterly Listing of Alien Insurers maintained by the International Insurers Department of the NAIC."

SECTION 6. G.S. 58-21-20(a) reads as rewritten:

"(a) ~~No surplus lines licensee shall place any coverage with a nonadmitted insurer, unless at the time of placement, such nonadmitted insurer:~~A surplus lines licensee shall not

place coverage with a nonadmitted insurer unless, at the time of placement, the surplus lines licensee has determined that the nonadmitted insurer satisfies the following:

(1) Has established satisfactory evidence of good repute and financial ~~integrity; and~~integrity.

(2) Qualifies under one of the following subdivisions:

a. Has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction, which equals the greater of either:

1. This State's minimum capital and surplus requirements under ~~G.S. 58-7-75, or~~G.S. 58-7-75.

2. Fifteen million dollars ~~($15,000,000),~~($15,000,000). ~~whichever is greater, except that nonadmitted insurers already qualified under this Article must have ten million dollars ($10,000,000) by December 31, 1991, twelve million five hundred thousand dollars ($12,500,000) by December 31, 1992, and fifteen million dollars ($15,000,000) by December 31, 1993. The requirements of this sub-subdivision may be satisfied by an insurer possessing less than the commitment capital and surplus upon an affirmative finding of acceptability by the Commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, and the insurer's record and reputation within the industry. In no event shall the Commissioner make an affirmative finding of acceptability when the insurer's capital and surplus is less than four million five hundred thousand dollars ($4,500,000).~~

~~In addition, an alien insurer qualifies under this subdivision if it complies with the capital and surplus requirements of this subdivision and maintains in the United States an irrevocable trust fund in either a national bank or a member of the Federal Reserve System, in an amount not less than five million four hundred thousand dollars ($5,400,000) for the protection of all of its policyholders in the United States, and the trust fund consists of cash, securities, letters of credit, or of investment of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers authorized to write like kinds of insurance in this State. The trust fund, which shall be included in any calculation of capital and surplus or its equivalent, shall have an expiration date which at no time shall be less than five years; or~~The requirements of this sub-subdivision may be satisfied by an insurer's possessing less than the minimum capital and surplus upon an affirmative finding of acceptability by the Commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability, and company record and reputation within the industry. In no event shall the Commissioner make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than four million five hundred thousand dollars ($4,500,000).

b. In the case of any Lloyd's plans or other similar group of insurers, which consists of unincorporated individual insurers, or a combination of both unincorporated and incorporated insurers,

maintains a trust fund in an amount of not less than one hundred million dollars ($100,000,000) as security to the full amount thereof for all policyholders and creditors in the United States of each member of the group, and the trust shall likewise comply with the terms and conditions established in subdivision (2)a. of this section for alien ~~insurers; and~~insurers.

c. In the case of an "insurance exchange" created by the laws of individual states, maintain capital and surplus, or the substantial equivalent thereof, of not less than seventy-five million dollars ($75,000,000) in the aggregate. For insurance exchanges which maintain funds in an amount of not less than fifteen million dollars ($15,000,000) for the protection of all insurance exchange policyholders, each individual syndicate shall maintain minimum capital and surplus, or the substantial equivalent thereof, of not less than five million dollars ($5,000,000). If the insurance exchange does not maintain funds in an amount of not less than fifteen million dollars ($15,000,000) for the protection of all insurance exchange policyholders, each individual syndicate shall meet the minimum capital and surplus requirements of subdivision (2)a. of this section.

d. In the case of a group of incorporated insurers under common administration, which has continuously transacted an insurance business outside the United States for at least three years immediately before this time, and which submits to this State's authority to examine its books and records and bears the expense of the examination, and maintains an aggregate policyholders' surplus of not less than ten billion dollars ($10,000,000,000), and maintains in trust a surplus of not less than one hundred million dollars ($100,000,000) for the benefit of United States surplus lines policyholders of any member of the group, and each insurer maintains capital and surplus of not less than twenty-five million dollars ($25,000,000) per company.

(3) Has caused to be provided to the Commissioner a copy of its current annual statement certified by such insurer; such statement to be provided no more than two months, and for alien insurers six months, after the close of the period reported upon and that is either:

a. Filed with and approved by the regulatory authority in the domicile of the nonadmitted insurer; or

b. Certified by an accounting or auditing firm licensed in the jurisdiction of the insurer's domicile; or

c. In the case of an insurance exchange, the statement may be an aggregate combined statement of all underwriting syndicates operating during the period reported."

SECTION 7. G.S. 58-21-35(a) reads as rewritten:

"**§ 58-21-35. Duty to file and retain reports.**

(a) Within 30 days after the placing of any surplus lines insurance, the surplus lines licensee shall file with the Commissioner a report in a format prescribed by the Commissioner regarding the insurance and including the following information:

(1) The name of the insured.

(2) The identity of the insurer or insurers.

(3) A description of the subject and location of the risk.

(4) The amount of premium charged for the insurance.

(5) The amount of premium tax for the insurance.
(6) The policy period.
(7) The policy number.
(7a) An acknowledged statement that the surplus lines licensee has complied with ~~G.S. 58-21-15.~~G.S. 58-21-15 or G.S. 58-21-16, whichever is applicable.
(8) The name, address, telephone number, facsimile telephone number, and electronic mail address of the licensee, as applicable.
(9) Any other relevant information the Commissioner may reasonably require.

(b) The licensee shall complete and retain a copy of the report in paper or electronic form as required by the Commissioner. The report required by this section and the quarterly report required by G.S. 58-21-80 shall be completed on a standardized form or forms prescribed by the Commissioner and are not public records under G.S. 132-1 or G.S. 58-2-100."

SECTION 8. G.S. 58-21-65(a) reads as rewritten:

"(a) ~~No~~ For insureds whose home state is this State, no agent or broker licensed by the Commissioner shall procure any contract of surplus lines insurance with any nonadmitted insurer, unless he possesses a current surplus lines insurance license issued by the Commissioner."

SECTION 9. G.S. 58-22-10(10) reads as rewritten:

"(10) "Risk retention group" means any corporation or other limited liability association:
a. Whose primary activity consists of assuming and spreading all or any portion of the liability exposure of its group members;
b. That is organized for the primary purpose of conducting the activity described under sub-subdivision a. of this subdivision;
c. That
(i) Is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or
(ii) Before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before that date, had certified to the insurance regulator of at least one state that it satisfied the capitalization requirements of such state; except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since that date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability, as such terms were defined in the Product Liability Risk Retention Act of 1981 before the effective date of the Risk Retention Act of 1986;
d. That does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such person;
e. That
~~(i) Has as its members only persons who have an ownership interest in the group and that has as its owners only persons who are members who are provided insurance by the risk retention group; or~~

~~(ii) Has as its sole member and sole owner an organization that is owned by persons who are provided insurance by the risk retention group;~~

(i) Has as it owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group; or

(ii) Has as its sole owner an organization that meets all of the following:

(I) Its members are only persons who comprise the membership of the risk retention group; and

(II) Its owners are only persons who comprise the membership of the risk retention group and who are provided insurance by such group;

f. Whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar, or common business trade, product, services, premises, or operations;

g. Whose activities do not include the provision of insurance other than:

(i) Liability insurance for assuming and spreading all or any portion of the similar or related liability exposure of its group members; and

(ii) Reinsurance with respect to the similar or related liability exposure of any other risk retention group, or any ~~members~~ member of such other group, that is engaged in businesses or activities so that such group or member meets the requirement described in sub-subdivision f. of this subdivision from membership in the risk retention group that provides such reinsurance; and

h. The name of which includes the phrase "Risk Retention Group"."

SECTION 10. This act becomes effective June 1, 2011.

SB 321 is identical to HB 299 which received a favorable report April 26th in the House Committee on Insurance and is currently in the House Committee on Finance.

The PCS for SB 321 makes two main changes: First, instead of having the Commissioner of Insurance decide which interstate agreement the State should enter to decide how to divide the surplus lines taxes we will receive from other states, the Revenue Laws study Commission will make that decision. Because neither interstate agreement is up and running yet, and because so many state legislatures are still in session and have not decided what they are going to do yet, the thinking was that it may be in the best interest of the state to do it this way. This is all General Fund money, it does not go to the Department.

The other changes the bill makes are more conforming changes to the new federal law.

PCS: The PCS for Senate Bill 321 deletes language authorizing the Commissioner of Insurance to enter into an interstate compact. Recommendations to enter into such an agreement and, if so, which agreement to enter into, shall be made to the 2012 Regular Session of the General Assembly by the Revenue laws Study Commission. The PCS also adds Section 9 concerning the retention of premium tax revenues for risks located in other states which have not entered into an agreement with NC (See Section 9 below) and makes other conforming changes.

SB 321 had no NO votes in the Senate.

2011 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
HB 501 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR THE FORMATION AND OWNERSHIP OF STOCK LIFE INSURANCE COMPANIES BY CREDIT UNIONS.

☒ 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 BANKING.

(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 2011

H D

HOUSE BILL 501
PROPOSED COMMITTEE SUBSTITUTE H501-CSTG-18 [v.4]

5/16/2011 2:44:36 PM

Short Title: Credit Union Ownership of Ins. Co. (Public)

Sponsors:

Referred to:

March 30, 2011

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE OWNERSHIP OF INSURANCE COMPANIES BY CREDIT UNIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 54-109.21(22) reads as rewritten:

"(22) Purchase or make available insurance for its directors, officers, agents, employees, and members; insurance may be provided through any insurance company or through any subsidiary insurance company owned by the credit union; and".

SECTION 2. G.S. 54-109.75 is amended by adding a new subsection to read:

"(c) Insurance may be provided through any insurance company or through any subsidiary insurance company owned by the credit union."

SECTION 3. G.S. 54-109.82 reads as rewritten:

"**§ 54-109.82. Investment of funds.**

The capital, deposits, undivided profits and reserve fund of the corporation may be invested only in any of the following ways:

...

(2) In capital shares, obligations, or preferred stock issues of any ~~agency~~ agency, company, or association organized either as a stock company, mutual association, or membership corporation, provided the membership or stockholdings, as the case may be, of the ~~agency~~ agency, company, or association are confined or restricted to credit unions or organizations of credit unions, or provided the purpose for which the ~~agency~~ agency, company, or association is organized or designed is to service or otherwise assist credit union operations.

...

(7) In an aggregate amount not to exceed twenty-five percent (25%) of the allocations to the reserve fund in any ~~agency~~ agency, company, or association of the type described in subdivision (2) of this section provided the purposes of the ~~agency~~ agency, company, or association are designed to assist in establishing and maintaining liquidity, solvency, and security in credit union operations.

...."

SECTION 4. G.S. 58-7-162(1) reads as rewritten:

"(1) Cash in the possession of the insurer, or in transit under its control, and including the true balance of any deposit in a solvent United States bank, savings and loan association, credit union, or trust company, and the balance of any such deposit in an insolvent United States bank, savings and loan association, credit union, or trust company, to the extent insured by a federal agency."

SECTION 5. G.S. 58-7-172 reads as rewritten:

"**§ 58-7-172. Cash and deposits.**

An insurer may have funds in coin or currency of the United States on hand or on deposit in any solvent national or state bank, savings and loan association, credit union, or trust company."

SECTION 6. G.S. 58-7-173(14) reads as rewritten:

"(14) Share or savings accounts of credit unions, savings and loan associations or building and loan associations."

SECTION 7. This act becomes effective October 1, 2011.

HOUSE BILL 501:
Credit Union Ownership Ins. Co

2011-2012 General Assembly

Committee:	House Insurance, if favorable, Banking	**Date:**	May 16, 2011
Introduced by:	Reps. Glazier, Dockham, Hamilton, Setzer	**Prepared by:**	Bill Patterson Committee Counsel
Analysis of:	PCS to First Edition H501-CSTG-18		

SUMMARY: ***The PCS to House Bill 501 will authorize any state-chartered credit union to offer insurance to its directors, officers, agents, employees and members through any subsidiary insurance company owned by the credit union.*** ***The PCS makes technical corrections to the bill and its title.***

CURRENT LAW: State-chartered credit unions are granted specific powers under Chapter 54 of the General Statutes.

- G.S. 54-109.21 authorizes credit unions to purchase or make available insurance for its directors, officers, agents, employees, and members.
- G.S. 54-109.75 authorizes credit unions to purchase or make available insurance for its members in amounts related to their respective ages, shares, deposits or loan balances or any combination of those factors. There is no current express statutory authority for state-chartered credit unions to form and own an insurance company for these purposes.
- G.S. 54-109.82 authorizes the investment of credit union funds in capital shares, obligations or preferred stock issues to "any agency or association organized either as a stock company, mutual association, or membership corporation, provided the membership or stockholdings, as the case may be, of the agency or association are confined or restricted to credit unions or organizations of credit unions, or provided the purpose for which the agency or association is organized or designed is to service or otherwise assist credit union operations."

Chapter 58 includes a number of sections relating to funds held or invested by insurance companies in financial institutions:

- G.S. 58-7-162(1) permits the balance of any insurance company's deposited in a U.S. bank, savings and loan, or trust company to be considered in determining the financial condition of the insurer.
- G.S. 58-7-172 authorizes an insurer to deposit funds with a national or state bank, savings and loan association or trust company.
- G.S. 58-173(14) permits an insurer to invest funds in share or savings accounts of savings and loan associations or building and loan associations.

BILL ANALYSIS: The PCS to House Bill 501 amends G.S. 54-109.21 and G.S. 54-109.75 to authorize credit unions to provide insurance through any insurance company, including any subsidiary insurance company owned by the credit union. The PCS makes conforming changes to G.S. 54-109.82 to authorize credit union funds to be invested in a "company" as well as an "agency or association." The PCS also makes conforming changes to G.S. 58-162(1), 58-172 and 58-173(14) to add "credit unions" to he list of financial institutions referenced in those sections.

EFFECTIVE DATE: This act becomes effective October 1, 2011.

H501-SMTG-22(CSTG-18) v1

HOUSE BILL 501

Short Title:	Credit Union Ownership of Stock Life Ins. Co.	(Public)
Sponsors:	Representatives Glazier, Dockham, Hamilton, and Setzer (Primary Sponsors). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Insurance, if favorable, Banking.	

March 30, 2011

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE FORMATION AND OWNERSHIP OF STOCK LIFE INSURANCE COMPANIES BY CREDIT UNIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 54-109.21(22) reads as rewritten:

"(22) Purchase or make available insurance for its directors, officers, agents, employees, and members; insurance may be provided through any insurance company or through any subsidiary insurance company owned by the credit union; and".

SECTION 2. G.S. 54-109.75 is amended by adding a new subsection to read:

"(c) Insurance may be provided through any insurance company or through any subsidiary insurance company owned by the credit union."

SECTION 3. G.S. 54-109.82 reads as rewritten:

"**§ 54-109.82. Investment of funds.**

The capital, deposits, undivided profits and reserve fund of the corporation may be invested only in any of the following ways:

...

(2) In capital shares, obligations, or preferred stock issues of any ~~agency~~ agency, company, or association organized either as a stock company, mutual association, or membership corporation, provided the membership or stockholdings, as the case may be, of the agency or association are confined or restricted to credit unions or organizations of credit unions, or provided the purpose for which the ~~agency~~ agency, company, or association is organized or designed is to service or otherwise assist credit union operations.

...

(7) In an aggregate amount not to exceed twenty-five percent (25%) of the allocations to the reserve fund in any ~~agency~~ agency, company, or association of the type described in subdivision (2) of this section provided the purposes of the ~~agency~~ agency, company, or association are designed to assist in establishing and maintaining liquidity, solvency, and security in credit union operations.

...."

SECTION 4. G.S. 58-7-162(1) reads as rewritten:

"(1) Cash in the possession of the insurer, or in transit under its control, and including the true balance of any deposit in a solvent United States bank, savings and loan association, credit union, or trust company, and the balance of any such deposit in an insolvent United States bank, savings and loan association, credit union, or trust company, to the extent insured by a federal agency."

SECTION 5. G.S. 58-7-172 reads as rewritten:

"**§ 58-7-172. Cash and deposits.**

An insurer may have funds in coin or currency of the United States on hand or on deposit in any solvent national or state bank, savings and loan association, credit union, or trust company."

SECTION 6. G.S. 58-7-173(14) reads as rewritten:

"(14) Share or savings accounts of credit unions, savings and loan associations or building and loan associations."

SECTION 7. This act becomes effective October 1, 2011.

2011 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

By Representative Dockham (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 575 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT IN LIEU OF CONTRACTUAL LIABILITY INSURANCE, A SERVICE CONTRACT PROVIDER MAY MAINTAIN A FUNDED RESERVE ACCOUNT FOR ITS OBLIGATIONS UNDER SERVICE CONTRACTS ISSUED AND OUTSTANDING IN THIS STATE.

☒ 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.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 575
PROPOSED COMMITTEE SUBSTITUTE H575-CSRG-15 [v.1]

5/17/2011 10:06:41 AM

Short Title: Service Agreements/Allow Reserve Account. (Public)

Sponsors:

Referred to:

April 4, 2011

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT IN LIEU OF CONTRACTUAL LIABILITY INSURANCE, A SERVICE CONTRACT PROVIDER MAY MAINTAIN A FUNDED RESERVE ACCOUNT FOR ITS OBLIGATIONS UNDER SERVICE CONTRACTS ISSUED AND OUTSTANDING IN THIS STATE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 66-373 reads as rewritten:

"**§ 66-373. Insurance policy requirements.**

(a) Each company or person subject to this section shall maintain contractual liability insurance or service agreement reimbursement insurance with an authorized insurer for one hundred percent (100%) of claims exposure, including reported and incurred but not reported claims and claims expenses, on business written in this State unless the company or ~~person:~~person complies with all of the following:

(1) Maintains an audited net worth of ~~one hundred million dollars ($100,000,000);~~ one hundred million dollars ($100,000,000).

(2) Has offered service agreement contracts or warranties, as applicable to the respective company, its parent company, or person, for at least the preceding 10 ~~years; and~~years.

(3) Either is required to file and has filed an SEC Form 10K or Form 20-F with the Securities and Exchange Commission (SEC) within the last calendar year or, if the company does not file with the SEC, can produce, upon request, a copy of the company's audited financial statements, which show a net worth of the company or person of at least one hundred million dollars ($100,000,000). A company or person may utilize its parent company's Form 10-K, Form 20-F, or audited financial statements to satisfy this requirement if the parent company agrees to guarantee the obligations of the company or person relating to service agreement contracts or warranties, as applicable to the respective company or person, sold by the company or person in this State.

In lieu of complying with subdivisions (1), (2), and (3) of this subsection, the company or person may maintain a funded reserve account for the purpose of meeting its obligations under contracts issued and outstanding in this State. The reserves shall not be less than forty percent

(40%) of gross consideration received, less claims paid, on the sale of the service contract for all in-force contracts.

..."

SECTION 2. This act becomes effective July 1, 2011.

HOUSE BILL 575:
Service Agreements/Allow Reserve Account

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	May 17, 2011
Introduced by:	Rep. Dockham	**Prepared by:**	Tim Hovis
Analysis of:	PCS to First Edition H575-CSRG-15		Committee Counsel

BACKGROUND: Article 43 of Chapter 66 of the General Statutes regulates motor vehicle, home appliance, and mechanical breakdown service agreements and the companies providing these agreements. Among its provisions, the Article requires service agreement providers to maintain insurance for 100% of claims exposure, unless the company complies with the following:

- Maintains an audited net worth of $100,000,000.
- Has offered services agreement contracts for at least 10 years.
- Is required and has filed necessary Securities and Exchange Commission forms or can produce audited financial statements showing a net worth of at least $100,000,000.

SUMMARY: In lieu of the insurance and financial requirements outlined above, House Bill 575 would allow service agreement providers to maintain a funded reserve account of not less than 40% of gross consideration received on the sale of service contracts for all in-force contracts, less claims paid.

EFFECTIVE DATE: House Bill 575 becomes effective July 1, 2011.

H575-SMRG-22(CSRG-15) v1

HOUSE BILL 575

Short Title:	Service Agreements/Allow Reserve Account.	(Public)
Sponsors:	Representative Dockham (Primary Sponsor). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Insurance.	

April 4, 2011

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT IN LIEU OF CONTRACTUAL LIABILITY INSURANCE, A SERVICE CONTRACT PROVIDER MAY MAINTAIN A FUNDED RESERVE ACCOUNT FOR ITS OBLIGATIONS UNDER SERVICE CONTRACTS ISSUED AND OUTSTANDING IN THIS STATE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 66-373 reads as rewritten:

"**§ 66-373. Insurance policy requirements.**

(a) Each company or person subject to this section shall maintain contractual liability insurance or service agreement reimbursement insurance with an authorized insurer for one hundred percent (100%) of claims exposure, including reported and incurred but not reported claims and claims expenses, on business written in this State unless the company or ~~person:~~person complies with all of the following:

(1) Maintains an audited net worth of ~~one hundred million dollars ($100,000,000);~~ one hundred million dollars ($100,000,000).

(2) Has offered service agreement contracts or warranties, as applicable to the respective company, its parent company, or person, for at least the preceding 10 ~~years; and~~years.

(3) Either is required to file and has filed an SEC Form 10K or Form 20-F with the Securities and Exchange Commission (SEC) within the last calendar year or, if the company does not file with the SEC, can produce, upon request, a copy of the company's audited financial statements, which show a net worth of the company or person of at least one hundred million dollars ($100,000,000). A company or person may utilize its parent company's Form 10-K, Form 20-F, or audited financial statements to satisfy this requirement if the parent company agrees to guarantee the obligations of the company or person relating to service agreement contracts or warranties, as applicable to the respective company or person, sold by the company or person in this State.

In lieu of complying with subdivisions (1), (2), and (3) of this subsection, the company or person may maintain a funded reserve account for the purpose of meeting its obligations under contracts issued and outstanding in this State. The reserves shall not be less than forty percent (40%) of gross consideration received, less claims paid, on the sale of the service contract for all in-force contracts. The reserve account shall be subject to examination and review by the Commissioner upon request.

..."

SECTION 2. This act becomes effective July 1, 2011.

ATTACHMENT IV

FUNDED RESERVE ACCOUNT (HOUSE BILL 575)

TALKING POINTS

1. THIS BILL AMENDS EXISTING LAW REGARDING SERVICE AGREEMENTS COVERED UNDER CHAPTER 66 OF THE GENERAL STATUTES.
2. THIS CHANGE WOULD PROVIDE THAT COMPANIES OFFERING SERVICE CONTRACTS COULD MEET THEIR FINANCIAL ASSURANCE REQUIREMENTS BY MAINTAINING A FUNDED RESERVE ACCOUNT.
3. THIS PROVISION WAS IN THE INSURANCE CODE IN CHAPTER 58 AND WAS INADVERTENTLY LEFT OUT WHEN THE SERVICE AGREEMENT PROVISIONS OF THE LAW WERE RECODIFIED IN 2007.
4. THIS CHANGE WOULD CONFORM NORTH CAROLINA LAW TO THE NAIC MODEL LAW. THIS FUNDED RESERVE OPTION IS THE STANDARD, NOT ONLY IN THE INDUSTRY BUT ALSO IN ALMOST EVERY OTHER STATE.
5. POSTING RESERVES HAS PROVEN THE MOST SOUND WAY IN PROMOTING SERVICE AGREEMENT PROVIDERS SOLVENCY.
6. A CONTRACTUAL LIABILITY REQUIREMENT ONLY, SIMPLY ADDS COSTS, HAS INDUCED UNSATISFACTORY RESERVING BY QUESTIONABLE OPERATORS, AND IS ADVERSE TO SMALL BUSINESS PROVIDERS FOR WHEN THE INSURANCE MARKET IS OR CAN BE UNAVAILABLE.

ATTACHMENT V

HOUSE BILL 575:
Service Agreements/Allow Reserve Account

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	May 16, 2011
Introduced by:	Rep. Dockham	**Prepared by:**	Tim Hovis
Analysis of:	First Edition		Committee Counsel

BACKGROUND: Article 43 of Chapter 66 of the General Statutes regulates motor vehicle, home appliance, and mechanical breakdown service agreements and the companies providing these agreements. Among its provisions, the Article requires service agreement providers to maintain insurance for 100% of claims exposure, unless the company complies with the following:

- Maintains an audited net worth of $100,000,000.
- Has offered services agreement contracts for at least 10 years.
- Is required and has filed necessary Securities and Exchange Commission forms or can produce audited financial statements showing a net worth of at least $100,000,000.

SUMMARY: In lieu of the insurance and financial requirements outlined above, House Bill 575 would allow service agreement providers to maintain a funded reserve account of not less than 40% of gross consideration received on the sale of service contracts for all in-force contracts, less claims paid. The reserve account is subject to examination and review by the Commissioner.

EFFECTIVE DATE: House Bill 575 becomes effective July 1, 2011.

H575-SMRG-20(e1) v1

2011 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

By Representative Dockham (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 617 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR THE REGULATION OF PORTABLE ELECTRONICS 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 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.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 617
PROPOSED COMMITTEE SUBSTITUTE H617-CSRG-14 [v.2]

5/16/2011 8:11:32 PM

Short Title: Portable Electronics Insurance Coverage. (Public)

Sponsors:

Referred to:

April 6, 2011

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE REGULATION OF PORTABLE ELECTRONICS INSURANCE.

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 44A.

"Portable Electronics Insurance.

"**§ 58-44A-1. Definitions.**

As used in this Article, the following definitions apply:

(1) Customer. – A person who purchases portable electronics or services.

(2) Enrolled customer. – A customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics.

(3) Location. – Any physical location in the State of North Carolina or any Web site, call center site, or similar location directed to residents of the State of North Carolina.

(4) Portable electronics. – Electronic devices that are portable in nature, their accessories, and services related to the use of the device.

(5) Portable electronics insurance. – Insurance providing coverage for the repair or replacement of portable electronics which may provide coverage for portable electronics against any one or more of the following causes of loss: (i) loss, (ii) theft, and (iii) inoperability due to mechanical failure, malfunction, damage, or other similar causes of loss. The term does not include the following:

a. A service contract or extended warranty providing coverage limited to the repair, replacement, or maintenance of property for the operational or structural failure of the property due to a defect in materials, workmanship, accidental damage from handling, power surges, or normal wear and tear.

b. A policy of insurance covering a seller's or a manufacturer's obligations under a warranty.

c. A homeowner's, renter's, private passenger automobile, commercial multiperil, or similar policy.

(6) Portable electronics transaction. – Either of the following:

a. The sale or lease of portable electronics by a vendor to a customer.
b. The sale of a service related to the use of portable electronics by a vendor to a customer.

(7) Supervising entity. – A business entity that is a licensed insurer or insurance producer.

(8) Vendor. – A person in the business of engaging in portable electronics transactions directly or indirectly.

"**§ 58-44A-5. Licensure of vendors.**

(a) A vendor is required to hold a limited lines license to sell or offer coverage under a policy of portable electronics insurance.

(b) A limited lines license issued under this subdivision shall authorize any employee or authorized representative of the vendor to sell or offer coverage under a policy of portable electronics insurance to a customer at each location at which the vendor engages in portable electronics transactions.

(c) Notwithstanding any other provision of law, a license issued pursuant to this section shall authorize the licensee and its employees or authorized representatives to engage in those activities that are permitted in this section.

"**§ 58-44A-10. Requirements for sale of portable electronics insurance.**

(a) At every location where portable electronics insurance is offered to customers, brochures or other written materials shall be made available to a prospective customer. Those materials shall do the following:

(1) Disclose that portable electronics insurance may provide a duplication of coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy, or other source of coverage.

(2) State that the enrollment by the customer in a portable electronics insurance program is not required in order to purchase or lease portable electronics or services.

(3) Summarize the material terms of the insurance coverage, including:

a. The identity of the insurer.
b. The identity of the supervising entity.
c. The amount of any applicable deductible and how it is to be paid.
d. Benefits of the coverage.
e. Key terms and conditions of coverage, such as whether portable electronics may be repaired or replaced with similar make and model reconditioned or nonoriginal manufacturer parts or equipment.

(4) Summarize the process for filing a claim, including a description of how to return portable electronics and the maximum fee applicable in the event the enrolled customer fails to comply with any equipment return requirements.

(5) State that the enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and the person paying the premium shall receive a refund of any applicable unearned premium.

(b) Portable electronics insurance may be offered on a month-to-month or other periodic basis as a group or master commercial inland marine policy issued to a vendor of portable electronics for its enrolled customers.

(c) Eligibility and underwriting standards for customers electing to enroll in coverage shall be established for each portable electronics insurance program.

(d) The terms of the termination or modification of coverage under a policy of portable electronic insurance offered in compliance with this section shall be as set forth in the policy.

"**§ 58-44A-15. Authority of vendors of portable electronics.**

(a) The employees and authorized representatives of vendors may sell or offer portable electronics insurance to customers and shall not be subject to licensure as an insurance producer under this Chapter provided that the following are true:

(1) The vendor obtains a limited lines license to authorize its employees or authorized representatives to sell or offer portable electronics insurance pursuant to this section.

(2) The insurer issuing the portable electronics insurance either directly supervises or appoints a supervising entity to supervise the administration of the program, including development of a training program for employees and authorized representatives of the vendors. The training required by this subdivision shall comply with the following:

a. The training shall be delivered to employees and authorized representatives of a vendor who are directly engaged in the activity of selling or offering portable electronics insurance.

b. The training may be provided in electronic form. If conducted in an electronic form, the supervising entity shall implement a supplemental education program regarding portable electronics insurance that is conducted and overseen by licensed employees of the supervising entity.

c. Each employee and authorized representative shall receive basic instruction about the portable electronics insurance offered to customers and the disclosures required under G.S. 58-44A-10.

(3) No employee or authorized representative of a vendor of portable electronics shall advertise, represent, or otherwise hold himself or herself out as a non-limited lines licensed insurance producer.

(b) The charges for portable electronics insurance coverage may be billed and collected by the vendor of portable electronics. Any charge to the enrolled customer for coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services, shall be separately itemized on the enrolled customer's bill. If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included with the portable electronics or related services. Vendors billing and collecting such charges shall not be required to maintain such funds in a segregated account, provided that the vendor is authorized by the insurer to hold such funds in an alternative manner and remits such amounts to the supervising entity within 60 days of receipt. All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Vendors may receive compensation for billing and collection services in accordance with G.S. 58-33-85.

"**§ 58-44A-20. Suspension or revocation of license.**

If a vendor of portable electronics or its employee or authorized representative violates any provision of this section, the Commissioner may do any of the following:

(1) Revoke or suspend a limited license issued under this Part in accordance with the provisions of G.S. 58-33-46.

(2) After notice and hearing, impose other penalties, including suspending the transaction of insurance at specific locations where violations of this Article have occurred, as the Commissioner deems necessary and reasonable to carry out the purpose of this Article.

"**§ 58-44A-25. Application for license.**

The prerequisites for issuance of a limited license under this Article are the filing with the Commissioner of the following

(1) A license application, signed by an officer of the applicant, for the limited license in such form or forms, and supplements thereto, and containing such information, as the Commissioner may prescribe.

(2) A certificate by the insurer that is to be named in such limited license, stating that it has satisfied itself that the named applicant is trustworthy and competent to act as its insurance agent for this limited purpose and that the insurer will appoint such applicant to act as the agent in reference to the doing so such kind or kinds of insurance as are permitted by this section, if the limited license applied for is issued by the Commissioner. Such certificate shall be subscribed to by an officer or managing agent of such insurer and affirmed as true under the penalties of perjury.

SECTION 2. This act becomes effective January 1, 2012.

HOUSE BILL 617:
Portable Electronics Insurance Coverage

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	May 16, 2011
Introduced by:	Rep. Dockham	**Prepared by:**	Tim Hovis
Analysis of:	PCS to First Edition H617-CSRG-14		Committee Counsel

SUMMARY: The Proposed Committee Substitute for House Bill 617 enacts a new Article 44A of Chapter 58 of the General Statutes, Portable Electronics Insurance, to provide for the regulation of portable electronics insurance and the licensing of vendors.

Sections enacted by the bill are outlined below.

G.S. 58-44A-1. Definitions

New G.S. 58-44A.1 contains definitions for the Article, including the following:

- "Portable electronics" are electronic devices that are portable in nature, their accessories, and services.
- "Portable electronics insurance" is insurance for the repair or replacement of portable electronics covering losses for loss, theft, or inoperability of the device. Portable electronics insurance does not include a service contract or extended warranty, a policy of insurance covering a seller's or manufacturer's obligations under a warranty, or a homeowner's, renter's private passenger auto, a commercial multiperil or similar policy.
- "Vendor" is a person in the business of engaging in portable electronics transactions directly or indirectly.

G.S. 58-44A.5. Licensure of vendors

Vendors are required to hold a limited lines license to sell or offer coverage. A limited lines license would enable the vendor and its employees and representatives to sell portable electronics coverage.

G.S. 58-44A-10. Requirements for sale of portable electronics insurance.

Written materials outlining the following must be made available at every location where insurance is offered:

- Disclosing that the insurance may be a duplication of the customer's existing coverage.
- Stating that enrollment is not required for purchase of the device.
- Summarizing the material terms of the coverage, and the process for filing a claim.
- Stating that cancellation and refund of applicable unearned premiums is available at any time.

G.S. 58-44A-15. Authority of vendors of portable electronics.

Employees and authorized representatives of a vendor are not subject to licensure if the vendor obtains a limited lines license and the insurer issuing the insurance supervises or appoints a supervising entity to administer the program, including a training program for employees and authorized representatives.

Charges for coverage may be billed and collected by the vendor. Charges that are not included in the cost purchase or lease of portable electronics services must be separately itemized. Vendors are not

required to hold the funds in a separate account, provided the insurer has authorized to hold the funds in an alternative manner and remit them to the supervising entity within 60 days of receipt.

G.S. 58-44A-20. Suspension or revocation of license.

The Commissioner is authorized to revoke or suspend the vendor's license for a violation of any provision of the Article and, after notice and hearing, may impose other penalties including suspending the transaction of insurance at specific locations where violations have occurred.

G.S. 58-44A-25. Application for license.

A license application, signed by an officer of the applicant, and an affirmed certificate by the insurer stating that the applicant is trustworthy and competent to act as its agent must be filed with the Commissioner to obtain a limited license under the Article.

EFFECTIVE DATE: The Proposed Committee Substitute for House Bill 617 becomes effective January 1, 2012.

H617-SMRG-21(CSRG-14) v3

HOUSE BILL 617

Short Title:	Portable Electronics Insurance Coverage.	(Public)
Sponsors:	Representative Dockham (Primary Sponsor). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Insurance.	

April 6, 2011

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE REGULATION OF PORTABLE ELECTRONICS INSURANCE.

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 44A.

"Portable Electronics Insurance.

"**§ 58-44A-1. Definitions.**

As used in this Article, the following definitions apply:

(1) Customer. – A person who purchases portable electronics or services.

(2) Enrolled customer. – A customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics.

(3) Location. – Any physical location in the State of North Carolina or any Web site, call center site, or similar location directed to residents of the State of North Carolina.

(4) Portable electronics. – Electronic devices that are portable in nature, their accessories, and services related to the use of the device.

(5) Portable electronics insurance. – Insurance providing coverage for the repair or replacement of portable electronics which may provide coverage for portable electronics against any one or more of the following causes of loss: loss, theft, inoperability due to mechanical failure, malfunction, damage, or other similar causes of loss. The term does not include the following:

a. A service contract or extended warranty providing coverage limited to the repair, replacement, or maintenance of property for the operational or structural failure of the property due to a defect in materials, workmanship, accidental damage from handling, power surges, or normal wear and tear.

b. A policy of insurance covering a seller's or a manufacturer's obligations under a warranty.

c. A homeowner's, renter's, private passenger automobile, commercial multiperil, or similar policy.

(6) Portable electronics transaction. – Either of the following:

a. The sale or lease of portable electronics by a vendor to a customer.

b. The sale of a service related to the use of portable electronics by a vendor to a customer.

(7) Supervising entity. – A business entity that is a licensed insurer or insurance producer.

(8) Vendor. – A person in the business of engaging in portable electronics transactions directly or indirectly.

"**§ 58-44A-5. Licensure of vendors.**

(a) A vendor is required to hold a limited lines license to sell or offer coverage under a policy of portable electronics insurance.

(b) A limited lines license issued under this subdivision shall authorize any employee or authorized representative of the vendor to sell or offer coverage under a policy of portable electronics insurance to a customer at each location at which the vendor engages in portable electronics transactions.

(c) In connection with a vendor's application for licensure, and quarterly thereafter, the vendor shall provide a list to the Commissioner of all locations in this State at which it offers coverage.

(d) Notwithstanding any other provision of law, a license issued pursuant to this section shall authorize the licensee and its employees or authorized representatives to engage in those activities that are permitted in this section.

"**§ 58-44A-10. Requirements for sale of portable electronics insurance.**

(a) At every location where portable electronics insurance is offered to customers, brochures or other written materials shall be made available to a prospective customer. Those materials shall do the following:

(1) Disclose that portable electronics insurance may provide a duplication of coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy, or other source of coverage.

(2) State that the enrollment by the customer in a portable electronics insurance program is not required in order to purchase or lease portable electronics or services.

(3) Summarize the material terms of the insurance coverage, including:

a. The identity of the insurer.

b. The identity of the supervising entity.

c. The amount of any applicable deductible and how it is to be paid.

d. Benefits of the coverage.

e. Key terms and conditions of coverage, such as whether portable electronics may be repaired or replaced with similar make and model reconditioned or nonoriginal manufacturer parts or equipment.

(4) Summarize the process for filing a claim, including a description of how to return portable electronics and the maximum fee applicable in the event the enrolled customer fails to comply with any equipment return requirements.

(5) State that the enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and the person paying the premium shall receive a refund of any applicable unearned premium.

(b) Portable electronics insurance may be offered on a month-to-month or other periodic basis as a group or master commercial inland marine policy issued to a vendor of portable electronics for its enrolled customers.

(c) Eligibility and underwriting standards for customers electing to enroll in coverage shall be established for each portable electronics insurance program.

"**§ 58-44A-15. Authority of venders of portable electronics.**

(a) The employees and authorized representatives of vendors may sell or offer portable electronics insurance to customers and shall not be subject to licensure as an insurance producer under this Chapter provided that the following are true:

(1) The vendor obtains a limited lines license to authorize its employees or authorized representatives to sell or offer portable electronics insurance pursuant to this section.

(2) The insurer issuing the portable electronics insurance either directly supervises or appoints a supervising entity to supervise the administration of the program, including development of a training program for employees and authorized representatives of the vendors. The training required by this subdivision shall comply with the following:

a. The training shall be delivered to employees and authorized representatives of a vendor who are directly engaged in the activity of selling or offering portable electronics insurance.

b. The training may be provided in electronic form. If conducted in an electronic form, the supervising entity shall implement a supplemental education program regarding portable electronics insurance that is conducted and overseen by licensed employees of the supervising entity.

c. Each employee and authorized representative shall receive basic instruction about the portable electronics insurance offered to customers and the disclosures required under G.S. 50-44A-10.

(3) No employee or authorized representative of a vendor of portable electronics shall advertise, represent, or otherwise hold himself or herself out as a non-limited lines licensed insurance producer.

(b) The charges for portable electronics insurance coverage may be billed and collected by the vendor of portable electronics. Any charge to the enrolled customer for coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services, shall be separately itemized on the enrolled customer's bill. If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included with the portable electronics or related services. Vendors billing and collecting such charges shall not be required to maintain such funds in a segregated account, provided that the vendor is authorized by the insurer to hold such funds in an alternative manner and remits such amounts to the supervising entity within 60 days of receipt. All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Vendors may receive compensation for billing and collection services.

"**§ 58-44A-20. Suspension or revocation of license.**

If a vendor of portable electronics or its employee or authorized representative violates any provision of this section, the Commissioner may do any of the following:

(1) After notice and hearing, impose fines not to exceed five hundred dollars ($500.00) per violation or five thousand dollars ($5,000) in the aggregate for such conduct.

(2) After notice and hearing, impose other penalties that the Commissioner deems necessary and reasonable to carry out the purpose of this Article, including the following:

a. Suspending the privilege of transacting portable electronics insurance pursuant to this section at specific business locations where violations have occurred.

b. Suspending or revoking the ability of individual employees or authorized representatives to act under the license.

"**§ 58-44A-25. Termination of portable electronics insurance.**

(a) An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least 30 days' notice.

(b) If the insurer changes the terms and conditions, then the insurer shall provide the vendor policyholder with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure, or other evidence indicating a change in the terms and conditions has occurred, and a summary of material changes.

(c) Notwithstanding subsection (a) of this section, an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon 15 days' notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim thereunder.

(d) Notwithstanding subsection (a) of this section, an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy for any of the following reasons:

(1) Nonpayment of premium.

(2) The enrolled customer ceases to have an active service with the vendor of portable electronics.

(3) An enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sent notice of termination to the enrolled customer within 30 calendar days after exhaustion of the limit. However, if notice was not timely sent, then enrollment shall continue, notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer.

(e) Where a portable electronics insurance policy is terminated by a policyholder, the policyholder shall mail or deliver written notice to each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The written notice shall be mailed or delivered to the enrolled customer at least 30 days prior to the termination.

(f) Whenever notice is required pursuant to this section, it shall be in writing and may be mailed or delivered to the vendor of portable electronics at the vendor's mailing address and to its affected enrolled customers' last known mailing addresses on file with the insurer. If notice is mailed, the insurer or vendor of portable electronics, as the case may be, shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service or other commercial mail delivery service. Alternatively, an insurer or vendor policyholder may comply with any notice required by this section by providing electronic notice to a vendor or its affected enrolled customers, as the case may be, by electronic means. If notice is accomplished through electronic means, the insurer or vendor of portable electronics, as the case may be, shall maintain proof that the notice was sent.

"**§ 58-44A-30. Application for license and fees.**

(a) A sworn application for a license under this Article shall be made to and filed with the Department of Insurance on forms prescribed and furnished by the Commissioner.

(b) The application shall do the following:

(1) Provide the name, residence address, and other information required by the Commissioner for an employee or officer of the vendor that is designated by the applicant as the person responsible for the vendor's compliance with the requirements of this Chapter. However, if the vendor derives more than fifty percent (50%) of its revenue from the sale of portable electronics insurance, then the information noted above shall be provided for all officers, directors,

and shareholders of record having beneficial ownership of ten percent (10%) or more of any class of securities registered under the federal securities law.

(2) Appoint the Commissioner as the applicant's attorney to receive service of all legal process issued against it in any civil action or proceeding in this State brought in connection with portable electronics insurance coverage and agreeing that process so served shall be valid and binding against the applicant. The appointment shall be irrevocable, shall bind the company and any successor in interest as the assets or liabilities of the applicant, and shall remain in effect as long as the applicant's licensure remains in force in this State.

(3) Provide the location of the applicant's home office.

(c) Applications for licensure under this Article shall be made within 90 days of the application being made available by the Commissioner.

(d) Initial licenses issued pursuant to this Article shall be valid for a period of 24 months.

(e) Each vendor of portable electronics licensed under this Chapter shall pay to the Commissioner a fee as prescribed by the Commissioner, subject to the following fee maximums:

(1) One thousand dollars ($1,000) for an initial license.

(2) Five hundred dollars ($500.00) for each renewal.

(3) One hundred dollars ($100.00) either for an initial license or for each renewal if the vendor is engaged in portable electronics transactions at 10 or fewer locations in the State."

SECTION 2. This act becomes effective October 1, 2011.

ATTACHMENT VI

Portable Electronics Bill Talking Points

1. The bill amends existing law to provide a regulatory framework for the offering of portable electronics in the state consistent with several other states who have implemented similar laws such as Virginia, California, Florida, Minnesota, Maryland, New York, and Texas among others
   A. Portable Electronics concept used to authorize a broad scope of coverage for consumer devices so law changes are not necessary every time a new product is brought to market.
      1) Recognizes that the types of products that consumers demand coverage on have expanded into more than just mobile telephones and now include wirelessly enabled laptops, GPS devices, PDAs, etc.
2. Coverage available under this type of insurance would protect against loss, theft, mechanical failure, malfunction, damage or other applicable perils
   A. Clearly exempts certain existing products from the regulatory framework created
      1) Service contracts;
      2) Insurance covering manufacturer's warranty; or
      3) Homeowner's, renter's, automobile, or similar policy that covers loss or theft of portable electronics.
3. Requires that vendors who offer to sell portable electronics insurance must obtain licensure on a corporate level
   A. Authorizes employees of vendors to offer portable electronics to consumers.
4. The bill provides for extensive consumer protection with respect to the sale of portable electronics insurance
   A. Requires materials to be available at locations selling portable electronics providing disclosures regarding the coverage
      1) May result in duplication of coverage under other insurance;
      2) Material terms;
      3) Material exclusions; and
      4) Claim filing process.
   B. Requires that coverage may be cancelled at any time with applicable unearned premiums paid returned to the consumer.
5. Requires the appointment of a supervising licensed entity to supervise administration of portable electronics program and training of employees of vendors
6. The proponents of the legislation have worked with the Department to develop the legislation's language.

MINUTES

HOUSE COMMITTEE ON INSURANCE

May 24, 2011

The House Committee on Insurance met in Room 1228 of the Legislative Building on May 24, 2011, at 1:00 pm. The following members were present: Representatives Dockham, Chair, Blust, Brown, Brubaker, Collins, Crawford, Current, Faison, Floyd, Glazier, Howard, Hurley, Insko, Johnson, McElraft, McGuirt, Murry, Pierce, Shepard, Steen, Stevens, Warren, and Wilkins. Tim Hovis, Bill Patterson, and Kory Goldsmith, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes. (Attachment I)

Representative Dockham, Chair, called the meeting to order at 1:00 pm. He introduced the pages and the Sergeant of Arms staff. (Attachment II) The following bills were considered:

HB 373, entitled, AN ACT TO FACILITATE THE PAYMENT OF INSURANCE PREMIUMS USING CREDIT CARDS AND TO PERMIT THE COMMISSIONER OF INSURANCE TO APPROVE NONTRADITIONAL GROUPS FOR GROUP LIFE INSURANCE. A proposed committee substitute bill was presented. Representative Brown moved to adopt the proposed committee substitute bill for consideration. The motion passed. The Chair recognized Mr. Tim Hovis, Staff Counsel, to explain the PCS. (Attachment III) Due to the amount of questions being raised, the committee tabled this bill until the next House Insurance Committee meeting scheduled for May 31, 2011.

HB 664, entitled, AN ACT TO PROVIDE CERTAIN INFORMATION REGARDING A DECEASED PERSON'S GROUP LIFE INSURANCE TO A FUNERAL DIRECTOR OR ESTABLISHMENT. The Chair recognized Representative Kelly Alexander, bill sponsor, to explain the bill. After a brief discussion, Representative Faison moved for a favorable report. The motion passed.

SB 608, entitled, AN ACT TO EXEMPT HEALTH CARE SHARING ORGANIZATIONS FROM THE HEALTH INSURANCE REGULATORY LAWS. Senator Hunt, bill sponsor, was not available to explain the bill. The Chair recognized Representative Murry to explain the bill. The companion bill to SB 608, HB 578, had previously been heard on April 27, 20011 in House Committee on Insurance and received a favorable report. Representative Faison moved for a favorable report. The motion passed.

There being no further business, the Chair adjourned the meeting at 1:20 pm.

Respectfully submitted,

Jerry C. Dockham

Representative Jerry C. Dockham, Chair

Regina Irwin

Regina Irwin, Committee Assistant

Attachments

AGENDA

HOUSE COMMITTEE ON INSURANCE

May 24, 2011

Room 1228

1:00 pm

OPENING REMARKS

Representative Jerry Dockham, Chairman
Insurance Committee

AGENDA ITEMS

HB 373 **Insurance Changes to Payments & Group Life.**
Representative Jerry Dockham, Sponsor

HB 664 **Disclosure/Group Life Insurance.**
Representative Kelly M. Alexander, Sponsor
Representative Bill Faison, Sponsor
Representative Jamie Boles, Jr., Sponsor

SB 608 **Health Care Sharing Organizations.**
Senator Neal Hunt, Sponsor

ADJOURNMENT

ATTACHMENT I

VISITOR REGISTRATION SHEET

Insurance — Name of Committee

05-24-2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rose Williams	NCDOI
DAVID BARNES	PS
MARTY BACOCK	AHIP
Alexa Ware	Research
Fran Piercy	Ragsdale Liggett
Susan Valauri	Nationwide
Robert Pasahal	Young Moore
Joe Guarino	AHCSM
Tami Fitzgerald	AHCSM

VISITOR REGISTRATION SHEET

Insurance - RM 1228 — 05-24-2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jon Carr	NC Funeral Directors Assoc
Dana Horne	SA

PLEASE PRINT

ATTACHMENT II

HOUSE PAGES

NAME OF COMMITTEE: INSURANCE DATE: May 24, 2011

1. **NAME:** Persephone Rogers
   County: Union
   Sponsor: Frann McCourt.
2. **NAME:** James Carelock
   County: Stanly
   Sponsor: Burr
3. **NAME:** Jessica Carelock
   County: Stanly
   Sponsor: Burr
4. **NAME:** Katherine Llewellyn
   County: Forsyth
   Sponsor: Rep. Parmon
5. **NAME:**
   County:
   Sponsor:

SERGEANTS-AT-ARMS

1. **Name:** Billy Jones
2. **Name:** Garland Shepherd
3. **Name:** Wayne Davis
4. **Name:**
5. **Name:**

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 373
PROPOSED COMMITTEE SUBSTITUTE H373-CSRG-16 [v.1]

5/23/2011 4:31:09 PM

Short Title: Insurance Changes to Payments & Group Life. (Public)

Sponsors:

Referred to:

March 17, 2011

A BILL TO BE ENTITLED

AN ACT TO FACILITATE THE PAYMENT OF INSURANCE PREMIUMS USING CREDIT CARDS AND TO PERMIT THE COMMISSIONER OF INSURANCE TO APPROVE NONTRADITIONAL GROUPS FOR GROUP LIFE INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-145 reads as rewritten:

"**§ 58-3-145. Solicitation, negotiation or payment of premiums on insurance policies.**

An insurer, agent, or broker may accept payment of an insurance premium by credit card if the insurer accepting payment by credit card meets the following conditions:

(1) ~~The insurer makes payment by credit card available to all existing and prospective insureds and does not limit the use of credit card payments to certain persons.~~ The insurer complies with the prohibition against unfair discrimination contained in G.S. 58-3-120.

(2) The insurer pays the fees charged by the credit card company for the payment of premiums by credit card."

SECTION 2. G.S. 58-58-135 reads as rewritten:

"**§ 58-58-135. "Group life insurance" defined.**

No policy of group life insurance shall be delivered in this State unless it conforms to one of the following descriptions:

...

(6) A policy issued to a group other than those described in subdivisions (1) through (5) of this section, subject to the following requirements:

a. Either of the following is true:

1. The Commissioner has made the following findings:

I. The issuance of the group policy is not contrary to the best interest of the public.

II. The issuance of the group policy would result in economies of acquisition or administration.

III. The benefits are reasonable in relation to the premiums charged.

2. Another state has approved the policy under requirements substantially similar to those contained in sub-sub-subdivision 1. of this sub-subdivision and the

Commissioner has not disapproved the issuance of the policy in this State on or after October 1, 2011.

b. The premium for the policy shall be paid from either the policyholder's funds or funds contributed by the covered persons, or from both.

c. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

~~(6)~~(7) Notwithstanding the provisions of this section, or any other provisions of law to the contrary, a policy may be issued to the employees of the State or any other political subdivision where the entire amount of premium therefor is paid by such employees."

SECTION 3. This act becomes effective October 1, 2011.

HOUSE BILL 373:
Insurance Changes to Payments & Group Life

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	May 23, 2011
Introduced by:	Rep. Dockham	**Prepared by:**	Tim Hovis Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***House Bill 373 would make the following changes to Chapter 58, Insurance, of the General Statutes: (1) deletes current law authorizing insurers, agents and brokers to accept payment of premiums by credit card only if the insurer makes payment available to all existing and prospective insureds; and (2) gives the Commissioner of Insurance discretion to approve "non-traditional' groups for the purposes of group life insurance coverage.***

BILL ANALYSIS: Section 1 of House Bill 373 amends G.S. 58-3-145 to delete language authorizing insurance premium payments by credit card if the insurer "makes payment by credit card available to all existing and prospective insureds and does not limit the use of credit card payments to certain persons." The bill would allow payment by credit card if the insurer does not "make any discrimination in favor of any person" as provided in G.S. 58-3-120.

Section 2 amends G.S. 58-58-135,*"Group life insurance" defined*, to allow the approval of "non-traditional" groups for life insurance coverage. Non-traditional groups could include, for example, church congregations, students, or volunteer emergency first-responders.

The bill would authorize the approval of a group life insurance policy issued to a group that meets one of the following:

1. The Commissioner finds that:
   - Issuance of the policy is not contrary to the public interest.
   - Issuance of the policy would result in economies of acquisition and administration.
   - Benefits are reasonable in relation to premiums charged.
2. Another state has approved the policy under substantially similar requirements to those listed above and the Commissioner has not disapproved the policy's issuance on or after October 1, 2011.

To be approved, premiums must be paid for policyholder's funds or funds contributed by covered persons. In addition, insurers must be able to exclude or limit coverage on any person with unsatisfactory evidence of individual insurability.

EFFECTIVE DATE: House Bill 373 becomes effective October 1, 2011.

H373-SMRG-23(e1) v4

HOUSE BILL 373

Short Title:	Insurance Changes to Payments & Group Life.	(Public)
Sponsors:	Representative Dockham (Primary Sponsor). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Insurance.	

March 17, 2011

A BILL TO BE ENTITLED

AN ACT TO FACILITATE THE PAYMENT OF INSURANCE PREMIUMS USING CREDIT CARDS AND TO PERMIT THE COMMISSIONER OF INSURANCE TO APPROVE NONTRADITIONAL GROUPS FOR GROUP LIFE INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-145 reads as rewritten:

"**§ 58-3-145. Solicitation, negotiation or payment of premiums on insurance policies.**

An insurer, agent, or broker may accept payment of an insurance premium by credit card if the insurer accepting payment by credit card meets the following conditions:

(1) ~~The insurer makes payment by credit card available to all existing and prospective insureds and does not limit the use of credit card payments to certain persons.~~ The insurer complies with the prohibition against unfair discrimination contained in G.S. 58-3-120.

(2) The insurer pays the fees charged by the credit card company for the payment of premiums by credit card."

SECTION 2. G.S. 58-58-135 reads as rewritten:

"**§ 58-58-135. "Group life insurance" defined.**

No policy of group life insurance shall be delivered in this State unless it conforms to one of the following descriptions:

...

(6) A policy issued to a group other than those described in subdivisions (1) through (5) of this section, subject to the following requirements:

a. Either of the following is true:

1. The Commissioner has made the following findings:

I. The issuance of the group policy is not contrary to the best interest of the public.

II. The issuance of the group policy would result in economies of acquisition or administration.

III. The benefits are reasonable in relation to the premiums charged.

2. Another state has approved the policy under requirements substantially similar to those contained in sub-sub-subdivision 1. of this sub-subdivision and the Commissioner has not previously disapproved the issuance of the policy in this State.

b. The premium for the policy shall be paid from either the policyholder's funds or funds contributed by the covered persons, or from both.

c. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

~~(6)~~(7) Notwithstanding the provisions of this section, or any other provisions of law to the contrary, a policy may be issued to the employees of the State or any other political subdivision where the entire amount of premium therefor is paid by such employees."

SECTION 3. This act becomes effective October 1, 2011.

2011 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

By Representative Dockham (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 664 A BILL TO BE ENTITLED AN ACT TO PROVIDE CERTAIN INFORMATION REGARDING A DECEASED PERSON'S GROUP LIFE INSURANCE TO A FUNERAL DIRECTOR OR ESTABLISHMENT.

☒ 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 _____.

HOUSE BILL 664

Short Title:	Disclosure/Group Life Insurance.	(Public)
Sponsors:	Representatives K. Alexander, Faison, and Boles (Primary Sponsors). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Insurance.	

April 7, 2011

A BILL TO BE ENTITLED

AN ACT TO PROVIDE CERTAIN INFORMATION REGARDING A DECEASED PERSON'S GROUP LIFE INSURANCE TO A FUNERAL DIRECTOR OR ESTABLISHMENT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-58-97 reads as rewritten:

"**§ 58-58-97. Provision of life insurance information upon notification of insured's death.**

(a) Any person licensed to practice funeral directing or any employee of a funeral establishment licensed under the provisions of Article 13A of Chapter 90 of the General Statutes providing funeral service, as that term is defined in G.S. 90-210.20, for a deceased person insured or believed to be insured under a contract of life insurance or under a group life insurance policy may request information regarding the deceased person's life insurance contracts by providing an insurer with (i) a copy of a notification of death filed pursuant to ~~G.S. 130A-112 and~~G.S. 130A-112, (ii) written authorization from the person or persons with legal authority to direct disposition of the deceased's body as prescribed under G.S. 90-210.124 or ~~G.S. 130A-420.~~ G.S. 130A-420, and (iii) in the case of a person covered or believed to be covered under a group life insurance policy, the affiliation of the deceased entitling them to coverage under the group life insurance policy. As soon as possible after receipt of the request, the life insurance company shall inform the person authorized by this section to make an inquiry of the following:

(1) The existence of any contract insuring the life of the deceased person.
(2) Any beneficiaries on record under any life insurance contract insuring the life of the deceased person.
(3) The amount of any liens or loans outstanding on the policy.
(4) The amount of benefits payable to the beneficiaries.
(5) Whether the policy has been reinstated within the last 24 months.

The insurer shall provide a claim form to any person or assignee making the request.

(b) If any person making a written request under subsection (a) of this section who has provided all the information required by subsection (a) of this section does not receive a timely response from the insurer, then the person may refer the request to the Consumer Services Division of the Department, which shall treat the referral as a consumer complaint. The referral shall include all the information provided to the insurer under subsection (a) of this section as well as copies of all communications and information received from the insurer regarding the request for information.

(c) If the beneficiary of record under the life insurance contract or group life insurance policy is not the estate of the deceased, then any person authorized to request information under subsection (a) of this section shall make reasonable efforts to locate the beneficiaries within 100 hours of receiving information from the insurance carrier regarding any life insurance contracts or group life insurance policies and shall provide to all beneficiaries all documents and information obtained from the insurance carrier. The person obtaining the information also shall inform all beneficiaries in writing in bold print that "THE BENEFICIARY OF A LIFE INSURANCE POLICY HAS NO LEGAL DUTY OR OBLIGATION TO SPEND ANY OF THAT MONEY ON THE FUNERAL, DEBTS, OR OBLIGATIONS OF THE DECEASED" and shall do so before discussing with the beneficiaries financial arrangements for burial of the deceased.

(d) Any licensee or employee of a funeral establishment licensed under Article 13A of Chapter 90 of the General Statutes who makes a false request for information under this section or fails to do that required by subsection (c) of this section shall be deemed guilty of fraud or misrepresentation in the practice of funeral service as defined in G.S. 90-210.25(e)(1)b. and unfit to practice funeral service."

SECTION 2. This act is effective when it becomes law.

HOUSE BILL 664:
Disclosure/Group Life Insurance

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	May 20, 2011
Introduced by:	Reps. K. Alexander, Faison, Boles	**Prepared by:**	Bill Patterson Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***House Bill 664 permits licensed funeral directors and funeral home employees to obtain concerning coverage for a deceased person under a group life insurance policy.***

CURRENT LAW: G.S. 58-58-97 allows persons licensed funeral directors or employees of licensed funeral homes to request information from an insurer regarding coverage of a deceased person under a life insurance contract, by providing the insurer with a copy of the notification of death and a written authorization from the deceased person's next of kin or person financially responsible for the services. The insurer is required to inform the requestor of:

- The existence of any contract insuring the life of the deceased.
- Beneficiaries on record.
- The amount of outstanding liens or loans on the policy.
- The amount of benefits payable to the beneficiaries.
- Whether the policy has been reinstated within the last 24 months.

BILL ANALYSIS: House Bill 664 amends G.S. 58-58-97 to permit a licensed funeral director or a person employed by a licensed funeral home to obtain information from an insurer about coverage for a deceased person under a group life insurance policy.

EFFECTIVE DATE: This act is effective when it becomes law.

H664-SMTG-25(e1) v2

2011 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

By Representative Dockham (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for

SB 608 A BILL TO BE ENTITLED AN ACT TO EXEMPT HEALTH CARE SHARING ORGANIZATIONS FROM THE HEALTH INSURANCE REGULATORY LAWS.

☒ 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 _____.

SENATE BILL 608*

Short Title:	Health Care Sharing Organizations.	(Public)
Sponsors:	Senators Hunt; Allran, Blake, Forrester, Rabon, Soucek, and Tillman.	
Referred to:	Health Care.	

April 19, 2011

A BILL TO BE ENTITLED

AN ACT TO EXEMPT HEALTH CARE SHARING ORGANIZATIONS FROM THE HEALTH INSURANCE REGULATORY LAWS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 49 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-49-12. Exceptions to jurisdiction; health care sharing organizations.**

A health care sharing organization shall not be subject to the jurisdiction of the Commissioner and shall not be considered to be engaging in the business of providing health care benefits as long as the health care sharing organization does the following:

(1) Maintains nonprofit entity status under the Internal Revenue Code.

(2) Limits its participants to those who share similar interests as defined by the organization.

(3) Provides for the financial or medical needs of a participant through contributions from one participant to another in accordance with criteria established by the health care sharing organization.

(4) Provides amounts that participants may contribute with no assumption of risk or promise to pay among the participants and no assumption of risk or promise to pay by the health care sharing organization to the participants.

(5) Publishes a written monthly statement to all participants that lists the total dollar amount of qualified needs submitted to the health care sharing organization, as well as the amount published or assigned to participants for their contribution.

(6) Provides a written disclaimer on or accompanying all applications and guideline materials distributed by or on behalf of the organization that reads, in substance, as follows:

'NOTICE: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be voluntary. No other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally liable for the payment of your own medical bills.'"

SECTION 2. This act becomes effective October 1, 2011.

SENATE BILL 608:
Health Care Sharing Organizations

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	May 23, 2011
Introduced by:	Sen. Hunt	**Prepared by:**	Tim Hovis
Analysis of:	First Edition		Committee Counsel

SUMMARY: Senate Bill 608 adds a new section to Chapter 58 of the General Statutes governing insurance to exempt health care sharing organizations from the jurisdiction of the Commissioner of Insurance. To qualify as a heath care sharing organization, an organization must satisfy the following requirements:

- Maintain nonprofit entity status
- Limit its participants to persons sharing similar interests
- Provide for the financial or medical needs of its participants through participant contributions
- Provide amounts that participants may contribute with no assumption of risk or promise to pay among the participants
- Assume no risk or promise to pay to its participants
- Publish a written monthly statement to all participants listing the total dollar amount of qualified needs and the amount assigned to its participants for their contribution
- Provide a written disclaimer on or accompanying all applications and guideline materials that reads, in substance, as follows:

  NOTICE: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be voluntary. No other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally liable for the payment of your own medical bills.

EFFECTIVE DATE: Senate Bill 608 becomes effective October 1, 2011.

S608-SMRG-24(e1) v1

MINUTES

HOUSE COMMITTEE ON INSURANCE

May 31, 2011

The House Committee on Insurance met in Room 1228 of the Legislative Building on May 31, 2011, at 1:00 pm. The following members were present: Representatives Dockham, Chair, Blust, Brown, Brubaker, Bryant, Collins, Crawford, Current, Faison, Floyd, Folwell, Graham, Hamilton, Howard, Hurley, Insko, Johnson, McGuirt, Pierce, Shepard, Steen, Warren, and Wray. Tim Hovis, Bill Patterson, and Amy Joe Johnson, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes. (Attachment I)

Representative Dockham, Chair, called the meeting to order at 1:00 pm. He introduced the pages and the Sergeant of Arms staff. (Attachment II) The following bills were considered:

HB 774, entitled, AN ACT TO DIRECT THE DEPARTMENTS OF AGRICULTURE AND INSURANCE TO STUDY OPTIONS FOR AGRICULTURAL CONTRACT GROWERS TO PROTECT THEMSELVES AGAINST FINANCIAL LOSSES DUE TO WEATHER, NATURAL DISASTERS, OR OTHER ACTS OF GOD. Representative T. Moore, bill sponsor, was not available to explain the bill. The Chair recognized Tim Hovis, Staff Counsel, to explain the bill. (Attachment III) After a brief discussion Representative Dockham moved for a favorable report and recommendation that the bill be re-referred to the Committee on RULES, CALENDAR, AND OPERATIONS OF THE HOUSE. The motion passed.

Representative Dockham requested, since he is the primary sponsor of HB 373 under consideration, Representative Collins, Vice-Chair, preside over the remainder of the meeting.

HB 373, entitled, AN ACT TO FACILITATE THE PAYMENT OF INSURANCE PREMIUMS USING CREDIT CARDS AND TO PERMIT THE COMMISSIONER OF INSURANCE TO APPROVE NONTRADITIONAL GROUPS FOR GROUP LIFE INSURANCE. A proposed committee substitute bill was presented. Representative Johnson moved to adopt the proposed committee substitute bill for consideration. The motion passed. The Chair recognized Representative Dockham, bill sponsor, to explain the proposed committee substitute bill. (Attachment IV) Representative Faison sent forth an amendment. (Attachment V) After a brief explanation of the amendment and discussion, the Chair recognized Ms. Rose Vaughn Williams, Legislative Counsel with the NC Department of Insurance and Mr. George Teague, Nelson Mullins Riley & Scarborogh, LLP, who spoke on the bill and in opposition of the amendment. Representative Dockham, bill sponsor, also spoke in opposition of the amendment and asked that members do not support the amendment. The chair moved for a vote on the amendment. With division having been called, the amendment failed eleven to twelve. Representative Johnson moved for a favorable report as to the committee substitute bill, which changes the title, unfavorable as to the original bill. The motion passed.

There being no further business, the Chair adjourned the meeting at 1:30 pm.

Respectfully submitted,

Representative Jerry C. Dockham, Chair

Regina Irwin, Committee Assistant

Attachments

AGENDA

HOUSE COMMITTEE ON INSURANCE

May 31, 2011

Room 1228

1:00 pm

OPENING REMARKS

Representative Jerry Dockham, Chairman
Insurance Committee

AGENDA ITEMS

HB 373 **Insurance Changes to Payments & Group Life.**
Representative Jerry Dockham, Sponsor

HB 774 **Study Insurance for Contract Growers.**
Representative Tim Moore, Sponsor

ADJOURNMENT

ATTACHMENT I

VISITOR REGISTRATION SHEET

Insurance — 4-31-11

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Stollon	Stone Farm
Michelle Healy	Smith-Anderson
Bob Mack	NCDOI
Bryan Heckle	NCDOI
Rose Williams	NCDOI
Pam Pate	Shipyard LA
Tom Bean	EDF
Betsy Vetter	Amer Heart Assn
Harry Pepper	MWC

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

MAY 31, 2011 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Henry Jones	Attorney Raleigh.
[signature]	" "
Jennifer Cohen	IFNC
Sara Fender	IFNC
Susan Valauri	NW
[signature]	NWMRS

PLEASE PRINT

ATTACHMENT II

HOUSE PAGES

NAME OF COMMITTEE: INSURANCE DATE: May 31, 2011

1. **NAME:** Wil Safrit
   County: Rowan
   Sponsor: Linda Johnson
2. **NAME:** Kelsie Maxwell
   County: Carteret County
   Sponsor: Pat McElraft
3. **NAME:** Katen Perry
   County: Carteret County
   Sponsor: Pat McElraft
4. **NAME:** Frances [redacted] McDonald
   County: Durham
   Sponsor: Larry Hall
5. **NAME:**
   County:
   Sponsor:

SERGEANTS-AT-ARMS

1. **Name:** Billy Jones
2. **Name:** Wayne Davis
3. **Name:** Garland Shepheard
4. **Name:**
5. **Name:**

2011 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

By Representative Dockham (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 774 A BILL TO BE ENTITLED AN ACT TO DIRECT THE DEPARTMENTS OF AGRICULTURE AND INSURANCE TO STUDY OPTIONS FOR AGRICULTURAL CONTRACT GROWERS TO PROTECT THEMSELVES AGAINST FINANCIAL LOSSES DUE TO WEATHER, NATURAL DISASTERS, OR OTHER ACTS OF GOD.

☒ With a favorable report and recommendation that the bill be re-referred to the Committee on RULES, CALENDAR, AND OPERATIONS OF THE HOUSE.

(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 _____.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H 2

HOUSE BILL 774
Corrected Copy 4/11/11

Short Title:	Study Insurance for Contract Growers.	(Public)
Sponsors:	Committee on Rules, Calendar, and Operations of the House (Primary Sponsor) For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Insurance, if favorable, Rules, Calendar, and Operations of the House.	

April 7, 2011

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENTS OF AGRICULTURE AND INSURANCE TO STUDY OPTIONS FOR AGRICULTURAL CONTRACT GROWERS TO PROTECT THEMSELVES AGAINST FINANCIAL LOSSES DUE TO WEATHER, NATURAL DISASTERS, OR OTHER ACTS OF GOD.

The General Assembly of North Carolina enacts:

SECTION 1. The Commissioner of Insurance, with the assistance of the Commissioner of Agriculture, shall study the availability and need for insurance products or statutory contractual requirements that will enable agricultural contract growers to protect themselves from financial loss resulting from loss of the contracted animals due to weather, natural disaster, or other act of God. The Commission shall address, at a minimum, the following issues:

(1) The current availability of and need for insurance products to protect contract growers who have a financial investment in the animals they tend, even if they do not own the animals.

(2) Standard contract language and terms in common use in the agricultural contract growing industry, and whether statutory protections or requirements are necessary to protect agricultural contract growers in the State from ruinous financial loss due to weather, natural disasters, or other acts of God.

The Commissioners may submit an interim report to the 2012 Regular Session of the 2011 General Assembly and shall submit a final report of their findings and recommendations, including any legislative proposals, to the 2013 General Assembly.

SECTION 2. This act is effective when it becomes law.

ATTACHMENT III

HOUSE BILL 774:
Study Insurance for Contract Growers

2011-2012 General Assembly

Committee:	Insurance, if favorable, Rules, Calendar, and Operations of the House	**Date:**	May 26, 2011
Introduced by:	Committee on Rules, Calendar, and Operations of the House	**Prepared by:**	Tim Hovis Committee Counsel
Analysis of:	Second Edition		

SUMMARY: House Bill 774 directs the Commissioner of Insurance, with the assistance of the Commissioner of Agriculture, to study the availability and need for insurance products or statutory contractual requirements to protect agriculture contract growers from financial loss resulting from the loss of animals due to weather, natural disaster, or other acts of God.

The study shall, at a minimum, address the following:

- The availability and need for insurance products to protect contract growers with a financial investment in the animals they tend, regardless of whether the grower owns the animals.
- Whether statutory protections or requirements are necessary to protect contract growers from financial loss.

The Commissioner may submit an interim report to the 2012 Regular Session and shall submit a final report, including legislative proposals, to the 2013 General Assembly.

EFFECTIVE DATE: House Bill 774 is effective when it becomes law.

H774-SMRG-26(e2) v1

2011 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
HB 373 A BILL TO BE ENTITLED AN ACT TO FACILITATE THE PAYMENT OF INSURANCE PREMIUMS USING CREDIT CARDS AND TO PERMIT THE COMMISSIONER OF INSURANCE TO APPROVE NONTRADITIONAL GROUPS FOR GROUP LIFE INSURANCE.

☒ With a favorable report as to the committee substitute bill, which changes the title, unfavorable as to the original bill.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House/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 2011

H D

HOUSE BILL 373
PROPOSED COMMITTEE SUBSTITUTE H373-CSRG-17 [v.5]

5/26/2011 4:45:04 PM

Short Title: Insurance Changes to Payments & Group Life. (Public)

Sponsors:

Referred to:

March 17, 2011

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE PAYMENT OF INSURANCE PREMIUMS USING DEBIT CARDS, TO FACILITATE THE PAYMENT OF INSURANCE PREMIUMS USING CREDIT AND DEBIT CARDS AND TO PERMIT THE COMMISSIONER OF INSURANCE TO APPROVE NONTRADITIONAL GROUPS FOR GROUP LIFE INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-145 reads as rewritten:

"**§ 58-3-145. Solicitation, negotiation or payment of premiums on insurance policies.**

An insurer, agent, or broker may accept payment of an insurance premium by credit card or debit card if the insurer accepting payment by credit card or debit card meets the following conditions:

(1) ~~The insurer makes payment by credit card available to all existing and prospective insureds and does not limit the use of credit card payments to certain persons.~~ The insurer complies with the prohibition against unfair discrimination contained in G.S. 58-63-15(7).

(2) The insurer pays the fees charged by the credit card company or debit card issuer for the payment of premiums by credit ~~card.~~card or debit card."

SECTION 2. G.S. 58-58-135 reads as rewritten:

"**§ 58-58-135. "Group life insurance" defined.**

No policy of group life insurance shall be delivered in this State unless it conforms to one of the following descriptions:

...

(5a) A policy issued to a group other than those described in subdivisions (1) through (5) of this section, subject to the following requirements:

a. Either of the following is true:

1. The Commissioner has made the following findings:

I. The issuance of the group policy is not contrary to the best interest of the public.

II. The issuance of the group policy would result in economies of acquisition or administration.

III. The benefits are reasonable in relation to the premiums charged.

2. Another state having requirements substantially similar to those contained in sub-sub-subdivision 1. of this sub-subdivision has made a determination that the requirements have been met.

b. The premium for the policy shall be paid from either the policyholder's funds or funds contributed by the covered persons, or from both.

c. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(6) Notwithstanding the provisions of this section, or any other provisions of law to the contrary, a policy may be issued to the employees of the State or any other political subdivision where the entire amount of premium therefor is paid by such employees."

SECTION 3. This act becomes effective October 1, 2011.

HOUSE BILL 373:
Insurance Changes to Payments & Group Life

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	May 26, 2011
Introduced by:	Rep. Dockham	**Prepared by:**	Tim Hovis
Analysis of:	PCS to First Edition H373-CSRG-17		Committee Counsel

SUMMARY: ***The Proposed Committee Substitute for House Bill 373 would make the following changes to Chapter 58, Insurance, of the General Statutes: (1) authorizes the payment of premiums by debit cards. Current law allows payment by credit cards only. The bill would allow the payment by credit cards and debit cards if the insurer does not discriminate among individuals of the same class; and (2) authorizes the issuance of life insurance coverage for certain "non-traditional' groups meeting requirements set forth in the bill.***

BILL ANALYSIS:

Section 1

Section 1 of the Proposed Committee Substitute for House Bill 373 amends G.S. 58-3-145 to allow the payment of premiums by debit cards, in addition to payment by credit cards as provided under current law. The bill would allow payment by credit or debit card if the insurer does not discriminate among individuals of the same class as provided in G.S. 58-63-15(7). The bill deletes current language authorizing insurance premium payments by credit card if the insurer "makes payment by credit card available to all existing and prospective insureds and does not limit the use of credit card payments to certain persons."

Section 2

Section 2 of the PCS for House Bill 373 amends G.S. 58-58-135,*"Group life insurance" defined*, to authorize the issuance of life insurance coverage for certain "non-traditional" groups. Non-traditional groups could include, for example, church congregations, students, or volunteer emergency first-responders.

CURRENT LAW: Under current law, G.S. 58-58-135 authorizes life insurance to be issued for the following 5 groups: (1) an employer for its employees (2) a creditor to insure its debtors; (3) a labor union to insure union members (4) a trust established by two or more employers or unions to insure its employees or union members; and (5) a professional or business association to insure its members.

A copy of G.S. 58-58-135 is included at the end of this summary.

BILL ANALYSIS: The PCS for House Bill 373 bill would add a sixth group to the list of approved groups in G.S. 58-58-135 to authorize the issuance of a group life insurance policy meeting the following requirements:

1. The Commissioner finds that:
   - Issuance of the policy is not contrary to the public interest.
   - Issuance of the policy would result in economies of acquisition and administration.
   - Benefits are reasonable in relation to premiums charged; **or**
2. Another state with requirements substantially similar to those listed above has made a determination that the requirements have been met.

To be approved, premiums must be paid from the policyholder's funds or funds contributed by covered persons. In addition, insurers must be able to exclude or limit coverage on any person with unsatisfactory evidence of individual insurability.

This language is identical to model language approved by the National Association of Insurance Commissioners.

EFFECTIVE DATE: House Bill 373 becomes effective October 1, 2011.

§ 58-58-135. "Group life insurance" defined.

No policy of group life insurance shall be delivered in this State unless it conforms to one of the following descriptions:

(1) A policy issued to an employer, or to the trustee of a fund established by an employer, which employer or trustee shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer subject to the following requirements:

a. The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof determined by conditions pertaining to their employment. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietors or partnerships if the business of the employer and of such affiliated corporations, proprietors or partnerships is under common control through stock ownership, contract, or otherwise. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietor or a partnership. The policy may provide that the term "employees" shall include retired employees. The term "employer" as used herein may be deemed to include any county, municipality, or the proper officers, as such, of any unincorporated municipality or any department, division, agency, instrumentality or subdivision of a county, unincorporated municipality or municipality. In all cases where counties, municipalities or unincorporated municipalities or any officer, agent, division, subdivision or agency of the same have heretofore entered into contracts and purchased group life insurance for their employees, such transactions, contracts and insurance and the purchase of the same is hereby approved, authorized and validated.

b. The premium for the policy shall be paid either wholly or partly from the employer's funds or funds contributed by him, or wholly or partly from funds contributed by the insured employees, or by both. A policy on which all or part of the premium is to be derived from funds contributed by the insured employees may be placed in force provided the group is structured on an actuarially sound basis. A policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

c. Repealed by Session Laws 2007-298, s. 7.6, effective October 1, 2007.

d. Repealed by Session Laws 1991 (Regular Session, 1992), c. 837, s. 6.

(2) A policy issued to a creditor, who shall be deemed the policyholder, to insure debtors of the creditor, subject to the following requirements:

a. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor whose indebtedness is repayable in installments, or all of any class or classes thereof determined by conditions pertaining to the indebtedness or to the purchase giving rise to the indebtedness. The policy may provide that the term "debtors" shall include the debtors of one or more subsidiary corporations, and the debtors of one or more affiliated corporations, proprietors or partnerships if the business of the policyholder and of such affiliated corporations, proprietors or partnerships is under common control through stock ownership, contract or otherwise.

b. The premium for the policy shall be paid from the creditor's funds, from charges collected from the insured debtors, or from both. A policy on which part or all of the premium is to be derived from the collection from the insured debtors or identifiable charges not required of uninsured debtors shall not include, in the class or classes of debtors eligible for insurance, debtors under obligations outstanding at its date of issue without evidence of individual insurability unless the group is structured on an

actuarially sound basis. A policy on which no part of the premium is to be derived from the collection of such identifiable charges must insure all eligible debtors, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

c. The policy may be issued only if the group of eligible debtors is then receiving new entrants at the rate of at least 100 persons yearly, or may reasonably be expected to receive at least 100 new entrants during the first policy year, and only if the policy reserves to the insurer the right to require evidence of individual insurability if less than seventy-five percent (75%) of the new entrants become insured.

d, e. Repealed by Session Laws 1975, c. 660, s. 4.

(3) A policy issued to a labor union, which shall be deemed the policyholder, to insure members of such union for the benefit of persons other than the union or any of its officials, representatives or agents, subject to the following requirements:

a. The members eligible for insurance under the policy shall be all of the members of the union, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the union, or both.

b. The premium for the policy shall be paid either wholly or partly from the union's funds, or wholly or partly from funds contributed by the insured members specifically for their insurance, or by both. A policy on which all or part of the premium is to be derived from funds contributed by the insured members specifically for their insurance may be placed in force provided the group is structured on an actuarially sound basis. A policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

c. The policy must cover at least 25 members at date of issue.

d. Repealed by Session Laws 1991 (Regular Session, 1992), c. 837, s. 6.

(4) A policy issued to the trustee of a fund established by two or more employers in the same industry or kind of business or by two or more labor unions, which trustee shall be deemed the policyholder, to insure employees of the employers or members of the unions for the benefit of persons other than the employers or the unions, subject to the following requirements:

a. The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions, or all of any class or classes thereof determined by conditions pertaining to their employment, or to memberships in the unions, or to both. The policy may provide that the term "employees" shall include the individual proprietor or partners if an employer is an individual proprietor or a partnership. The policy may provide that the term "employees" shall include the trustee or the employees of the trustee, or both, if their duties are principally connected with such trusteeship. The policy may provide that the term "employees" shall include retired employees.

b. The premium for the policy shall be paid wholly or partly from funds contributed by the participating employer, labor union, or the insured persons.

If none of the premium paid by the participating employer or labor union is to be derived from funds contributed by the insured persons specifically for the insurance, all eligible employees of that particular participating employer or labor union must be insured, or all except any as to whom evidence of insurability is not satisfactory to the insurer.

If part of the premium paid by the participating employer or labor union is to be derived from funds contributed by the insured persons specifically for their insurance, coverage may be placed in force on employees of a participating employer or on members of a participating labor union provided the group is structured on an actuarially sound basis.

c. The policy must cover at least 100 persons at date of issue.
d. Repealed by Session Laws 1991 (Regular Session, 1992), c. 837, s. 6.

(5) A policy issued to an association of persons having a common professional or business interest, which association shall be deemed the policyholder, to insure members of such association for the benefit of persons other than the association or any of its officials, representatives or agents, subject to the following requirements:

a. Such association shall have had an active existence for at least two years immediately preceding the purchase of such insurance, was formed for purposes other than procuring insurance and does not derive its funds principally from contributions of insured members toward the payment of premiums for the insurance.
b. The members eligible for insurance under the policy shall be all of the members of the association or all of any class or classes thereof determined by conditions pertaining to their employment, or the membership in the association, or both. The policy may provide that the term "members" shall include the employees of members, if their duties are principally connected with the member's business or profession.
c. The premium for the policy shall be paid either wholly or partly from the association's funds, or wholly or partly from funds contributed by the insured members specifically for their insurance, or by both. No policy may be issued if the Commissioner finds that the rate of insured members' contributions will exceed the maximum rate customarily charged employees insured under like group life insurance policies issued in accordance with the provisions of subdivision (1). A policy on which all or part of the premium is to be derived from funds contributed by the insured members specifically for their insurance may be placed in force provided the group is structured on an actuarially sound basis. A policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.
d. The policy must cover at least 25 members at date of issue.
e. Repealed by Session Laws 1991 (Regular Session, 1992), c. 837, s. 6.

(6) Notwithstanding the provisions of this section, or any other provisions of law to the contrary, a policy may be issued to the employees of the State or any other political subdivision where the entire amount of premium therefor is paid by such employees.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H 1

HOUSE BILL 373

Short Title:	Insurance Changes to Payments & Group Life.	(Public)
Sponsors:	Representative Dockham (Primary Sponsor). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Insurance.	

March 17, 2011

A BILL TO BE ENTITLED

AN ACT TO FACILITATE THE PAYMENT OF INSURANCE PREMIUMS USING CREDIT CARDS AND TO PERMIT THE COMMISSIONER OF INSURANCE TO APPROVE NONTRADITIONAL GROUPS FOR GROUP LIFE INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-145 reads as rewritten:

"**§ 58-3-145. Solicitation, negotiation or payment of premiums on insurance policies.**

An insurer, agent, or broker may accept payment of an insurance premium by credit card if the insurer accepting payment by credit card meets the following conditions:

(1) ~~The insurer makes payment by credit card available to all existing and prospective insureds and does not limit the use of credit card payments to certain persons.~~ The insurer complies with the prohibition against unfair discrimination contained in G.S. 58-3-120.

(2) The insurer pays the fees charged by the credit card company for the payment of premiums by credit card."

SECTION 2. G.S. 58-58-135 reads as rewritten:

"**§ 58-58-135. "Group life insurance" defined.**

No policy of group life insurance shall be delivered in this State unless it conforms to one of the following descriptions:

...

(6) A policy issued to a group other than those described in subdivisions (1) through (5) of this section, subject to the following requirements:

a. Either of the following is true:

1. The Commissioner has made the following findings:

I. The issuance of the group policy is not contrary to the best interest of the public.

II. The issuance of the group policy would result in economies of acquisition or administration.

III. The benefits are reasonable in relation to the premiums charged.

2. Another state has approved the policy under requirements substantially similar to those contained in sub-sub-subdivision 1. of this sub-subdivision and the Commissioner has not previously disapproved the issuance of the policy in this State.

b. The premium for the policy shall be paid from either the policyholder's funds or funds contributed by the covered persons, or from both.

c. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

~~(6)~~(7) Notwithstanding the provisions of this section, or any other provisions of law to the contrary, a policy may be issued to the employees of the State or any other political subdivision where the entire amount of premium therefor is paid by such employees."

SECTION 3. This act becomes effective October 1, 2011.

ATTACHMENT IV

WHY HB 373 DOES NOT DISADVANTAGE THE COMMISSIONER?

A. SECTION 2 OF HB 373 COMES DIRECTLY FROM THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS. THE LANGUAGE WAS FULLY VETTED DURING A LENGTHY COMMITTEE PROCESS AND ADOPTED BY THE FULL BODY OF THE NAIC. CURRENTLY, 31 STATES HAVE ADOPTED THE 3 PRONGED MODEL TEST.

B. SECTION (5A)(A)(2) DOESN'T ALLOW INSURERS TO MARKET TO GROUPS APPROVED IN OTHER STATES IF THERE LAWS ARE SUBSTANTIALLY DIFFERENT FROM THE LAWS OF NORTH CAROLINA. IN PRACTICE, THIS IS NEVER A CONCERN BECAUSE ALL STATES THAT APPROVE DISCRETIONARY GROUPS FOLLOW THE 3 PRONGED TEST IN (5A)(A)(1). IF THERE WAS EVER A CONCERN OR QUESTION, THE NORTH CAROLINA COMMISSIONER WOULD BE THE FINAL AUTHORITY OF WHETHER ANOTHER STATE'S LAWS WERE SUBSTANTIALLY SIMILAR TO NORTH CAROLINA'S.

TALKING POINTS RE: HOUSE BILL 373

"OUSE BILL 373 IS A RELATIVELY SIMPLE BILL THAT DOES TWO THINGS. IT AMENDS URRENT LAW REGARDING WHO CAN HAVE ACCESS TO GROUP LIFE INSURANCE AND AMENDS THE CURRENT LAW REGARDING WHO CAN PAY FOR INSURANCE PREMIUMS BY CREDIT CARD OR DEBIT CARD.

WITH REGARD TO GROUP LIFE INSURANCE, HOUSE BILL 373 WOULD GRANT THE COMMISSIONER OF INSURANCE THE DISCRETIONARY AUTHORITY PRESCRIBED IN HOUSE BILL 373 WILL EXPAND THE ACCESS OF LIFE INSURANCE COVERAGE TO GROUPS OF NORTH CAROLINIANS THAT CURRENTLY DO NOT QUALIFY, FOR EXAMPLE: CHURCH CONGREGANTS; ADULT STUDENTS; BANK ACCOUNT HOLDERS; AND COMMUNITY VOLUNTEERS WHO ARE EMERGENCY FIRST-RESPONDERS AND OTHER WELL-DESERVING GROUPS WHO DESIRE LIFE INSURANCE.

CURRENTLY, NORTH CAROLINA'S GROUP LIFE INSURANCE LAW PERMITS ONLY A LIMITED NUMBER OF GROUPS FOR PURPOSES OF INSURANCE: 1) EMPLOYERS; 2) CREDITORS; 3) LABOR UNIONS; 4) TRUSTS; AND 5) ASSOCIATIONS. THIS LIST OF "ROUPS IS TOO RESTRICTIVE TO EFFECTIVELY SERVICE THE LIFE INSURANCE NEEDS F ALL NORTH CAROLINIANS.

GRANTING GREATER DISCRETION WILL NOT ERODE COMMISSIONER'S REGULATORY AUTHORITY

THE PURPOSE OF THE ORIGINAL STATUTE WAS TO PREVENT INAPPROPRIATE GROUPS . GRANTING GREATER DISCRETIONARY AUTHORITY TO THE DIRECTOR WILL NOT DILUTE THAT GOAL. BEFORE A DISCRETIONARY GROUP IS APPROVED, IT MUST SATISFY A 3-PRONGED TEST:

(1) THE ISSUANCE OF SUCH GROUP POLICY IS NOT CONTRARY TO THE BEST INTEREST OF THE PUBLIC;

(2) THE ISSUANCE OF THE GROUP POLICY WOULD RESULT IN ECONOMIES OF ACQUISITION OR ADMINISTRATION; AND

(3) THE BENEFITS ARE REASONABLE IN RELATION TO THE PREMIUMS CHARGED.

HIRTY-ONE (31) STATES HAVE ALREADY PASSED LEGISLATION THAT PROVIDES FOR HE DISCRETION TO APPROVE NON-ENUMERATED GROUPS. FURTHERMORE, THIS

LANGUAGE IS NOW IDENTICAL TO THE MODEL LANGUAGE PROMULGATED BY THE NAIC.

N THESE STATES, THE COMMISSIONER STILL RETAINS THE AUTHORITY TO DISAPPROVE ANY PROPOSED GROUP THAT IS CONTRARY TO THE BEST INTERESTS OF THE PUBLIC BUT, THE COMMISSIONER HAS THE ABILITY TO APPROVE PROPOSED GROUP PLAN DESIGNS THAT MEET THESE REQUIREMENTS AND ARE OTHERWISE CONSISTENT WITH APPLICABLE INSURANCE LAWS.

WITH REGARD TO CREDIT CARD PAYMENTS, HOUSE BILL 373 WOULD AUTHORIZE GREATER USE OF CREDIT CARDS OR DEBIT CARDS TO PURCHASE INSURANCE.

AS YOU KNOW, MORE AND MORE PEOPLE ARE DOING BUSINESS OVER THE PHONE OR ON-LINE. CONSUMERS DOING BUSINESS OVER THE PHONE OR ON-LINE ARE VERY ACCUSTOMED TO USING CREDIT CARDS OR DEBIT CARDS TO MAKE PAYMENT, AND CONSUMERS MAY PREFER TO USE A CREDIT CARD RATHER THAN PROVIDE PERSONAL BANK ACCOUNT INFORMATION OVER THE PHONE OR ON-LINE. SO, INSURERS DOING BUSINESS IN THE TELEPHONE AND ON-LINE DISTRIBUTION CHANNELS REALLY NEED) ALLOW THE USE OF CREDIT CARDS TO ACCOMMODATE CONSUMER PREFERENCES. THE EXISTING NORTH CAROLINA LAW, NC INS. CODE SECTION 58-3-145, PROVIDES THAT INSURERS CAN ONLY ACCEPT PAYMENT OF PREMIUMS BY CREDIT CARD IF THE "INSURER MAKES PAYMENT BY CREDIT CARD AVAILABLE TO ALL EXISTING AND PROSPECTIVE INSUREDS."

EXTENDING THE USE OF CREDIT CARDS TO ALL EXISTING AND PROSPECTIVE INSUREDS PRESENTS A SIGNIFICANT BUSINESS CHALLENGE. ANY COMPANY WITH A SIZEABLE IN-FORCE BLOCK OF BUSINESS MAY HAVE EXISTING POLICIES ADMINISTERED ON MULTIPLE SYSTEMS. IT MAY COST A SUBSTANTIAL AMOUNT OF MONEY TO UPDATE EXISTING SYSTEMS TO ALLOW FOR PAYMENT OF PREMIUMS BY CREDIT CARD. SECONDLY, THERE IS A COST ASSOCIATED WITH MAKING A PAYMENT BY CREDIT CARD. IN-FORCE POLICIES MAY NOT HAVE BEEN PRICED FOR THAT COST. THIRD, THE NORTH CAROLINA LAW WOULD SEEM TO ENCOMPASS VARIABLE BUSINESS--THERE SEEMS TO BE NO ABILITY TO VARY PAYMENT OPTIONS BY RODUCT LINE--AND CREATE ISSUES WITH THE SEC RULE PROHIBITING THE SOLICITATION OF A LOAN TO FUND AN EQUITY PRODUCT.

THE COSTS ASSOCIATED WITH TRYING TO INCLUDE ALL INSUREDS WOULD "LIMINATE THE BUSINESS INCENTIVE TO INCREASE THE CONVENIENCE WHICH CCOMPANIES THE USE OF CREDIT CARDS OR DEBIT CARDS AS A FORM OF PAYMENT.

ATTACHMENT V

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 373 DATE May 31

S. B. No. _____ Amendment No. _____

(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE ✓

Rep.) Faison
)
Sen.)

moves to amend the bill on page 2, line 5 1-4

( ) WHICH CHANGES THE TITLE

by deleting these lines in their entirety; and

on page 1, lines 25-27, by rewriting these lines to read:

"through (5) of this section, if the Commission has made all of the following findings:" and

on lines 28-33, by renumbering these subdivisions as "a.", "b.", and "c.".

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

MINUTES

HOUSE COMMITTEE ON INSURANCE

June 7, 2011

The House Committee on Insurance met in Room 1228 of the Legislative Building on June 7, 2011, at 1:00 pm. The following members were present: Representatives Dockham, Chair, Brubaker, Burr, Collins, Crawford, Faison, Floyd, Hurley, Insko, Jackson, McGuirt, Mills, Murry, Pierce, and Steen. Tim Hovis and Bill Patterson, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes. (Attachment I)

Representative Dockham, Chair, called the meeting to order at 1:00 pm. He introduced the pages and the Sergeant of Arms staff. (Attachment II) The following bills were considered:

HB 244, entitled, AN ACT TO AUTHORIZE STERLING MONTESSORI ACADEMY AND CHARTER SCHOOL TO ELECT TO PARTICIPATE IN THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES. A proposed committee substitute bill was presented. Representative Faison moved to adopt the proposed committee substitute bill for consideration. The motion passed. The chair Recognized Representative Murry, bill sponsor, to explain the bill. Representative Faison moved for a favorable report as to the committee substitute bill, which changes the title, unfavorable as to the original bill. The motion passed.

HB 232, entitled, AN ACT TO PROVIDE THAT THERE SHALL BE NO PREMIUM SURCHARGE OR ASSESSMENT OF POINTS UNDER THE SAFE DRIVER INCENTIVE PLAN FOR ANY CONVICTION OF SPEEDING FIFTEEN MILES PER HOUR OR LESS OVER THE SPEED LIMIT. The Chair recognized Representative Spear, bill sponsor, to explain the bill. House Bill 232 amends G.S. 58-36-75(f) to increase the limit from 10 to 15 miles per hour or less over the speed limit the conviction of which will not result in to a premium surcharge or assessment of insurance points under the Safe Driver Incentive Plan. As under the current law, this subsection applies only if the violation did not occur in a school zone and there is no other moving traffic violation during the experience period. The higher speed would help clear courts on traffic days because drivers would no longer be lining up to convince District Attorneys to reduce their tickets so they can avoid higher insurance charges. Jennifer Cohen, IFNC, Harry Kaplan, AAA of NC, and Glenn Jernigan, GMAC Insurance, spoke in opposition of HB 232, indicating that insurance points are a deterrent and helps discourage speeding. David Stoller, State Farm Insurance, father of three, said forcing a young driver to go to court and stand in line teaches a lesson about the consequences of risky behavior.

After some discussion, Representative Floyd moved for a favorable report. With division having been called, the motion passed six to five.

There being no further business, the chair adjourned the meeting at 1:20 pm.

Respectfully submitted,

Jerry Dockham

Representative Jerry C. Dockham, Chair

Regina Irwin

Regina Irwin, Committee Assistant

Attachments

AGENDA

HOUSE COMMITTEE ON INSURANCE

June 7, 2011

Room 1228

1:00 pm

OPENING REMARKS

Representative Jerry Dockham, Chairman
Insurance Committee

AGENDA ITEMS

BILL NO.	SHORT TITLE
HB 232	Safe Driver Incentive Plan Changes. Representative Tim Spear, Bill Sponsor
HB 244	State Health Plan/Add Sterling Montessori. Representative Tom Murry, Bill Sponsor

ADJOURNMENT

ATTACHMENT I

VISITOR REGISTRATION SHEET

INSURANCE — June 07, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	BMAC Insurance
[signature]	Nelson Mullins
Rose Williams	NCDOI
[signature]	DES
[signature]	Nationwide
[signature]	NW
[signature]	MWC
Sara Fender	IFNC
Jennifer Cohen	IFNC
[signature]	MFA
DAVID RICE	MANNING FULTON

VISITOR REGISTRATION SHEET

INSURANCE — June 07, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Sollen	State Farm
Steve Woodson	NCFB
Robert Pasichal	Young Moore
Emily Grimm	MWC
Mike Stewart	NC Chamber
Bruce Nichols	BCBSNC
Mark Fleming	BCBSNC
Chad Barefoot	CAPA

VISITOR REGISTRATION SHEET

INSURANCE — June 07, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	NMRS
Blake Prechthe	SEANC
Jonathon Martin	JLF

PLEASE PRINT

ATTACHMENT II

HOUSE PAGES

NAME OF COMMITTEE: INSURANCE **DATE:** June 7, 2011

1. NAME: Thomas Whitman

County: New Hanover

Sponsor: Representative Justice

2. NAME: Daniel Burnette

County: Vance

Sponsor: Representative Crawford

3. NAME:

County:

Sponsor:

4. NAME:

County:

Sponsor:

5. NAME:

County:

Sponsor:

SERGEANTS-AT-ARMS

1. Name: Billy Jones

2. Name: Wayne Davis

3. Name:

4. Name:

5: Name:

2011 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☐ Committee Substitute for
HB 244 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE STERLING MONTESSORI ACADEMY AND CHARTER SCHOOL TO ELECT TO PARTICIPATE IN THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES.

☒ With a favorable report as to the committee substitute bill, which changes the title, unfavorable as to the original bill.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House/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 2011

H D

HOUSE BILL 244
PROPOSED COMMITTEE SUBSTITUTE H244-CSRG-18 [v.7]

6/5/2011 12:13:55 PM

Short Title: State Health Plan/Add Schools. (Public)

Sponsors:

Referred to:

March 8, 2011

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE STERLING MONTESSORI ACADEMY AND CHARTER SCHOOL AND THE CASA ESPERANZA MONTESSORI CHARTER SCHOOL TO ELECT TO PARTICIPATE IN THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. Notwithstanding the time limitation contained in G.S. 135-45.5, the Boards of Directors of (i) Sterling Montessori Academy and Charter School, located in Morrisville, North Carolina and (ii) the Casa Esperanza Montessori Charter School, located in Raleigh, North Carolina, may elect to become participating employing units in the State Health Plan for Teachers and State Employees in accordance with Article 3A of Chapter 135 of the General Statutes. The election authorized by this section shall be made no later than 30 days after the effective date of this act and shall be made in accordance with all other requirements of G.S. 135-45.5.

SECTION 2. This act is effective when it becomes law.

HOUSE BILL 244:
State Health Plan/Add Schools

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	June 5, 2011
Introduced by:	Rep. Murry	**Prepared by:**	Tim Hovis
Analysis of:	PCS to First Edition H244-CSRG-18		Committee Counsel

SUMMARY: ***The Proposed Committee Substitute for House Bill 244 would authorize, notwithstanding the time limitation in G.S. 135-45.5, the Boards of Directors of Sterling Montessori Charter School in Morrisville and the Casa Esperanza Montessori Charter School in Raleigh to elect to become participating employing units in the State Health Plan. Election to participate must be made within 30 days of the bill's effective date and must be made in accordance with all other requirements of G.S. 135-45.5.***

EFFECTIVE DATE: House Bill 244 is effective when it becomes law.

BACKGROUND: G.S. 135-45.5 requires the board of directors of a charter school operated by a nonprofit corporation to elect whether to become a participating employer in the State Health Plan. The election must be made no later than 30 days after signing the written charter with the local school administrative unit. The board of directors must notify eligible employees in writing as to whether the board elected to become a participating employer in the Plan.

G.S. 135-45.5 is set forth below.

§ 135-45.5. Optional participation for charter schools operated by private nonprofit corporations.

(a) The board of directors of each charter school operated by a private nonprofit corporation shall elect whether to become a participating employer in the Plan in accordance with this Article. This election shall be in writing, shall be made no later than 30 days after this section becomes law, and shall be filed with the Executive Administrator and Board of Trustees and with the State Board of Education. For each charter school employee who is employed on or before the date the board makes the election, membership in the Plan is effective as of the date the board makes the election. For each charter school employee who is employed after the date the board makes the election, membership in the Plan is effective as of the date of that employee's entry into eligible service. This subsection applies only to charter schools that received State Board of Education approval under G.S. 115C-238.29D in 1997 or 1998.

(b) No later than 30 days after both parties have signed the written charter under G.S. 115C-238.29E, the board of directors of a charter school operated by a private nonprofit corporation shall elect whether to become a participating employer in the Plan in accordance with this Article. This election shall be in writing and filed with the Executive Administrator, the Board of Trustees, and the State Board of Education. This election is effective for each charter school employee as of the date of that employee's entry into eligible service. This subsection applies to charter schools that receive State Board of Education approval under G.S. 115C-238.29D after 1998.

(c) A board's election to become a participating employer in the Plan under this section is irrevocable and shall require all eligible employees of the charter school to participate.

(d) If a charter school's board of directors does not elect to become a participating employer in the Plan under this section, that school's employees and the dependents of those employees are not eligible for any benefits under the Plan on account of employment with a charter school.

(e) The board of directors of each charter school shall notify each of its employees as to whether the board elected to become a participating employer in the Plan under this section. This notification shall be in writing and shall be provided within 30 days of the board's election or at the time an initial offer for employment is made, whichever occurs last. If the board did not elect to become a participating employer in the Plan, the notice shall include a statement that the employee shall have no legal recourse against the board or the State for any possible benefit under the Plan. The employee shall provide written acknowledgment of the employee's receipt of the notification under this subsection.

H 1

HOUSE BILL 244

Short Title:	State Health Plan/Add Sterling Montessori.	(Public)
Sponsors:	Representative Murry (Primary Sponsor). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Insurance.	

March 8, 2011

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE STERLING MONTESSORI ACADEMY AND CHARTER SCHOOL TO ELECT TO PARTICIPATE IN THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. Notwithstanding the time limitation contained in G.S. 135-45.5, the Board of Directors of Sterling Montessori Academy and Charter School, located in Morrisville, North Carolina, may elect to become a participating employing unit in the State Health Plan for Teachers and State Employees in accordance with Article 3A of Chapter 135 of the General Statutes. The election authorized by this section shall be made no later than 30 days after the effective date of this act and shall be made in accordance with all other requirements of G.S. 135-45.5.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: Proposed Committee Substitute to HB 244 (H244-CSRG-18 [v.2])

SHORT TITLE: State Health Plan/Add Sterling Montessori [and Casa Esperanza Montessori].

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: The bill permits the Board of Directors of Sterling Montessori Academy and Charter School and Casa Esperanza Montessori Charter School, which are public charter schools, to become participating employers under the Plan within 30 days after the act becomes law. Under G.S. 135-45.5, an election to join the Plan by the board of a charter school is irrevocable and shall require all eligible employees of the charter school to participate.

EFFECTIVE DATE: When it becomes law.

ESTIMATED IMPACT ON STATE:

The consulting actuary for the State Health Plan for Teachers and State Employees, Aon Consulting, estimates a financial loss to the Plan of $336,800 for FY 2011-2012 if Sterling Montessori and Casa Esperanza charter schools both elect to participate in the Plan.

Aon Consulting noted that by solely comparing the Plan's current average plan membership and the combined charter schools' submitted employee and dependent demographic data, each charter school group should produce less in expected claims, on average, as compared to the Plan's covered group. However, absent historical claims experience data from either school to substantiate this assessment, Aon Consulting noted that there is no basis to rule out the risk of either school group having higher average claims costs than the current plan members. Therefore, for the purposes of estimating the combined schools' potential cost impact to the Plan, Aon Consulting assumed potential claims for each school would be 150% greater on average due to expected adverse selection of costlier plan members entering the Plan. Even with this assumption, and given the small size of each respective school, Aon Consulting estimates the projected costs would have a negligible impact on the Plan.

Hartman & Associates, consulting actuary for the General Assembly's Fiscal Research Division, estimates that the financial impact on the Plan would not be material upon Sterling Montessori and Casa Esperanza charter schools electing to participate in the Plan.

Hartman and Associates noted that the employee and dependent demographics of the combined schools' groups would be expected to produce similar costs as compared to the Plan's membership, and that given the minimal number of prospective employees and dependents to be enrolled, there is not expected to be a significant financial impact as a percent of total claims. Hartman & Associates, however, also noted the lack of available historical claims experience from either School to assess potential adverse selection against the Plan.

The additional cost impact of the bill, projected by either consulting actuary, would be expected to impact total claims growth by approximately one hundredth of one percent (0.01%) for the 2011-2012 fiscal year based on the highest estimate of additional cost (i.e., $336,800).

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.

Authorized Charter Schools: As of December 2010, there are 59 charter schools with 3,524 enrolled active employees and dependents participating in the Plan.

Data submitted by the Schools: Aon Consulting and Hartman and Associates based their respective analyses in part on a Distribution of Participants schedule submitted by each school. The schedules below reflect the age and sex demographic data for employees and dependents for each of the respective schools. Neither school provided claims experience data due to a refusal of their respective incumbent carriers to release claims information on each School's participants.

Distribution of Participants – Sterling Montessori

	Active Employees			Dependents of Active Employees			Retired Employees			Dependents of Retired Employees		
Ages	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	0	0	0	0	0	0			0			0
5-9	0	0	0	1	0	1			0			0
10-14	0	0	0	1	3	4			0			0
15-19	0	0	0	1	3	4			0			0
20-24	0	0	0	1	1	2			0			0
25-29	0	4	4	0	0	0			0			0
30-34	4	7	11	0	0	0			0			0
35-39	2	8	10	0	0	0			0			0
40-44	1	17	18	1	1	2			0			0
45-49	1	7	8	0	2	2			0			0
50-54	1	9	10	1	0	1			0			0
55-59	1	1	2	1	0	1			0			0
60-64	1	0	1	0	0	0			0			0
65-69	0	2	2	0	0	0			0			0
70-74	0	1	1	0	0	0			0			0
75-79	0	0	0	0	0	0			0			0
>79	0	0	0	0	0	0			0			0
Unknown	0	0	0	0	0	0			0			0
TOTAL	11	56	67	7	10	17	0	0	0	0	0	0

Distribution of Participants – Casa Esperanza

	Active Employees			Dependents of Active Employees			Retired Employees			Dependents of Retired Employees		
Ages	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4			0		1	1			0			0
5-9			0	3	1	4			0			0
10-14			0		4	4			0			0
15-19			0			0			0			0
20-24		1	1	1	1	2			0			0
25-29	1	6	7			0			0			0
30-34		7	7			0			0			0
35-39		11	11			0			0			0
40-44	1	5	6			0			0			0
45-49		3	3	1		1			0			0
50-54		6	6			0			0			0
55-59		2	2			0			0			0
60-64		2	2	1		1			0			0
65-69			0			0			0			0
70-74			0			0			0			0
75-79			0			0			0			0
>79			0			0			0			0
Unknown			0			0			0			0
TOTAL	2	43	45	6	7	13	0	0	0	0	0	0

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.

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 $2.90 billion for FY 2011-12 and $3.08 billion for FY 2012-13. 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.

The following table provides a summary of most monthly premium rates for the Plan in FY 2010-11:

Coverage Type	PPO Basic Employee/ Retiree	PPO Basic Employer	PPO Standard Employee/ Retiree	PPO Standard Employer
Non-Medicare Active Employee/Retiree				
Employee	$0.00	$410.80	$0.00	$410.80
Employee + Child(ren)	$178.68	$410.80	$237.62	$410.80
Employee + Spouse	$460.36	$410.80	$547.48	$410.80
Employee + Family	$490.34	$410.80	$580.44	$410.80

Coverage Type	PPO Basic Employee/ Retiree	PPO Basic Employer	PPO Standard Employee/ Retiree	PPO Standard Employer
Medicare Primary for Only Employee/Retiree				
Employee	$0.00	$312.76	$0.00	$312.76
Employee + Child(ren)	$187.60	$312.76	$237.62	$312.76
Employee + Spouse	$469.28	$312.76	$547.48	$312.76
Employee + Family	$499.26	$312.76	$580.44	$312.76

The employer share of premiums for retirees is paid from the Retiree Health Benefit Fund. During FY 2010-11, employers contribute 4.9% of active employee payroll into the Fund. Total contributions for the year are projected to be approximately $721 million.

Financial Condition

Current and Projected Results for 2009-11 Biennium – The following summarizes actual financial results for FY 2009-10 and projected financial results for FY 2010-11, based on financial experience through December, 2010.

	($ millions) Actual FY 2009-10	Projected FY 2010-11
Beginning Cash Balance	$189.9	$121.5
Receipts:		
Net Premium Collections	$2,412.6	$2,677.4
Early Retirement Reinsurance Program	$0.0	$45.0
Medicare Part D Subsidies	$74.4	$60.5
Investment Earnings	$3.5	$2.4
Total	**$2,490.5**	**$2,785.3**
Disbursements:		
Net Medical Claim Payment Expenses	$1,797.5	$1,860.5
Net Pharmacy Claim Payment Expenses	$596.7	$647.7
Administration and Claims-Processing Expenses	$164.6	$171.7
Total	**$2,558.9**	**$2,679.9**

Net Operating Income (Loss)	**($68.4)**	**$105.4**

Financial Projection 2011-13 Biennium – The following summarizes a financial projection conducted by the Plan's consulting actuary, Aon Consulting, for the 2011-13 biennium. The information is provided by fiscal year based on year-to-date financial experience (through December 2010) and other updated factors. The projection assumes a 9.5% annual claims growth trend, that benefit provisions remain the same, and that both employer and member-paid premiums are increased by 6.3% effective July 1, 2011 and July 1, 2012.

	($ millions) Projected FY 2011-12	Projected FY 2012-13
Beginning Cash Balance	$226.8	$239.0
Receipts:		
Net Premium Collections	$2,829.0	$2,995.2
Early Retirement Reinsurance Program	$25.6	$0.0
Medicare Part D Subsidies	$60.1	$62.6
Investment Earnings	$2.3	$2.5
Total	**$2,917.0**	**$3,060.3**
Disbursements:		
Net Medical Claim Payment Expenses	$2,065.1	$2,199.0
Net Pharmacy Claim Payment Expenses	$659.2	$699.4
Administration and Claims-Processing Expenses	$180.5	$183.6
Total	**$2,904.8**	**$3,082.0**
Net Operating Income (Loss)	**$12.2**	**($21.7)**

This projection incorporates $151 million in projected savings over the biennium from a new Pharmacy Benefit Manager (PBM) contract to be effective October 1, 2011. It assumes that the Plan maintains "grandfathered" status under the federal Affordable Care Act (ACA). It assumes the Plan experiences an increase of $33 million in claims over the biennium due to requirements in the ACA to cover additional dependents.

Other Information

In the 2009-11 biennium, the annual premium increases were applied at the beginning of each fiscal year of the biennium. Historically, the Plan had applied a premium increase in October of the first fiscal year of a 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 9.5% annually according to the Plan's consulting actuary. Investment earnings are based upon a 1.0% return on available cash balances. The active population is projected to decline by 1% per year, the COBRA population is projected to remain constant, and the retired population is projected to increase by 1% per year.

Enrollment as of December 31, 2010

State Health Plan Enrollment as of December 31, 2010

I. No. of Participants	Basic	Standard	Total	Percent of Total
Actives				
Employees	65,849	256,468	322,317	48.6%
Dependents	50,588	105,759	156,347	23.6%
Sub-total	116,437	362,227	478,664	72.2%
Retired				
Employees	16,429	143,764	160,193	24.2%
Dependents	4,352	14,173	18,525	2.8%
Sub-total	20,781	157,937	178,718	26.9%
Former Employees with Continuation Coverage				
Employees	1,014	1,237	2,251	0.3%
Dependents	403	347	750	0.1%
Sub-total	1,417	1,584	3,001	0.5%
Firefighters, Rescue Squad & National Guard				
Employees	2	3	5	0.0%
Dependents	1	2	3	0.0%
Sub-total	3	5	8	0.0%
Local Governments				
Employees	486	1,429	1,915	0.3%
Dependents	303	629	932	0.1%
Sub-total	789	2,058	2,847	0.4%
Total				
Employees	83,780	402,901	486,681	73.4%
Dependents	55,647	120,910	176,557	26.6%
Grand Total	**139,427**	**523,811**	**663,238**	**100%**
Percent of Total	**21.0%**	**79.0%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Total
Employee Only	55,472	335,154	390,626
Employee Child(ren)	13,817	36,176	49,993
Employee Spouse	5,719	17,462	23,181
Employee Family	8,772	14,109	22,881
Total	**83,780**	**402,901**	**486,681**

Percent Enrollment by Contract	Basic	Standard	Total
Employee Only	66.2%	83.2%	80.3%
Employee Child(ren)	16.5%	9.0%	10.3%
Employee Spouse	6.8%	4.3%	4.8%
Employee Family	10.5%	3.5%	4.7%
Total	**100.0%**	**100.0%**	**100.0%**

III. Enrollment by Sex	Basic	Standard	Total
Female	75,627	338,703	414,330
Male	63,800	185,108	248,908
Total	**139,427**	**523,811**	**663,238**

Percent Enrollment by Sex	Basic	Standard	Total
Female	54.2%	64.7%	62.5%
Male	45.8%	35.3%	37.5%
Total	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Total
19 & Under	35,455	74,859	110,314
20 to 29	12,915	46,222	59,137
30 to 44	31,582	98,133	129,715
45 to 54	27,089	85,600	112,689
55 to 64	29,854	106,470	136,324
65 & Over	2,532	112,527	115,059
Total	**139,427**	**523,811**	**663,238**

Percent Enrollment by Age	Basic	Standard	Total
19 & Under	25.4%	14.3%	16.6%
20 to 29	9.3%	8.8%	8.9%
30 to 44	22.7%	18.7%	19.6%
45 to 54	19.4%	16.3%	17.0%
55 to 64	21.4%	20.3%	20.6%
65 & Over	1.8%	21.5%	17.3%
Total	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	53,034	11,292	64,326
Medicare Eligible	107,159	7,233	114,392
Total	**160,193**	**18,525**	178,718

Percent Enrollment by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.1%	61.0%	36.0%
Medicare Eligible	66.9%	39.0%	64.0%
Total	**100.0%**	**100.0%**	100.0%

VI. Enrollment By Major Employer Groups	Employees	Dependents	Total
State Agencies	75,779	33,151	108,930
UNC System	50,357	29,457	79,814
Local Public Schools	180,864	86,046	266,910
Local Community Colleges	15,317	7,693	23,010
Other			
Local Governments	1,915	932	2,847
COBRA	2,251	750	3,001
Nat. Guard, Fire & Rescue	5	3	8
Sub-total	326,488	158,032	484,520
Retirement System	160,193	18,525	178,718
Total	**486,681**	**176,557**	**663,238**

Percent Enrollment by Major Employer Groups	Employees	Dependents	Total
State Agencies	15.6%	18.8%	16.4%
UNC System	10.3%	16.7%	12.0%
Local Public Schools	37.2%	48.7%	40.2%
Local Community Colleges	3.1%	4.4%	3.5%
Other			
Local Governments	0.4%	0.5%	0.4%
COBRA	0.5%	0.4%	0.5%
Nat. Guard, Fire & Rescue	0.0%	0.0%	0.0%
Sub-total	67.1%	89.5%	73.1%
Retirement System	32.9%	10.5%	26.9%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, House Bill 244, "House Bill 244 Proposed Committee Substitute H244-CSRG-18 [v.2]: An Act to Authorize Sterling Montessori Academy and the Casa Esperanza Montessori Charter School to Elect to Participate in the State Health Plan for Teachers and State Employees," June 1, 2011, an original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, House Bill 244, " House Bill 244 Proposed Committee Substitute H244-CSRG-18 [v.2] State Health Plan/Add Sterling Montessori Academy," June 1, 2011, 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:

Lynn Muchmore, Director
Fiscal Research Division

DATE: June 7, 2011

2011 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

By Representative Dockham (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 232 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT THERE SHALL BE NO PREMIUM SURCHARGE OR ASSESSMENT OF POINTS UNDER THE SAFE DRIVER INCENTIVE PLAN FOR ANY CONVICTION OF SPEEDING FIFTEEN MILES PER HOUR OR LESS OVER THE SPEED LIMIT.

☒ 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 _____.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H 1

HOUSE BILL 232

Short Title:	Safe Driver Incentive Plan Changes.	(Public)
Sponsors:	Representative Spear (Primary Sponsor). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Insurance.	

March 7, 2011

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT THERE SHALL BE NO PREMIUM SURCHARGE OR ASSESSMENT OF POINTS UNDER THE SAFE DRIVER INCENTIVE PLAN FOR ANY CONVICTION OF SPEEDING FIFTEEN MILES PER HOUR OR LESS OVER THE SPEED LIMIT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-36-75 reads as rewritten:

"**§ 58-36-75. At-fault accidents and certain moving traffic violations under the Safe Driver Incentive Plan.**

...

(f) The subclassification plan shall provide that with respect to a conviction for a "violation of speeding ~~10 miles per hour or less~~ 15 miles per hour or less over the speed limit" there shall be no premium surcharge nor any assessment of points unless there is a driving record consisting of a conviction or convictions for a moving traffic violation or violations, except for a prayer for judgment continued for any moving traffic violation, during the three years immediately preceding the date of application or the preparation of the renewal. The subclassification plan shall also provide that with respect to a prayer for judgment continued for any moving traffic violation, there shall be no premium surcharge nor any assessment of points unless the vehicle owner, principal operator, or any licensed operator in the owner's household has a driving record consisting of a prayer or prayers for judgment continued for any moving traffic violation or violations during the three years immediately preceding the date of application or the preparation of the renewal. For the purpose of this subsection, a "prayer for judgment continued" means a determination of guilt by a jury or a court though no sentence has been imposed. For the purpose of this subsection, a "violation of speeding ~~10 miles per hour or less~~ 15 miles per hour or less over the speed limit" does not include the offense of speeding in a school zone in excess of the posted school zone speed limit."

SECTION 2. This act becomes effective January 1, 2012.

HOUSE BILL 232:
Safe Driver Incentive Plan Changes

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	June 5, 2011
Introduced by:	Rep. Spear	**Prepared by:**	Tim Hovis
Analysis of:	First Edition		Committee Counsel

SUMMARY: ***House Bill 232 amends G.S. 58-36-75(f) to provide that a conviction of 15 miles per hour or less over the speed limit will not result in a premium surcharge or assessment of insurance points under the Safe Driver Incentive Plan. This limit is set under current law at 10 miles per hour or less over the speed limit.***

CURRENT LAW: G.S. 58-36-75(f) provides that there will be no premium surcharge or assessment of insurance points under the Safe Driver Incentive Plan for a conviction of speeding 10 miles per hour or less over the posted speed limit if the violation did not occur in a school zone and there is no other moving traffic violation during the experience period. A prayer for judgment continued (PJC) is not considered a prior conviction under this section.

BILL ANALYSIS: House Bill 232 amends G.S. 58-36-75(f) to increase the limit from 10 to 15 miles per hour or less over the speed limit the conviction of which will not result in to a premium surcharge or assessment of insurance points under the Safe Driver Incentive Plan. As under the current law, this subsection applies only if the violation did not occur in a school zone and there is no other moving traffic violation during the experience period. A PJC is not considered a prior conviction under this section.

EFFECTIVE DATE: House Bill 232 becomes effective January 1, 2012.

BACKGROUND: G.S. 58-36-65 directs the North Carolina Rate Bureau to file with the Commissioner of Insurance a Safe Driver Incentive Plan, subject to the Commissioner's review, modification and approval. The Commissioner is then required to promulgate a SDIP that "distinguishes among various classes of drivers that have safe driving records and various classes of drivers that have a record of at-fault accidents; a record of convictions of major moving traffic violations; a record of convictions of minor moving traffic violations; or a combination thereof; and that provides for premium differentials among those classes of drivers." For each point assessed under the SDIP, the Commissioner may authorize an insurer to implement a surcharge above the State's approved automobile insurance rate. Under the SDIP, an insurer is required to notify an insured of any surcharge or loss of discount resulting from the accumulation of points under the SDIP.

Although the SDIP is largely promulgated administratively by the Commissioner, certain SDIP assessments and surcharges and exclusions from assessment are required by statute. G.S. 58-36-75 excludes the following from the assessment of points: (1) at-fault minor accidents if there is no conviction of a moving traffic violation and no licensed operators in the household have convictions or at-fault accidents during the experience period; (2) a conviction of speeding 10 mph or less over the posted speed limit if the violation did not occur in a school zone and there is no other moving traffic violation during the experience period (a prayer for judgment continued (PJC) is not considered a prior conviction under this section); and (3) one PJC for each household during an experience period.

MINUTES

HOUSE COMMITTEE ON INSURANCE

June 14, 2011

The House Committee on Insurance met in Room 1228 of the Legislative Building on June 14, 2011, at 1:00 pm. The following members were present: Representatives Dockham, Chair, Current, Faison, Floyd, Folwell, Glazier, Graham, Hamilton, Hurley, Insko, McGuirt, Murry, Pierce, Setzer, Shepard, Steen, Stevens, Warren, Wilkins, and Wray. Tim Hovis and Amy Joe Johnson, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes. (Attachment I)

Representative Dockham, Chair, called the meeting to order at 1:00 pm. He introduced the pages and the Sergeant of Arms staff. (Attachment II) The following bills were considered:

SB 702, entitled, A BILL TO BE ENTITLED AN ACT TO ALLOW THE STATE TREASURER TO PURCHASE LIABILITY INSURANCE. The Chair recognized Senator Meredith, bill sponsor, to explain the bill. SB 702 adds new GS 147-69.3A as the title indicates. Insurance purchased may be of any kind and may cover all risks or potential liability for the Treasurer, board members serving on boards housed in the Treasurer's office, and employees and agents of the Treasurer, including liability for investments managed by the Treasurer. It specifies that purchase of insurance does not waive sovereign immunity or other defenses. After some discussion Representative Faison moved for a favorable report. The motion passed.

SB 647, entitled, A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR THE CREATION OF MUTUAL INSURANCE HOLDING COMPANIES. Senator Rucho, bill sponsor, was not available to explain the bill. The Chair recognized Tim Hovis, Staff Counsel, to explain the bill. (Attachment III) The Chair recognized Mr. Steven Sawyer, Vice President of Regulatory Affairs for Medical Mutual Insurance Company of NC (Attachment IV) and Ms. Kimberly Moore, Director of Marketing and Public Affairs for NC Mutual Life Insurance Company (Attachment V) to speak on the bill. Representative Faison sent forth an amendment. The amendment moves to amend the bill on page 7, line 18-20 by rewriting the lines to read: "provided in this Part." (Attachment VI) The Chair moved to adopt the amendment for discussion. The motion passed. After a brief explanation and discussion of the amendment, Representative Dockham moved for the adoption of the amendment, and with the majority being in favor, the amendment was adopted. The Chair recognized Ms. Rose Vaughn Williams, Legislative Counsel with the NC Department of Insurance, to present the Department's view on this bill. Ms. Williams indicated that the Department of Insurance supports the bill. The Department strongly objected, however, to the language in the newly proposed G.S. 58-10-300 which would provide exemptions to the investment restrictions set out in G.S. 58-19-10. North Carolina's investment laws for insurance companies are based on NAIC models for solvency and the Department thinks they should be applied here. The

Department strongly supports the amendment to the bill to strike the provision in 58-10-300 that removed the language that said Mutual insurance holding companies' investments in subsidiaries, including intermediate holding companies, shall not be subject to any of the restrictions on investment activities set forth in G.S. 58-19-10. The Department is very relieved the committee voted to strike that language. Ms. Williams presented a letter from Mr. Wayne Goodwin, NC Commissioner of Insurance, and requested the letter be made part of the minutes. (Attachment VII) Due to the amount of questions being raised, this bill was displaced to allow another bill to be heard in this committee meeting.

SB 744, entitled, A BILL TO BE ENTITLED AN ACT TO ALLOW EMPLOYERS ACCESS TO INFORMATION ABOUT THEIR GROUP HEALTH PLANS. The Chair recognized Senator Goolsby, bill sponsor, to explain the bill. Senator Goolsby asked for SB 744 to be taken off the calendar.

SB 738, entitled, A BILL TO BE ENTITLED AN ACT TO REQUIRE THAT A PERSON THAT HOLDS CERTAIN ALCOHOLIC BEVERAGE CONTROL PERMITS HAVE AT LEAST ONE MILLION DOLLARS IN LIABILITY INSURANCE. The Chair recognized Senator Goolsby, bill sponsor, to explain the bill. SB 783 increases the total amount of damages that may be awarded to aggrieved parties against an ABC permittee or local Alcoholic Beverage Control Board resulting from sale of alcohol to underage person from $500,000 to 1,000,000 per occurrence. The bill also requires a person holding an on-premise ABC permit to maintain a policy of liability insurance in an amount of not less than $1,000,000. The Chair recognized Tim Hovis, Staff Counsel, to speak on the bill. (Attachment VIII) After some discussion Representative Hamilton moved for a favorable report. The motion passed.

There being no further business, the Chair adjourned the meeting at 1:55 pm.

Respectfully submitted,

Jerry C. Dockham

Representative Jerry C. Dockham, Chair

Regina Irwin

Regina Irwin, Committee Assistant

Attachments

AGENDA

HOUSE COMMITTEE ON INSURANCE

June 14, 2011

Room 1228

1:00 pm

OPENING REMARKS

Representative Jerry Dockham, Chairman
Insurance Committee

AGENDA ITEMS

SB 647 **Mutual Insurance Holding Companies.**
Senator Bob Rucho, Sponsor

SB 702 **Director and Officer Insurance for Treasurer.**
Senator Wesley Meredith, Sponsor

SB 738 **Liability Insurance Required for ABC Permits.**
Senator Thom Goolsby

SB 744 **Transparency in the Cost of Health Care.**
Senator Thom Goolsby

ADJOURNMENT

ATTACHMENT I

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

June 14, 2011
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Solari	DST
Kara Petteway	DST
Mary Freeman	NC AE
Carolyn Smith	DST
Barbara Candler	BSCBS
John Dervin	Governor's Office
John Hardin	MFS
Susan Valauri	NW
Kim Creech	NCBA
Mark Mone	NC Mutual Life Ins
Steven Sawyer	Medical Mutual of NC
Tony Tenge	NMRS
Rose Wilkes	NCDOT

VISITOR REGISTRATION SHEET

INSURANCE — June 14, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Randy Pridgen	Capitol Health
Matthew Gilmore	DST
Lawless Bean	City of Wilmington
Ken Wright	BCBSNC
Peter Daniel	NC Farm Bureau
Mark Fleming	work for Peter Daniel
[illegible]	work for Mark Fleming
Marty Babcock	AHIP
Sara Fender	IFNC
Robert Pasha	Young Moore
[illegible]	Rep. Murry's Office

VISITOR REGISTRATION SHEET

INSURANCE — June 14, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Hunt Harris	NMSS-NC
Abby Forcum Nelson	NMSS-NC
Michelle Frazier	MFS
Jennifer Cohen	IFNC
PAIGE WORSHAM	LEGISLATIVE REPORTING SERVICE
Chuck Stone	SEANC
Bob Blackwell	Cherokee
David Hoke	~~EBCI~~ ABC Comm
	LPAs

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

June 14, 2011
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	NCDS
Morgan Beam	Y.A.

PLEASE PRINT **ATTACHMENT II**

HOUSE PAGES

NAME OF COMMITTEE: INSURANCE DATE: June 14, 2011

1. NAME: Meghan Brooks
   County: Wake
   Sponsor: Representative Efton Sager
2. NAME: Morgan Bizzell
   County: Onslow
   Sponsor: Rep. Shepard
3. NAME: Wes Hamner
   County: Gaston
   Sponsor: Rep. Current
4. NAME: Tyler Coe
   County: Davidson
   Sponsor: Rep. Dockham
5. NAME: Ashley Silver
   County: Nash
   Sponsor: Angela Bryant

SERGEANTS-AT-ARMS

1. Name: Fred Hines
2. Name: Garland Shepheard
3. Name:
4. Name:
5: Name:

2011 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☒Committee Substitute for
SB 702 A BILL TO BE ENTITLED AN ACT TO ALLOW THE STATE TREASURER TO PURCHASE LIABILITY INSURANCE.

☒ 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 _____.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S 3

SENATE BILL 702
Insurance Committee Substitute Adopted 6/7/11
Third Edition Engrossed 6/7/11

Short Title: Director and Officer Insurance for Treasurer. (Public)

Sponsors:

Referred to:

April 20, 2011

A BILL TO BE ENTITLED

AN ACT TO ALLOW THE STATE TREASURER TO PURCHASE LIABILITY INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 6 of Chapter 147 of the General Statutes is amended by adding a new section to read:

"**§ 147-69.3A. Liability insurance for State Treasurer.**

(a) The State Treasurer may purchase commercial insurance of any kind to cover all risks or potential liability of the State Treasurer, boards in the Department of the State Treasurer, members of boards in the Department of the State Treasurer, and employees and agents of the State Treasurer, including the risks and potential liability related to investments managed by the State Treasurer.

(b) Board members and employees of boards in the Department of the State Treasurer shall be considered State employees for purposes of Articles 31 and 31A of Chapter 143 of the General Statutes. To the extent that the State Treasurer purchases commercial liability insurance coverage in excess of one hundred fifty thousand dollars ($150,000) per claim for liability arising under Article 31 or 31A of Chapter 143 of the General Statutes, the provisions of G.S. 143-299.4 shall not apply. To the extent that the State Treasurer purchases commercial insurance coverage for liability arising under Article 31 or 31A of Chapter 143 of the General Statutes, the provisions of G.S. 143-300.6(a) shall not apply.

(c) The purchase of insurance by the State Treasurer under this section shall not be construed to waive sovereign immunity or any other defense available to the State Treasurer, boards in the Department of the State Treasurer, members of boards in the Department of the State Treasurer, or employees or agents of the State Treasurer in an action or contested matter in any court, agency, or tribunal. The purchase of insurance by the State Treasurer shall not be construed to alter or expand the limitations on claims or payments established in G.S. 143-299.2 or limit the right of the State Treasurer, board members, employees, or agents to defense by the State as provided by G.S. 143-300.3."

SECTION 2. This act is effective when it becomes law.

SENATE BILL 702:
Director and Officer Insurance for Treasurer

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	June 13, 2011
Introduced by:	Sen. Meredith	**Prepared by:**	Tim Hovis
Analysis of:	Third Edition		Committee Counsel

SUMMARY: ***Senate Bill 702 creates a new G.S. 147-69.3A to authorize the State Treasurer to purchase commercial liability insurance to cover the liability of the State Treasurer, and boards, board members, employees and agents of the State Treasurer, including coverage for potential liability related to investments managed by the State Treasurer.***

CURRENT LAW: Under the doctrine of sovereign immunity, the State is generally immune from suit for the negligent acts of its employees. However, the State has waived its sovereign immunity to the extent suit is authorized under Article 31 of Chapter 143, *Tort Claims against State Departments and Agencies*, also known as the Tort Claims Act. There is a $1,000,000 cap on the State's liability under the Act on account of injury to any one person, less any commercial liability insurance.

While sovereign immunity bars suit against the State, it does not bar suit against state employees. Article 31A of Chapter 143, *Defense of State Employees, Medical Contractors and Local Sanitarians*, provides that the State may, upon request of an employee, provide for the defense of any civil or criminal action brought against an employee in his individual capacity for acts in the course and scope of his employment. As under the Tort Claims Act, there is a $1,000,000 cap on the amount paid for a judgment against an employee or employees for any one claim. The amount paid by the State is excess coverage and is reduced by any liability insurance coverage.

With regard to the payment of claims under Article 31 or Article 31A, the unit of State government that employed the employee is responsible for paying the first $150,000. **G.S. 143-299.4 and G.S. 143-300.6** require each State agency to transfer to the Office of State Budget and Management its proportionate share of lapsed salaries to the Office of State Budget and Management to pay the balance of a claim in excess of $150,000. If the agency has sufficient resources, the Director may require the agency to pay the full claim.

BILL SUMMARY: Senate Bill 702 creates a new G.S. 147-69.3A to authorize the State Treasurer to purchase commercial liability insurance to cover the liability of the State Treasurer, boards and members of boards in the Department of the State Treasurer, and employees and agents of the State Treasurer, including coverage for risks and liability related to investments managed by the State Treasurer.

Subsection (b) of the new G.S. 147-69.3A provides that Board members and employees of boards are considered State employees for purposes of the Tort Claims Act (Article 31) and Article 31A, Defense of State Employees. However the bill provides that, to the extent the State Treasurer purchases liability coverage, the provisions of G.S. 143-299.4 and G.S. 143-300.6(a) do not apply. (The State Treasurer would not have to transfer funds to the Office of State Budget and Management to cover any judgment paid by the State over $150,000.)

Subsection (c) provides that the purchase of liability insurance shall not be construed to (i) waive sovereign immunity or any other defense available to the State Treasurer and its boards, employees or agents; (ii) expand the maximum to be paid by the State; or (iii) limit the State Treasurer's, board member's, or employee's right to a defense by the State.

EFFECTIVE DATE: Senate Bill 702 is effective when it becomes law.

SENATE BILL 647
Insurance Committee Substitute Adopted 6/7/11

Short Title: Mutual Insurance Holding Companies. (Public)

Sponsors:

Referred to:

April 19, 2011

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE CREATION OF MUTUAL INSURANCE HOLDING COMPANIES.

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 8. Mutual Insurance Holding Companies.

"**§ 58-10-275. Definitions.**

The following definitions apply in this Part:

(1) Affiliated. – Defined in G.S. 58-19-5.

(2) Control. – Defined in G.S. 58-19-5.

(3) Domestic mutual insurance company. – An insurance company organized on a mutual plan and incorporated under the laws of North Carolina.

(4) Interested person. – With respect to another person, includes any of the following:

a. Any affiliated person.

b. Any member of the immediate family of any natural person who is an affiliated person of such company.

c. Any person or partner or employee of any person who at any time since the beginning of the last two completed fiscal years of such company has acted as legal counsel for such company.

d. Any natural person whom the Commissioner by order shall have determined to be an interested person by reason of having had, at any time since the beginning of the last two completed fiscal years of such company, a material business or professional relationship with such company or with the principal executive officer of such company.

(5) Intermediate holding company. – A holding company that is a subsidiary of a mutual insurance holding company or part of a holding company system controlled by a mutual insurance holding company subject to the terms and conditions of Article 19 of this Chapter and that either directly or through a subsidiary intermediate holding company has one or more subsidiary reorganized insurance companies of which a majority of the voting shares of the capital stock would otherwise have been required by this section to be at all times owned by the mutual insurance holding company.

(6) Limited application. – An application by a domestic mutual insurance company for reorganization to a mutual insurance holding company which will hold, at all times, one hundred percent (100%) of the stock of its insurance subsidiaries.

(7) Majority of the voting shares of the capital stock of the reorganized insurance company. – Shares of the capital stock of a reorganized insurance company which carry the right to cast a majority of the votes entitled to be cast by all of the outstanding shares of the capital stock of the reorganized insurance company for the election of directors and on all other matters submitted to a vote of the shareholders of the reorganized insurance company.

(8) Member of the immediate family. – Any parent, spouse of a parent, child, spouse of a child, spouse, brother, or sister, including step and adoptive relationships.

(9) Mutual insurance holding company. – A holding company organized on a mutual plan and incorporated under the laws of North Carolina, resulting from the reorganization of a domestic mutual insurance company pursuant to this Part, with one or more stock insurance holding company subsidiaries or stock insurance company subsidiaries.

(10) Plan of reorganization. – A plan to reorganize a domestic mutual insurance company by forming a mutual insurance holding company.

(11) Standard application. – An application by a domestic mutual insurance company for reorganization to a mutual insurance holding company which may sell interests in its subsidiaries to third parties.

(12) Stock. – Any security evidencing an equity interest in the issuing entity.

(13) Stock offering. – Any proposed sale, exchange, transfer, or other change of ownership of stock or of securities convertible into or exchangeable or exercisable for stock. For the purposes of this Article, "stock offering" shall not include any of the following:

a. An offering of preferred stock which is not convertible or exchangeable into common stock and which has no ordinary voting rights.

b. A transfer of stock among any of the following:

1. A mutual insurance holding company.

2. An insurance company subsidiary of a mutual insurance holding company.

3. An intermediate holding company subsidiary of a mutual insurance holding company.

4. An insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company.

(14) Subsidiary. – Defined in G.S. 58-19-5.

"**§ 58-10-280. General provisions.**

(a) A domestic mutual insurance company, upon approval of the Commissioner, may reorganize by forming an insurance holding company based upon a mutual plan and by continuing the corporate existence of the reorganizing insurance company as a stock insurance company. If the Commissioner, after a public comment period as provided in G.S. 58-10-285, or, if applicable, a public hearing, is satisfied that the interests of the policyholders are properly protected and that the plan of reorganization is fair and equitable to the policyholders, the Commissioner may approve the proposed plan of reorganization and may require as a condition of approval such modifications of the proposed plan of reorganization as the Commissioner finds necessary for the protection of the policyholders' interests. The Commissioner may retain

consultants as provided in G.S. 58-10-285 to assist in the review of the proposed plan. The Commissioner shall retain jurisdiction over a mutual insurance holding company organized under this Part to assure that policyholder interests are protected. All of the initial shares of the capital stock of the reorganized insurance company shall be issued to the mutual insurance holding company. The membership interests of the policyholders of the reorganized insurance company shall become membership interests in the mutual insurance holding company, pursuant to the terms and conditions of the plan of reorganization approved by the Commissioner. Policyholders of the reorganized insurance company shall be members of the mutual insurance holding company in accordance with the articles of incorporation and bylaws of the mutual insurance holding company. The mutual insurance holding company shall at all times own a majority of the voting shares of the capital stock of the reorganized insurance company.

(b) A domestic mutual insurance company, after approval by the Commissioner, may reorganize by merging its policyholders' membership interests into a mutual insurance holding company formed under subsection (a) of this section and continuing the corporate existence of the reorganizing insurance company as a stock insurance company subsidiary of the mutual insurance holding company. If the Commissioner is satisfied that the interests of the policyholders are properly protected and that the merger of interests is fair and equitable to the policyholders, the Commissioner may approve the proposed merger of interests and may require as a condition of approval such modifications of the proposed merger of interests as the Commissioner finds necessary for the protection of the policyholders' interests. The Commissioner may retain consultants as provided in G.S. 58-10-285. The Commissioner has jurisdiction over the mutual insurance holding company organized under this Part to assure that policyholder interests are protected. All of the initial shares of the capital stock of the reorganized insurance company shall be issued to the mutual insurance holding company. The membership interests of the policyholders of the reorganized insurance company shall, pursuant to the terms and conditions of the plan of reorganization approved by the Commissioner, become membership interests in the mutual insurance holding company. Policyholders of the reorganized insurance company shall be members of the mutual insurance holding company in accordance with subsection (a) of this section and the articles of incorporation and bylaws of the mutual insurance holding company. The mutual insurance holding company shall at all times own a majority of the voting shares of the capital stock of the reorganized insurance company.

(c) A mutual insurance holding company resulting from the reorganization of a domestic mutual insurance company that was organized under Articles 7 and 8 and other applicable provisions of this Chapter shall be incorporated under this Chapter. The articles of incorporation and any amendments to such articles of the mutual insurance holding company shall be subject to approval of the Commissioner in the same manner as those of a mutual insurance company.

(d) A mutual insurance holding company is an insurer subject to Article 30 of this Chapter and shall automatically be a party to any proceeding under Article 30 of this Chapter involving an insurance company which, as a result of a reorganization under subsection (a) or (b) of this section, is a subsidiary of the mutual insurance holding company. In any proceeding under Article 30 of this Chapter involving the reorganized insurance company, the assets of the mutual insurance holding company are deemed to be assets of the estate of the reorganized insurance company for purposes of satisfying the claims of the reorganized insurance company's policyholders. A mutual insurance holding company shall not dissolve or liquidate without the approval of the Commissioner or as ordered by the court pursuant to Article 30 of this Chapter.

(e) G.S. 58-10-10 and G.S. 58-10-12 are not applicable to a reorganization or merger of interests under this Part. G.S. 58-10-10 and G.S. 58-10-12 are applicable to demutualization of

a mutual insurance holding company that resulted from the reorganization of a domestic mutual insurance company organized under this Chapter as if the mutual insurance holding company was a mutual insurance company.

(f) A membership interest in a domestic mutual insurance holding company shall not constitute a security as defined in Chapter 78A of the General Statutes.

(g) The majority of the voting shares of the capital stock of the reorganized insurance company, which is required by this section to be at all times owned by a mutual insurance holding company, shall not be conveyed, transferred, assigned, pledged, subjected to a security interest or lien, encumbered, or otherwise hypothecated or alienated by the mutual insurance holding company or intermediate holding company. Any conveyance, transfer, assignment, pledge, security interest, lien, encumbrance, or hypothecation or alienation of, in, or on the majority of the voting shares of the reorganized insurance company is a violation of this section and shall be void in inverse chronological order of the date of such conveyance, transfer, assignment, pledge, security interest, lien, encumbrance, or hypothecation or alienation, as to the shares necessary to constitute a majority of such voting shares. The majority of the voting shares of the capital stock of the reorganized insurance company shall not be subject to execution and levy as provided in Chapter 1 of the General Statutes. The shares of the capital stock of the surviving or new company resulting from a merger or consolidation of two or more reorganized insurance companies or two or more intermediate holding companies that were subsidiaries of the same mutual insurance holding company are subject to the same requirements, restrictions, and limitations to which the shares of the merging or consolidating reorganized insurance companies or intermediate holding companies were subject by this section prior to the merger or consolidation. The ownership of a majority of the voting shares of the capital stock of the reorganized insurance company that are required by this section to be at all times owned by a parent mutual insurance holding company includes indirect ownership through one or more intermediate holding companies in a corporate structure approved by the Commissioner. However, indirect ownership through one or more intermediate holding companies shall not result in the mutual insurance holding company owning less than the equivalent of a majority of the voting shares of the capital stock of the reorganized insurance company. The Commissioner shall have jurisdiction over an intermediate holding company as if it were a mutual insurance holding company.

(h) The applicant's articles of incorporation or bylaws, as appropriate, shall require a policyholder vote of approval of the reorganization by a two-thirds majority of the domestic mutual insurance company's policyholders voting on it in person, by proxy, or by mail at a meeting called for the purpose of voting on the reorganization.

"**§ 58-10-285. Application; contents; process.**

(a) An application shall be designated as either a limited application or a standard application. The filing of a limited application shall not preclude the subsequent filing of an application for approval of an initial sale of stock as provided in G.S. 58-10-315.

(b) The application shall be filed in triplicate with the Commissioner and shall include the following items:

(1) Designation as a limited or standard application.

(2) A plan of reorganization as set forth in G.S. 58-10-290.

(3) A plan to obtain the approval of the policyholders in accordance with this Part and the applicant's articles of incorporation and bylaws.

(4) A copy of the mutual insurance holding company's proposed articles of incorporation and bylaws specifying all membership rights.

(5) The names, addresses, and occupational information of all corporate officers and members of the initial mutual insurance holding company board of directors.

(6) Information sufficient to demonstrate that the financial condition of the applicant will not be diminished upon reorganization.

(7) A copy of the proposed articles of incorporation and bylaws for any insurance company subsidiary or intermediate holding company subsidiary.

(8) A "Form A" filing as described in Chapter 11 of Title 11 of the North Carolina Administrative Code.

(9) A statement that the application is in compliance with all pertinent North Carolina General Statutes and Administrative Rules and that the requirements for a plan of reorganization have been fulfilled.

(10) An index demonstrating wherein the application information supplied in compliance with this subsection is found.

(11) The applicable fee required by subsection (f) of this section.

(12) Any other information requested by the Commissioner at any time during the course of proceedings.

(c) Upon receipt and review by the Commissioner of all information provided pursuant to subsection (b) of this section, the Commissioner may establish a period during which the Department will receive and consider public comments on the proposed reorganization. The Commissioner may inform the public of the limited or standard application in a manner deemed appropriate by the Commissioner and may hold a public hearing concerning the application.

(d) The Commissioner may contract, at the expense of the person filing the application, with any attorneys, actuaries, economists, accountants, consultants, or other professional advisors not otherwise a part of the Commissioner's staff to assist the Commissioner in reviewing the application. These contracts are personal professional service contracts exempt from Articles 3 and 3C of Chapter 143 of the General Statutes.

(e) The expenses of mailing any notices and other materials required by this section shall be borne by the person filing the application.

(f) An applicant filing a limited application under this section shall submit with the application under subsection (b) of this section an application fee of two hundred fifty dollars ($250.00). An applicant filing a standard application under this section shall submit with the application under subsection (b) of this section an application fee of five hundred dollars ($500.00).

"**§ 58-10-290. Plan of reorganization.**

(a) A limited application plan of reorganization shall include the following provisions:

(1) Establishing a mutual insurance holding company with at least one stock insurance company subsidiary or one intermediary stock holding company with a stock insurance company subsidiary, the shares of which shall be held exclusively by the mutual insurance holding company.

(2) Protecting the interests of existing policyholders.

(3) Ensuring immediate membership in the mutual insurance holding company of all existing policyholders of the reorganizing domestic mutual insurance company.

(4) Describing a plan providing for membership interests of future policyholders.

(5) Describing the number of members of the board of directors of the mutual insurance holding company required to be policyholders.

(6) Demonstrating that, in the event of proceedings under Article 30 of this Chapter involving a stock insurance company subsidiary of the mutual insurance holding company which resulted from the reorganization of a domestic mutual insurance company, the assets of the mutual insurance holding company will be available to satisfy the policyholder obligations of the stock insurance company.

(7) Describing how any accumulation or prospective accumulation of earnings by the mutual insurance holding company in excess of that determined by the board of directors of the mutual insurance holding company to be necessary shall inure to the exclusive benefit of the policyholders of its insurance company subsidiaries who are members.

(8) Describing the nature and content of the annual report and financial statement to be sent to each member.

(9) Describing any other relevant matters the applicant deems appropriate.

(b) A standard application plan of reorganization shall include the following provisions:

(1) Establishing a mutual insurance holding company with at least one stock insurance company subsidiary or one wholly owned intermediate stock holding company with a stock insurance company subsidiary, the shares of which shall be held exclusively by the wholly owned intermediate holding company.

(2) Protecting the interests of existing policyholders.

(3) Ensuring immediate membership in the mutual insurance holding company of all existing policyholders of the reorganizing domestic mutual insurance company.

(4) Providing for membership interests of future policyholders.

(5) Describing the number of members of the board of directors of the mutual insurance holding company required to be policyholders.

(6) Demonstrating that, in the event of proceedings under Article 30 of this Chapter involving a stock insurance company subsidiary of the mutual insurance holding company which resulted from the reorganization of a domestic mutual insurance company, the assets of the mutual insurance holding company will be available to satisfy the policyholder obligations of the stock insurance company.

(7) Describing how any accumulation or prospective accumulation of earnings by the mutual insurance holding company in excess of that determined by the board of directors of the mutual insurance holding company to be necessary shall inure to the exclusive benefit of the policyholders of its insurance company subsidiaries who are members.

(8) Describing the nature and content of the annual report and financial statement to be sent to each member.

(9) Describing the applicant's plan for a stock offering in accordance with the provisions of G.S. 58-10-315.

(10) Describing any other relevant matters the applicant deems appropriate.

(c) With regard to either a limited or standard application, the plan of reorganization submitted to the Commissioner shall demonstrate the following:

(1) Policyholder interests are properly preserved and protected.

(2) The plan is fair and equitable to policyholders.

(3) The financial condition of the applicant will not be diminished.

"**§ 58-10-295. Powers of the Commissioner.**

(a) The Commissioner shall at all times retain jurisdiction over the mutual insurance holding company, its intermediate holding company subsidiaries with stock insurance company subsidiaries, and its stock insurance company subsidiaries.

(b) Following any public comment period or hearing pursuant to G.S. 58-10-285, the Commissioner by order shall approve, conditionally approve, or deny an application. The Commissioner may require, as a condition of approval of the proposed reorganization, modifications of the proposed plan of reorganization that the Commissioner finds necessary. The applicant shall accept the required modifications by filing appropriate amendments to the

proposed plan of reorganization with the Commissioner within 30 days of the date of the Commissioner's order requiring the modifications. If the applicant does not accept the required modifications by failing to file the required amendments to the proposed plan of reorganization within 30 days, the proposed reorganization shall be deemed denied.

(c) An approval or conditional approval of a plan of reorganization shall expire if the reorganization is not completed within 210 days after the approval or conditional approval unless the time period is extended by the Commissioner upon a showing of good cause.

(d) The Commissioner may revoke approval or conditional approval of an applicant's plan of reorganization in the event the Commissioner finds the applicant has failed to comply with the plan of reorganization. The Commissioner may compel completion of a plan of reorganization unless the plan is abandoned in its entirety, in accordance with the applicant's provisions for governance.

(e) Upon completion of all elements of a plan of reorganization, the applicant shall provide a notice of completion to the Commissioner.

"**§ 58-10-300. Special financial requirements.**

(a) Mutual insurance holding companies and their insurance company subsidiaries and affiliates shall comply with the provisions of Article 19 of this Chapter except as expressly provided in this Part. Mutual insurance holding companies' investments in subsidiaries, including intermediate holding companies, shall not be subject to any of the restrictions on investment activities set forth in G.S. 58-19-10.

(b) When a mutual insurance holding company acquires or plans to acquire more than fifty percent (50%) of a stock insurance company, the mutual insurance holding company shall submit to the Commissioner a plan describing any membership interests of policyholders.

(c) Each mutual insurance holding company shall supply to the Commissioner, by April 1 of each year, an annual statement consisting of the following:

(1) An income statement.
(2) A balance sheet.
(3) A cash flow statement.
(4) Complete information on the status of any closed block formed as a part of a plan of reorganization.
(5) An investment plan covering all assets.
(6) A statement disclosing any intention to pledge, borrow against, alienate, hypothecate, or in any way encumber the assets of the mutual insurance holding company.

(d) At least fifty percent (50%) of the net worth of the mutual insurance holding company, based upon generally accepted accounting practices, shall be invested in insurance company subsidiaries. The Commissioner may waive the fifty percent (50%) limitation upon a showing of good cause.

(e) No policyholder who is a member of a mutual insurance holding company shall receive on account of such membership interest any payment of a policy credit, dividend, or other distribution unless the payment has been approved by the Commissioner. The Commissioner, if satisfied the proposed payment is fair and equitable to policyholders who are members, may approve the proposed payment and may require as a condition of the approval modification of the proposed payment that the Commissioner finds necessary for the protection of the policyholders.

(f) Mutual insurance holding companies shall comply with Part 3 of this Article and shall be considered a domestic insurer for the purposes of compliance with Part 3.

"**§ 58-10-305. Reorganization of domestic mutual insurer with mutual insurance holding company.**

A domestic mutual insurance company may apply to reorganize by merging its policyholders' membership interests into a mutual insurance holding company by filing with the

Commissioner a joint application with the mutual insurance holding company complying with the provisions of G.S. 58-10-285.

"**§ 58-10-310. Mergers of mutual insurance holding companies.**

A mutual insurance holding company may apply to merge with another mutual insurance holding company by filing with the Commissioner a plan of merger and complying with the provisions of Article 19 of this Chapter.

"**§ 58-10-315. Stock offerings.**

(a) No stock offering by a mutual insurance holding company, an insurance company subsidiary of a mutual insurance holding company, an intermediate holding company subsidiary of a mutual insurance holding company, or an insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company shall occur without the prior approval of the Commissioner.

(b) Every application for approval of a stock offering shall contain the following information:

(1) A description of the stock intended to be offered by the applicant, including a description of all shareholder rights.

(2) The total number of shares authorized to be issued, the estimated number the applicant requests permission to offer, and the intended date or range of dates for the offer.

(3) A justification for a uniform planned offering price or a justification of the method by which the offering price will be determined.

(4) The name or names of any underwriter, syndicate member, or placement agent involved and, if known, the name or names of each entity, person, or group of persons to whom the stock offering is to be made who will control five percent (5%) of the total outstanding class of shares, and the manner in which the offer is to be tendered. If any such entity or person is a corporation or business organization, the name of each member of its board of directors or equivalent management team shall be provided along with the name of each member of the board of directors of the offeror. Copies of any filings with the United States Securities and Exchange Commission disclosing intended acquisitions of the stock shall be included in the application.

(5) A description of stock subscription rights to be afforded members of the mutual insurance holding company in conjunction with the stock offering.

(6) A detailed description of all expenses to be incurred in conjunction with the stock offering.

(7) An explanation of how funds raised by the stock offering are to be used.

(8) Any other information requested by the Commissioner.

(c) No application regarding a planned stock offering shall be approved unless the plan contains the following provisions:

(1) Prohibiting officers, directors, and insiders of the mutual insurance holding company and its subsidiaries and affiliates from purchase or ownership of shares of the stock offering, or issuance of stock options to or for the benefit of such officers, directors, and insiders, in excess of five percent (5%) of the stock offering. The Commissioner may waive this requirement upon a showing of good cause. This subdivision does not limit the rights of officers, directors, and insiders from exercising subscription rights that are generally accorded members of the mutual insurance holding company. However, pursuant to those subscription rights, the officers, directors, and insiders of the mutual insurance holding company and its subsidiaries and affiliates may not purchase or own, in the aggregate, more than five percent (5%) of the stock offering.

(2) Requiring that, after the initial stock offering, a majority of the board of directors of the mutual insurance holding company be persons who are not interested persons of the mutual insurance holding company or of an affiliated person of the company. For purposes of this subdivision, a member of the mutual insurance holding company or a policyholder of any of its insurance company subsidiaries shall not be considered an "interested person" or an "affiliated person." The Commissioner may waive this requirement upon a showing of good cause.

(3) For the mutual insurance holding company to adopt articles of incorporation prohibiting any waiver of dividends from stock subsidiaries except under conditions specified in its articles of incorporation and after approval of the waiver by the board of directors of the mutual insurance holding company and the Commissioner.

(4) Requiring that, after the initial stock offering by an insurance company subsidiary of a mutual insurance holding company, an intermediate holding company subsidiary of a mutual insurance holding company, or an insurance company subsidiary of an intermediate holding company subsidiary of a mutual insurance holding company, the boards of directors of each insurance company or intermediate holding company include at least three directors who are not interested persons of the mutual insurance holding company. The Commissioner may waive this requirement upon a showing of good cause.

(5) Establishing, within the board of directors of the corporation offering stock, a pricing committee consisting exclusively of directors who are not members of management of the insurance company subsidiary whose responsibility is to evaluate and approve the price of any stock offering.

(d) An insurance company subsidiary of a mutual insurance holding company, an intermediate holding company subsidiary of a mutual insurance holding company, or an insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company may issue more than one class of stock, provided, however, that the issuer complies with all of the following requirements:

(1) At all times a majority of the voting stock is held by the mutual insurance holding company or its subsidiary.

(2) No class of common stock may possess greater dividend or other rights than the class held by the mutual insurance holding company or its subsidiary.

(e) The Commissioner may retain, at the expense of the person filing the application, any attorneys, actuaries, economists, accountants, consultants, or other professional advisors not otherwise a part of the Commissioner's staff to assist the Commissioner in reviewing the application. These contracts are personal professional service contracts exempt from Articles 3 and 3C of Chapter 143 of the General Statutes.

(f) The expenses of mailing any notices and other materials required by this section shall be borne by the person filing the application.

(g) Upon receipt and review by the Commissioner of all information provided under this section, the Commissioner may establish a period during which the Department will receive and consider public comments about the proposed offering. The Commissioner shall inform the public of the offering by posting information about the application in a manner deemed appropriate by the Commissioner. The Commissioner may hold a public hearing concerning the application or the proposed offering. Following any public comment period or hearing, if applicable, the Commissioner may approve, conditionally approve, or deny the application. The Commissioner may approve the application if the following apply:

(1) The offering complies with this Part and other provisions of law.

(2) The method for establishing the price of a stock offering is consistent with generally accepted market or industry practices for establishing stock offering prices in similar transactions.

(3) The plan and offering will not unfairly impact the interests of members of the mutual insurance holding company.

Nothing in this subsection shall be deemed to prohibit the filing of a registration statement with the United States Securities and Exchange Commission before or concurrently with the giving of notice to members.

(h) Notwithstanding the provisions of subsections (a) through (g) of this section, stock offerings which are not an initial stock offering, and which are proposed by entities with a class of securities regularly traded on the New York Stock Exchange, the American Stock Exchange, or another exchange approved by the Commissioner, or designated on the National Association of Securities Dealers Automated Quotations national market system (NASDAQ), may be sold in accordance with the following procedure: if a mutual insurance holding company, an insurance company subsidiary of a mutual insurance holding company, an intermediate holding company, or an insurance company subsidiary of an intermediate holding company intends to make a stock offering which would be governed by the provisions of this subsection, that entity shall deliver to the Commissioner, not less than 60 days prior to the offering, a notice of the planned stock offering and all of the following information:

(1) The total number of shares intended to be offered.

(2) The intended date of sale.

(3) Evidence the stock is regularly traded on one of the public exchanges specified in this subsection.

(4) A record of the trading price and trading volume of the stock during the prior 52 weeks.

The Commissioner shall be deemed to have approved the sale unless, within 60 days following receipt of such notice, the Commissioner issues an objection to the sale. If the Commissioner issues an objection to the sale, the application process set forth in subsections (a) through (g) of this section shall be followed to determine whether the Commissioner approves of the proposed sale.

(i) Approval of a stock offering obtained under either subsection (g) or (h) of this section shall expire 120 days following the date of the approval or deemed approval, except as otherwise provided by order of the Commissioner.

(j) No prospectus, information, sales material, or sales presentation by the applicant, or by any representative, agent, or affiliate of the applicant, shall contain a representation that the Commissioner has endorsed the price, price range, or any other information relating to the stock.

(k) No company making a stock offering under this section shall engage in any of the following practices:

(1) Borrow funds from the mutual insurance holding company, or its subsidiaries and affiliates, to finance the purchase of any portion of a stock offering.

(2) Pay any commissions, "special fees," or any other special payments or extraordinary compensation to officers, directors, interested persons, and affiliates for arranging, promoting, aiding, or assisting in reorganization to a mutual insurance holding company or for arranging, promoting, aiding, assisting, or participating in the structuring and placement of a stock offering.

(3) Enter into an understanding or agreement transferring legal or beneficial ownership of stock to another person to avoid the requirements of this Part.

"**§ 58-10-320. Regulation of holding company system.**

(a) All material transactions, as that term is defined under Part 3 of this Article, between or among subsidiaries and affiliates of the mutual insurance holding company, must, after review and exercise of director duties by the directors of the mutual insurance holding company, be approved by a majority of the directors of the mutual insurance holding company as being fair and reasonable.

(b) If the Commissioner determines that activities within a mutual insurance holding company system have violated provisions of the General Statutes of North Carolina or the North Carolina Administrative Code or acted to circumvent requirements or prohibitions contained in the General Statutes or Administrative Code, the Commissioner may prohibit or order rescission of any transaction relating to those activities.

"**§ 58-10-325. Reporting of stock ownership and transactions.**

(a) Any director or officer of a mutual insurance holding company, its subsidiary, or affiliate, who acquires directly or indirectly the beneficial ownership of any security issued by any intermediate holding company or any insurance company subsidiary of an intermediate holding company or mutual insurance holding company shall, within 15 days following the transaction, file with the Commissioner a statement of the transaction on the form prescribed by the Commissioner.

(b) A mutual insurance holding company, and its subsidiaries and affiliates, shall file with the Commissioner, within 15 days of receipt, copies of Form 3, Form 4, and Schedule 13D, or any equivalent filings, such filings made under the federal Securities Exchange Act of 1934, as amended."

SECTION 2. This act is effective when it becomes law.

SENATE BILL 647:
Mutual Insurance Holding Companies

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	June 14, 2011
Introduced by:	Sen. Rucho	**Prepared by:**	Tim Hovis Committee Counsel
Analysis of:	Second Edition		

SUMMARY: ***A "mutual insurance company" is a company that is owned by its policyholders. No stock is available for purchase. Senate Bill 647 would authorize a domestic mutual insurance company, with the approval of two-thirds of its policyholders voting, to reorganize as a mutual insurance holding company. Members of the mutual insurance company would receive ownership interest in the mutual insurance holding company. The mutual insurance company would then be converted into a stock insurance company held by the holding company. In addition to approval by the policyholders, the Commissioner of Insurance must approve the reorganization as fair and equitable to the policyholders. Also, the holding company must at all times own a majority of the voting shares of the mutual insurance company.***

As a stock insurance company, the mutual insurer would be able to raise capital. In addition, under the bill, the mutual insurance holding company would not be subject to the limitations on investments applicable to insurers. Following reorganization, the Commissioner of Insurance would, however, retain jurisdiction over the mutual insurance holding company, the mutual insurance company, and any stock insurance subsidiaries, including the approval of all stock offerings and mergers.

BILL ANALYSIS: Senate Bill 647 adds a new Part 8 to Article 10 of Chapter 58 of the General Statutes, entitled "*Mutual Insurance Holding Companies.*" Among its provisions, the bill creates the following new sections:

➢ ***G.S. 58-10-275. Definitions.***

The bill defines terms used in the act. Definitions include the following:

- "Domestic mutual insurance company" -- an insurance company organized on a mutual plan and incorporated under the laws of North Carolina.
- "Mutual insurance holding company" -- a holding company organized on a mutual plan and incorporated under the laws of North Carolina, resulting from the reorganization of a domestic mutual insurance company...with one or more stock insurance holding company subsidiaries or stock insurance company subsidiaries.
- "Limited application" -- an application for reorganization to a mutual insurance holding company which will hold one hundred percent of the stock of its insurance subsidiaries.
- "Standard application" -- an application for reorganization to a mutual insurance holding company which may sell interests in its subsidiaries to third parties.

➢ ***G.S. 58-10-280. General provisions.***

With the Commissioner's approval, the bill authorizes a domestic mutual insurance company to form an insurance holding company based upon a mutual plan and continue its corporate existence as a stock insurance company subsidiary of the holding company. The membership interest of the policyholders in the mutual company shall, subject to the Commissioner's approval, become membership interests in the mutual insurance holding company. The Commissioner may require modification of the plan as necessary to protect the policyholders' interests. The Commissioner also retains jurisdiction over the holding company. The holding company shall at all times own a majority of the voting shares of stock of the reorganized stock

insurance company. The policyholders of the mutual company must approve the reorganization by a two-thirds majority of those voting. In any delinquency proceeding under Chapter 58, the assets of the holding company are deemed to be assets of the reorganized mutual insurance company.

➢ ***G.S. 58-10-285. Application; contents; process.***

A limited or standard application, including a plan of reorganization, must be filed with the Commissioner. The Commissioner receives and considers public comment and may hold a public hearing. Applicants must pay to the Commissioner a fee of $250 for each limited application and $500 for each standard application under this section.

➢ ***G.S. 58-10-290. Plan of reorganization.***

A limited or standard plan of reorganization submitted to the Commissioner must include provisions as outlined and must demonstrate the following:

- Policyholder interests are properly preserved and protected
- Plan is fair and equitable
- The financial condition of the applicant will not be diminished.

➢ ***G.S. 58-10-295. Powers of the Commissioner.***

The Commissioner retains jurisdiction over the mutual insurance holding company, intermediate holding company subsidiaries with stock insurance subsidiaries, and stock insurance subsidiaries. Approval of a plan of operation may be conditioned on modifications deemed necessary by the Commissioner. If modifications are not made within 30 days, the plan is deemed to be denied. If the reorganization is not completed within 210 days of approval or conditional approval by the Commissioner, the approval expires unless the time period is extended by the Commissioner. The Commissioner may revoke approval if the applicant fails to comply with the plan of reorganization.

➢ ***G.S. 58-10-300. Special financial requirements.***

A mutual insurance holding company is subject to the provisions of the Insurance Holding Company System Regulatory Act, Article 19 of Chapter 58, but is not subject to the restrictions on investment activities by domestic insurers as provided in G.S. 58-19-10 of the Act. (G.S. 58-19-10 regulates the investment activities of domestic insurers, not insurance holding companies.)

This section also requires a mutual insurance holding company to do the following:

- Upon acquisition or plan to acquire more than 50% of a stock insurance company, submit to the Commissioner of a plan describing the membership interests of policyholders.
- Invest at least 50% or more of its net worth in insurance company subsidiaries, unless waived by the Commissioner.
- File a report with the Commissioner disclosing all material transactions (acquisition and disposition of assets, nonrenewal and cancellation of reinsurance).

➢ ***G.S. 58-10-315. Stock offerings.***

The Commissioner must give prior approval of all stock offerings of a mutual insurance holding company, and its insurance company subsidiaries, intermediate holding company subsidiaries, and any insurance company subsidiaries of an intermediate holding company subsidiary of a mutual insurance holding company. Applications for approval of a stock offering must include a description of the stock, the total number of shares to be issued, justification for offering price, and a description of rights afforded members of the mutual insurance holding company.

Planned stock offerings must:

- Prohibit officers, directors and insiders of the holding company and its subsidiaries and affiliates from purchase or ownership of shares in excess of 5% of the offering.
- Require that after the offering a majority of the Board of directors be persons who are not interested persons of the holding company or of an affiliated person of the company as defined under the Article.
- Provide for the holding company to adopt articles of incorporation prohibiting waiver of dividends from stock subsidiaries except under specified circumstances.
- Require that after the initial stock offering the boards of directors of each insurance company or intermediate holding company include at least three members who are not interested persons of the holding company. (This may be waived by the Commissioner.)
- Establish within the board of the offering corporation a pricing committee consisting exclusively of directors who are not members of management of the insurance company subsidiary.

Insurance company subsidiaries and intermediate holding company subsidiaries may only issue more than one class of stock if the mutual holding company retains at all times a majority of the voting stock and no class of common stock possesses a greater dividend or other rights than the mutual holding company's class of stock.

The Commissioner may establish a period for public comment on the proposed offering and may hold a public hearing. The offering may be approved if it: (1) complies with this Part; (2) the price is established by generally accepted market or industry practices; (3) the plan and offering will not unfairly impact the interests of mutual insurance holding company's members.

Approval of a stock offering under this section expires 120 days following approval, unless the Commissioner orders otherwise.

➢ ***G.S. 58-10-320. Regulation of holding company system.***

All material transactions (acquisition and disposition of assets, nonrenewal and cancellation of reinsurance) between or among subsidiaries and affiliates of a mutual insurance holding company must be approved by a majority of the board of directors of the mutual holding company. Also, if the Commissioner determines that a mutual holding company's activities have violated the General Statutes or the Administrative Code, the Commissioner may prohibit or order rescission of the transaction.

➢ ***G.S. 58-10-325. Reporting of stock ownership and transactions.***

Directors and officers of a mutual insurance holding company or its subsidiaries or affiliates who acquire beneficial ownership of any security issued by any intermediate holding company or any insurance company subsidiary must file a statement with the Commissioner within 15 days of the transaction.

EFFECTIVE DATE: Senate Bill 647 is effective when it becomes law.

S647-SMRG-45(e2) v2

Re: Senate Bill 647, Mutual Insurance Holding Companies
Testimony to House Insurance Committee
Tuesday, June 14, 2011, 1:00 p.m.

I am Steven Sawyer, Vice President of Regulatory Affairs for Medical Mutual Insurance Company of North Carolina.

Medical Mutual is a North Carolina domestic mutual insurance company. Medical Mutual began operations in 1975, and today is the leading provider of professional liability insurance for independent physicians and surgeons in North Carolina.

Thank you for the opportunity to speak today in support of Senate Bill 647.

In a mutual insurance company, such as Medical Mutual Insurance Company of North Carolina, the policyholders are the owners of the insurance company. Senate Bill 647 would permit these policyholders to exchange their ownership interests in the mutual insurance company for ownership interests in a newly formed mutual insurance holding company.

The mutual insurance holding company concept is not new, having been first created in Iowa in 1995. Today, at least 24 other states allow mutual insurance holding companies; 6 of those states are in the Southeast: Florida, Kentucky, Louisiana, Mississippi, South Carolina, and Virginia.

When enacted, Senate Bill 647 will establish a legal and regulatory framework for the creation of mutual insurance holding companies in North Carolina. Senate Bill 647 is based on the Iowa mutual insurance holding company statute, which was recommended by the North Carolina Department of Insurance as the preferred model to follow. We have worked with the North Carolina Department of Insurance on this legislation.

There are numerous benefits in the formation of a mutual insurance holding company, including:

- Access to capital without threatening policyholder rights or sacrificing the benefits of the mutual form of ownership.

- Flexibility in capital structure without the time and cost of a full demutualizaton, which is particularly important to small mutual insurance companies.

- Ability to effectively deploy capital in a manner that supports the core insurance company operations.

We believe that enactment of Senate Bill 647 will help to modernize North Carolina's insurance regulatory framework by adopting an operating structure that is widely accepted in many other states.

We also believe that enactment of Senate Bill 647 will promote a more business-friendly environment for mutual insurance companies in North Carolina, creating more opportunities for growth, new jobs and other positive economic benefits.

These benefits of forming a mutual insurance holding company can be realized without sacrificing the policyholder protections currently in the insurance laws or the authority the Commissioner of Insurance has to enforce those protections.

The mutual insurance company, after converting to a stock insurance company owned by the newly formed mutual insurance holding company, continues to be subject to all applicable insurance laws and regulations and the oversight of the Commissioner of Insurance.

Senate Bill 647 contains numerous policyholder protections, including:

- 2/3 of the voting policyholders must approve of a plan to reorganize the mutual insurance company and form the mutual insurance holding company.
- The Commissioner of Insurance must determine that formation of the mutual insurance holding company is fair and equitable to the

policyholders, and must approve the reorganization and formation of the mutual insurance holding company.

- The mutual insurance holding company must provide annual reports to the Commissioner of Insurance, including financial statements.
- Any merger, acquisition or stock offering by a reorganized mutual insurance company or by the mutual insurance holding company must have the prior approval of the Commissioner of Insurance.
- The mutual insurance holding company is considered an insurer for purpose of any delinquency proceeding initiated by the Commissioner of Insurance against the reorganized mutual insurance company.

We believe that Senate Bill 647 is a very balanced piece of legislation, providing mutual insurance companies with an opportunity to improve their operations while maintaining all current policyholder protections, and giving the Commissioner of Insurance full regulatory purview over any reorganization.

Thank you again for the opportunity to speak this morning. I will be glad to answer any questions.

Contact Information
Steven W. Sawyer
Vice President of Regulatory Affairs
Medical Mutual Insurance Company of North Carolina
919-878-7502
steven.sawyer@mmicnc.com

Medical Mutual℠
PROTECTING OUR PROFESSION

Re: Senate Bill 647, Mutual Insurance Holding Companies
Testimony to Senate Insurance Committee
Wednesday, June 1, 2011, 10:00 a.m.
Legislative Building #1027

I am Kimberly Moore, Director of Marketing and Public Affairs for North Carolina Mutual Life Insurance Company.

North Carolina Mutual was founded in Durham in 1898 and remains the oldest and largest life insurer with roots in the African American community. We are proud of our rich history and ability to remain in business for over 112 years.

I would like to thank each of you for the opportunity to join our friends with Medical Mutual in speaking today to support Senate Bill 647.

North Carolina Mutual has a long history of providing products and services to the underserved. It is our tradition of meeting unmet needs that places us in the unique position of continuing to be the insurer of choice for over 300,000 policyholders nationwide. As Steven stated, these policyholders now own the company.

We have weathered several economic and social storms throughout history and remain the only life insurer domiciled in the state of North Carolina.

In order to continue to change and grow with our current and potential policyholder base we need access to capital. Over the years our surplus has suffered as most insurance companies can agree under the harsh realities of the recession and the volatility of investment markets.

These circumstances require that our state provide an amicable environment for companies like ours to do business. We agree that a modernizing of the insurance laws would benefit the state and those doing business in it.

In order for our company to gain flexibility in our capital structure without the time and cost of full demutualization – a mutual holding company framework would be ideal. Companies like ours will be able to raise and deploy capital to support and expand our operations thereby creating jobs and other positive residual economic benefits.

Senate Bill 647 will allow for the creation of mutual insurance holding companies in North Carolina; it is modeled on the Iowa statutes and regulations. In fact it was the language of the Iowa law that informed the drafting of our current proposed legislation. In a mutual insurance company the policyholders are the owners of the insurance company. Senate Bill 647 would permit these policyholders to exchange their ownership interests in the mutual insurance company for ownership interests in a newly formed mutual insurance holding company. In this process, the mutual insurance company would be converted to a stock insurance company, and it would be owned by the mutual insurance holding company.

It is our position that Senate Bill 647 provides the state of North Carolina an opportunity to modernize its insurance laws while keeping the interest of policyholders first and insuring the current level of oversight by the Department of Insurance. In essence modernization with out sacrificing the interest of policyholders.

Again, thank you for allowing me these moments to share our position and I welcome any further discussion that you would like to have.

ATTACHMENT VI

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. 2nd

H. B. No. _____ DATE _____

S. B. No. 647 Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

~~Rep.~~)
Sen.) Falson

1 moves to amend the bill on page 7, line 18-20
2 ( ) WHICH CHANGES THE TITLE
3 by rewriting the lines to read:
4 "provided in this Part."
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SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

North Carolina
DEPARTMENT OF INSURANCE
Wayne Goodwin | Commissioner of Insurance

June 3, 2011

The Honorable Bob Rucho
North Carolina Senator
300-A Legislative Office Building
300 N. Salisbury Street
Raleigh, NC 27603-5925

BY HAND DELIVERY

Re: SB 647 Mutual Insurance Holding Companies

Dear Senator Rucho,

Thank you for including the Department in the discussions on this bill. I support the main purpose of the bill and most sections of the bill as drafted. However, as you know, I am troubled by the language of the newly proposed G.S. 58-10-300 which attempts to provide exemptions to the investment restrictions set out in G.S. 58-19-10. These investment restrictions are designed to protect the financial stability of companies. Exemptions to the provisions of G.S. 58-19-10 create potential financial risks that should not be permitted in an insurance operation. Accordingly, I do not support any exemption to G.S. 58-19-10 and respectfully request that the provisions of G.S. 58-19-10 remain applicable to mutual insurance holding companies. If you decide to allow the mutual insurance companies to have these exemptions, I respectfully request that portion of the bill be given a sunset provision, to end after a period of five years unless the General Assembly reviews the provision at that time and decides it should continue.

With best regards,

Wayne Goodwin

Wayne Goodwin
NC Commissioner of Insurance

SENATE BILL 744
Insurance Committee Substitute Adopted 6/9/11
Third Edition Engrossed 6/9/11

Short Title: Transparency in the Cost of Health Care. (Public)

Sponsors:

Referred to:

April 20, 2011

A BILL TO BE ENTITLED

AN ACT TO ALLOW EMPLOYERS ACCESS TO INFORMATION ABOUT THEIR GROUP HEALTH PLANS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 8. Reporting of Group Claims Information to Employers With Fifty-One or More Covered Employees.

"**§ 58-50-300. Definitions.**

The following definitions apply to this Part:

(1) Insurer. – Defined in G.S. 58-3-167(b).

(2) Protected Health Information. – Defined in the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, as amended.

"**§ 58-50-305. Access to information by employers.**

(a) An employer with 51 or more covered employees shall be entitled to a report of claim information from its insurer for its employee group health plan. The report shall include the following information for the 24 months prior to the employer's request if the request is made to the employer's current insurer or for the 12 months prior to the employer's request if the request is made to the employer's prior insurer, subject to the other provisions of this Part:

(1) Aggregate incurred claims experience by month, including claims experience for medical, dental, and pharmacy benefits, as applicable.

(2) Total premium paid by month.

(3) Total number of covered members on a monthly basis.

(4) A separate description and individual claims report for any individual whose total paid claims exceed twenty-five thousand dollars ($25,000) during the 12-month period preceding the date of the report, including the following information related to the claims for that individual:

a. A unique identifying number, characteristic, or code for the individual, so as not to identify the individual by name, social security number, subscriber or member identification number, policy number, or other information that could allow the employer to identify the individual.

b. The amounts paid.

c. Dates of service.

d. Primary procedure codes or diagnosis codes or both.

(b) In order to receive the information contained in subdivision (4) of subsection (a) of this section, an appropriately authorized representative of the employer must issue to the health care benefits provider a certification substantially similar to the following:

'I hereby certify that the plan documents comply with the requirements of 45 C.F.R. § 164.504(f)(2) and that the employer will safeguard and limit the use and disclosure of protected health information that the employer may receive from the health care benefits provider only to perform plan administration functions.'

An insurer may use its own certification document as long as it references requirements of 45 C.F.R. Section 164.504(f)(2).

(c) An employer shall be entitled to request and receive information under this Part up to one year following the termination of the contract with the health care benefits provider to provide health care benefits for the employer's employees.

"**§ 58-50-310. Provision of report by insurer.**

(a) Upon written request by an employer under G.S. 58-50-305, a health care benefits provider shall, within 30 business days of the completed request, provide the information required under G.S. 58-50-305 in one of the following forms:

(1) In a written report.

(2) Through an electronic file transmitted by secure electronic mail or a secure file transfer protocol site.

(3) By making the required information available through a secure Web site or Web portal accessible by the requesting employer.

(b) A health care benefits provider shall not disclose protected health information in a report of claim information provided under this Part if the health insurance issuer is prohibited from disclosing that information under another State or federal law that imposes more stringent privacy restrictions than those imposed under this Section, including, without limitation, the more stringent privacy restrictions imposed under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, as amended. To withhold information in accordance with this subsection, the health insurance issuer must do all of the following:

(1) Notify the plan, plan sponsor, or plan administrator requesting the report that information is being withheld.

(2) Provide to the plan, plan sponsor, or plan administrator a list of categories of claim information that the health insurance issuer has determined are subject to the more stringent privacy restrictions under another State or federal law.

(c) An insurer shall not be required to provide a report to an employer more than once in a 12-month period.

"**§ 58-50-315. Applicability of Part to governmental entities; reports not public record.**

(a) A governmental entity that contracts with an insurer may request a report under this Part as an employer.

(b) A report of claim information provided under this Part to a governmental entity shall be confidential and shall not be a public record under Chapter 132 of the General Statutes.

"**§ 58-50-320. Compliance with Part does not create liability.**

An insurer that releases information, including protected health information, in accordance with this Part has not violated a standard of care and is not liable for civil damages resulting from, and is not subject to criminal prosecution for, releasing that information.

"**§ 58-50-325. Penalty for noncompliance.**

An insurer that does not comply with the provisions of this Part shall be subject to the provisions of G.S. 58-2-70."

SECTION 2. This act becomes effective January 1, 2012.

SENATE BILL 744:
Transparency in the Cost of Health Care

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	June 14, 2011
Introduced by:	Sen. Goolsby	**Prepared by:**	Amy Jo Johnson
Analysis of:	Third Edition		Staff Attorney

SUMMARY: Senate Bill 744 outlines a procedure for an employer to obtain claim information from its health benefits provider for its employee group health plan.

CURRENT LAW: The Health Information Portability and Accountability Act of 1996 (HIPAA) protects all *"individually identifiable health information"* held or transmitted by a covered entity or its business associate. Protected Health Information (PHI) is certain health-related information that identifies the individual, or for which there is a reasonable basis to believe can be used to identify the individual, by use of common identifiers.

Under HIPAA, a group health plan and the health insurer or HMO offered by the plan may disclose the following PHI to the plan sponsor:

- Enrollment or disenrollment information.
- Summary health information for the plan sponsor to use to obtain premium bids. "Summary health information" is information that summarizes claims history, claims expenses, or types of claims experience of the plan members, and is stripped of certain individual identifiers.
- PHI of the group health plan's enrollees for the plan sponsor to perform plan administration functions. The plan must receive certification from the plan sponsor that the group health plan document has been amended to impose restrictions on the plan sponsor's use and disclosure of the protected health information.

BILL ANALYSIS: Senate Bill 744 enacts **§58-50-305**, which entitles an employer to a report of claim information from its insurer for its employee group health plan. The bill outlines what the report must include. The information in the report must not contain information that identifies an employee. A separate report with individualized claims information must be included for any individual whose total paid claims exceeded $25,000 during the 12-month period prior to the employer request. The employer must submit a certification stating the plan documents comply with federal law and that the employer will safeguard and limit the uses of the health information it receives and that the employer is using the information to perform plan administrative functions.

Senate Bill 744 enacts **§58-50-310**, which directs this report to be provided to the employer within 30 days in one of three stipulated formats. An employer may request only one report in a 12-month period. The insurer will not disclose PHI that it is prohibited from disclosing under State or federal law, other than HIPAA. If an insurer is withholding information, the insurer must provider certain information regarding its decision to the employer.

Any information received by a governmental entity will not be a public record. Compliance with Senate Bill 744 will not create liability for any health insurer who releases information. If an insurer does not comply, the insurer is subject to suspension or revocation of its licensure or certification or to a monetary penalty pursuant to G.S. 58-2-70.

EFFECTIVE DATE: This act becomes effective October 1, 2011.

S744-SMTK-53(e3) v1

2011 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

By Representative Dockham (Chair) for the Committee on INSURANCE.

☒Committee Substitute for

SB 738 A BILL TO BE ENTITLED AN ACT TO REQUIRE THAT A PERSON THAT HOLDS CERTAIN ALCOHOLIC BEVERAGE CONTROL PERMITS HAVE AT LEAST ONE MILLION DOLLARS IN LIABILITY INSURANCE.

☒ 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 _____.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S 3

SENATE BILL 738
Insurance Committee Substitute Adopted 6/7/11
Third Edition Engrossed 6/8/11

Short Title: Liability Insurance Required for ABC Permits. (Public)

Sponsors:

Referred to:

April 20, 2011

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT A PERSON THAT HOLDS CERTAIN ALCOHOLIC BEVERAGE CONTROL PERMITS HAVE AT LEAST ONE MILLION DOLLARS IN LIABILITY INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 18B-123 reads as rewritten:

"**§ 18B-123. Limitation on damages.**

The total amount of damages that may be awarded to all aggrieved parties pursuant to any claims for relief under this Article is limited to no more than ~~five hundred thousand dollars ($500,000)~~ one million dollars ($1,000,000) per occurrence. When all claims arising out of an occurrence exceed ~~five hundred thousand dollars ($500,000),~~one million dollars ($1,000,000), each claim shall abate in the proportion it bears to the total of all claims."

SECTION 2. Article 1 of Chapter 18B of the General Statutes is amended by adding a new section to read:

"**§ 18B-123.1. Liability insurance required.**

A person holding an ABC permit or permits issued pursuant to G.S. 18B-1001(1), (3), (5), and (10) shall maintain in full force and effect a policy of liability insurance in an amount of not less than one million dollars ($1,000,000). A person that has a lapse in coverage under such policy or cancels a policy required by this section shall have any ABC permits issued to them summarily revoked by the Commission upon notification of such lapse by the policyholder or issuer. The revocation authorized by this section is not subject to the provisions of Chapter 150B of the General Statutes. The requirement of liability insurance under this section does not replace or eliminate any other remedy an aggrieved party may have in the law or at common law."

SECTION 3. Article 1 of Chapter 18B of the General Statutes is amended by adding a new section to read:

"**§ 18B-123.2. Notification of lapse or cancellation required.**

An insurance company that issues a policy of liability insurance under G.S. 18B-123.1 to a person who holds an ABC permit or permits issued pursuant to G.S. 18B-1001(1), (3), (5), and (10) shall notify the Commission within 10 days of the cancellation or lapse of the liability insurance policy."

SECTION 4. This act becomes effective December 1, 2011, and applies to all ABC permits issued, registered, or renewed on or after that date.

SENATE BILL 738:
Liability Insurance Required for ABC Permits

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	June 14, 2011
Introduced by:	Sen. Goolsby	**Prepared by:**	Tim Hovis
Analysis of:	Third Edition		Committee Counsel

SUMMARY: ***Senate Bill 738 increases the total amount of damages that may be awarded to aggrieved parties against an ABC permittee or local Alcoholic Beverage Control Board resulting from sale of alcohol to an underage person from $500,000 to $1,000,000 per occurrence. The bill also requires a person holding an on-premises ABC permit to maintain a policy of liability insurance in an amount of not less than $1,000,000.***

CURRENT LAW: Article 1A of Chapter 18B, *Compensation for Injury caused by Sales to Underage Persons*, provides that an aggrieved party has a claim for damages against a permittee or local ABC Board if (i) the permittee or the local board, or their respective agents or employees, sales or furnishes an alcoholic beverage to an underage person; (ii) the consumption of that beverage causes or contributes to, the underage person being impaired within the meaning of G.S. 20-138.1 and (iii) the injury that resulted was proximately caused by the underage person's negligent operation of a vehicle while impaired.

G.S. 18B-123 provides that the total amount of damages that may be awarded to all aggrieved parties under the Article is $500,000. If all claims arising out of an occurrence exceed this amount, each claim is abated in proportion.

BILL ANALYSIS: **Section 1** of Senate Bill 738 increases the total amount of damages that may be awarded to all aggrieved parties against an ABC permittee or local Alcoholic Beverage Control Board, and their agents or employees, under G.S.18B-123 from $500,000 to $1,000,000.

Section 2 adds a new G.S. 18B-123.1 requiring a person holding a permit for the on-premises consumption of alcohol to maintain a policy of liability insurance in an amount of not less than $1,000,000. This section also requires the ABC Commission to revoke any ABC permit upon notification of a lapse in of cancellation of liability insurance coverage.

Section 3 adds G.S. 18B-123.2 to require an insurance company to notify the Commission within 10 days of a cancellation or lapse of a liability insurance policy issued under G.S. 18B-123.1 to a person holding an ABC permit or permits for the on-premises consumption of alcohol.

EFFECTIVE DATE: Senate Bill 738 becomes effective December 1, 2011 and applies to all ABC permits issued, registered or renewed on or after that date.

S738-SMRG-46(e3) v1



NORTH CAROLINA HOUSE OF REPRESENTATIVES

2012 SHORT SESSION

HOUSE STANDING COMMITTEE ON INSURANCE

REPRESENTATIVE JERRY C. DOCKHAM
CHAIRMAN

REGINA IRWIN, COMMITTEE CLERK

HOUSE COMMITTEE ON INSURANCE
2011 – 2012 SESSION

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MCELRAFT, Pat	Vice-Chair	Nancy Fox	733-6275	637	38
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BLUST, John		Betty Childress	733-5781	1229	25
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BRYANT, Angela		Karon Hardy	733-5878	542	102
BURR, Justin		Dina Long	733-5908	538	40
CRAWFORD, Jim		Linda Winstead	733-5824	1321	24
CURRENT, William		Wendy Miller	733-5809	418B	41
FAISON, Bill		Lavada Vitalis	715-3019	405	84
FLOYD, Elmer		Barbara McMillian	733-5959	1311	114
FOLWELL, Dale		Reston Jones	733-5787	301F	99
GLAZIER, Rick		Carin Savel	733-5601	1021	92
GRAHAM, Charles		Linda Laton	715-0875	1315	115
HAMILTON, Susi		Ruth Merkle	733-5754	1319	117
HOWARD, Julia		Abigail Rea	733-5904	1106	2
HURLEY, Pat		Deborah Holder	733-5865	532	44
INSKO, Verla		Gina Insko	733-7208	603	70
JACKSON, Darren		Angela McMillian	733-5974	1019	106
JOHNSON, Linda		Joanna Hogg	733-5861	301D	15

MCGUIRT, Frank	Brittany Eller	715-3007	1015	101
MILLS, Grey	Wanda Benson	733-5741	2221	50
MURRY, Tom	Linda Sebastian	733-5602	2121	86
PIERCE, Garland	Mildred Alston	733-5803	1204	46
SHEPARD, Phillip	Pamela Pate	715-9644	301N	98
STEEN, Fred	Chris Floyd	733-5881	305	27
STEVENS, Sarah	Julie Garrison	715-1883	416A	56
WAINWRIGHT, William	Blinda Edwards	733-5995	613	12
WARREN, Harry	Shara Graham	733-5784	533	74
WILKINS, W. A. "Winkie"	Nancy Brantley	715-0850	1301	47
WRAY, Michael	Lisa Brown	733-5662	502	60

Tim Hovis
Bill Patterson
Kory Goldsmith
Committee Counsel
LOB – Room 545
Tel: 733-2578

NORTH CAROLINA GENERAL ASSEMBLY

INSURANCE

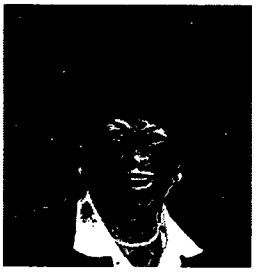
2012 SHORT SESSION



REP. DOCKHAM
CHAIRMAN



REP. COLLINS
VICE - CHAIR



REP. MCELRAFT
VICE - CHAIR



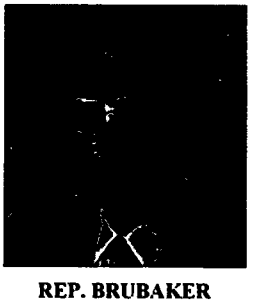
REP. SETZER
VICE - CHAIR



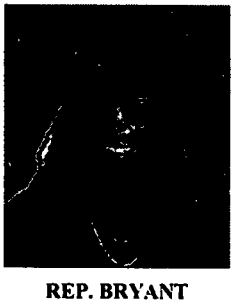
REP. BLUST



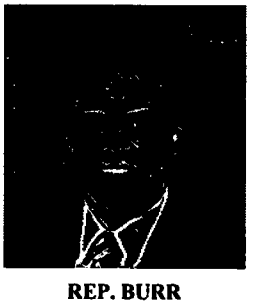
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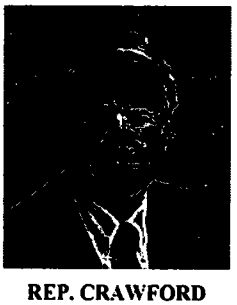
REP. BRUBAKER



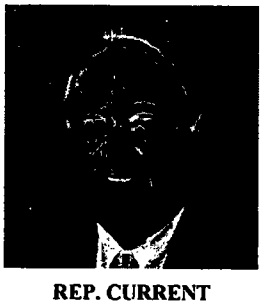
REP. BRYANT



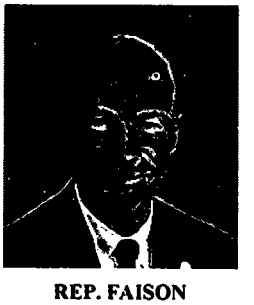
REP. BURR



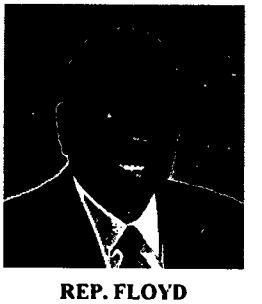
REP. CRAWFORD



REP. CURRENT



REP. FAISON



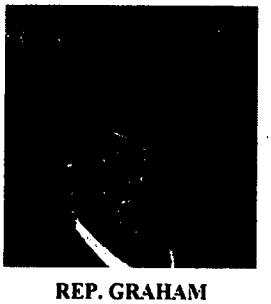
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REP. FOLWELL



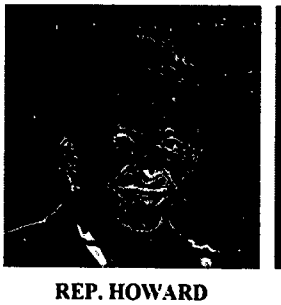
REP. GLAZIER



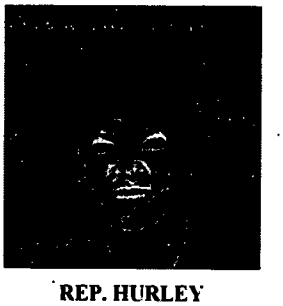
REP. GRAHAM



REP. HAMILTON



REP. HOWARD



REP. HURLEY

NORTH CAROLINA GENERAL ASSEMBLY

INSURANCE

2012 SHORT SESSION



REP. INSKO



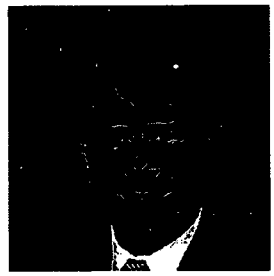
REP. JACKSON



REP. JOHNSON



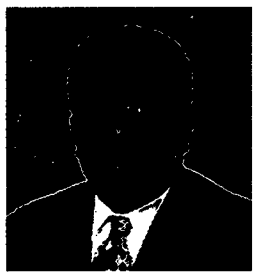
REP. MCGUIRT



REP. MILLS



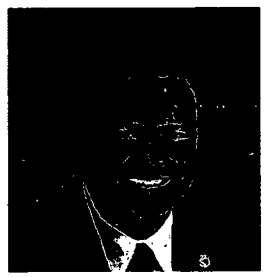
REP. MURRY



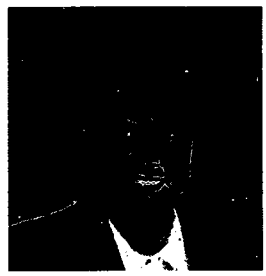
REP. PIERCE



REP. SHEPARD



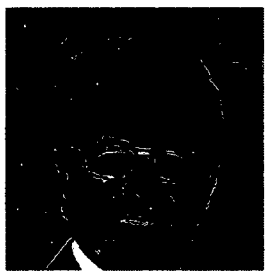
REP. STEEN



REP. STEVENS



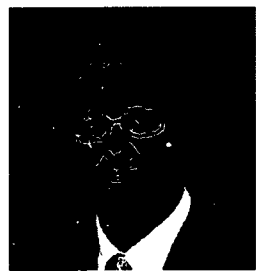
REP. WAINWRIGHT



REP. WARREN



REP. WILKINS



REP. WRAY

ATTENDANCE

HOUSE COMMITTEE ON INSURANCE

2012 SHORT SESSION

DATES	06-12-2012	06-19-2012	06-26-2012												
DOCKHAM, Jerry **Chair**	X	X	X												
BLUST, John		X	X												
BROWN, Larry	X	X	X												
BRUBAKER, Harold	X														
BRYANT, Angela		X	X												
BURR, Justin	X	X													
COLLINS, Jeff **Vice-Chair**	X	X	X												
CRAWFORD, Jim	X														
CURRENT, William	X		X												
FAISON, Bill															
FLOYD, Elmer	X	X	X												
FOLWELL, Dale	X		X												
GLAZIER, Rick															
GRAHAM, Charles		X	X												
HAMILTON, Susi	X	X	X												
HOWARD, Julia	X		X												
HURLEY, Pat	X	X	X												
INSKO, Verla	X	X	X												
JACKSON, Darren	X	X	X												
JOHNSON, Linda															
MCELRAFT, Pat **Vice-Chair**	X	X	X												
MCGUIRT, Frank	X	X	X												
MILLS, Grey	X	X													
MURRY, Tom	X	X	X												
PIERCE, Garland		X	X												
SETZER, Mitchell **Vice-Chair**															

SHEPARD, Phillip	X	X	X												
STEEN, Fred	X		X												
STEVENS, Sarah	X	X	X												
WAINWRIGHT, William															
WARREN, Harry	X	X	X												
WILKINS, W. A. "Winkie"		X	X												
WRAY, Michael	X	X	X												

Bill	Introducer	Short Title		Date	Latest Action
H 155	Faison	MEDICAL MALPRACTICE INSURANCE COVERAGE.	H	02-22-2011	Ref to the Com on Insurance, if favorable, Commerce and Job Development
H 244=	Murry	STATE HEALTH PLAN/ADD SCHOOLS; WHISTLEBLOWERS.	*H	06-11-2012	Ref To Com On Insurance
H 496	Moore	INSURANCE CO-PAYS FOR CHIROPRACTIC SERVICES.	*H	03-29-2011	Ref To Com On Insurance
H 820	McElraft	STUDY BEACH PLAN.	H	04-07-2011	Ref To Com On Insurance
H 834=	Rhyne, Jr.	REDUCE OVERPOPULATION OF REINSURANCE FACILITY.	H	04-07-2011	Ref To Com On Insurance
H1044	Shepard	MOTORCYCLE INSURANCE DISCOUNT/MILITARY.	H	05-23-2012	Ref To Com On Insurance
H1053=	Dockham	IMPROVE PROPERTY INSURANCE RATE MAKING.	H	05-23-2012	Ref To Com On Insurance
S 647	Rucho	MUTUAL INSURANCE HOLDING COMPANIES.	*H	06-09-2011	Ref To Com On Insurance
S 656	Davis	RIGHT TO CHOOSE PHYSICAL THERAPIST.	*H	06-13-2011	Ref To Com On Insurance
S 738	Goolsby	LIABILITY INSURANCE REQUIRED FOR ABC PERMITS.	*H	06-13-2011	Ref To Com On Insurance
S 744	Goolsby	TRANSPARENCY IN THE COST OF HEALTH CARE.	*H	06-13-2011	Ref To Com On Insurance
S 836=	Brown	IMPROVE PROPERTY INSURANCE RATE MAKING.	*H	06-12-2012	Re-ref Com On Insurance

'$' 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.

MINUTES

HOUSE COMMITTEE ON INSURANCE

June 12, 2012

The House Committee on Insurance met in Room 1228 of the Legislative Building on June 12, 2012, at 1:00 pm. The following members were present: Representatives Dockham, Chair, Brown, Brubaker, Burr, Collins, Crawford, Current, Floyd, Folwell, Hamilton, Howard, Hurley, Insko, Jackson, McElraft, McGuirt, Mills, Murry, Shepard, Steen, Stevens, Warren, and Wray. Tim Hovis, Kory Goldsmith, Amy Jo Johnson, Bill Patterson, and David Vanderweide, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes. (Attachment I)

Representative Dockham, Chair, called the meeting to order at 1:00 pm. He introduced the pages and the Sergeant of Arms staff. (Attachment II) The following bills were considered:

SB 656, entitled, AN ACT TO ENSURE THAT PATIENTS HAVE THE RIGHT TO CHOOSE THEIR PHYSICAL THERAPISTS UNDER THEIR HEALTH BENEFIT. A Proposed Committee Substitute bill was presented. Representative Brown moved to adopt the PCS for consideration. The motion passed. The Chair recognized Senator Davis, bill sponsor, to explain the bill. Senate Bill 656 adds physical therapists to the list of providers from which an individual has the right to choose the provider of services under a health benefit plan. Mr. Dean McColl, President, NC Physical Therapy Association spoke in support of the bill. The Chair recognized Amy Jo Johnson, Staff Counsel, to explain the PCS (Attachment III). The Proposed Committee Substitute corrects the effective date and conforms section 2 of the bill to last year's changes to the State Health Plan. Representative Murry moved for a favorable report as to House committee substitute bill, unfavorable as to Senate committee substitute bill. The motion passed.

SB 647, entitled, AN ACT TO PROVIDE FOR THE CREATION OF MUTUAL INSURANCE HOLDING COMPANIES. A Proposed Committee Substitute bill was presented. Representative Jackson moved to adopt the PCS for consideration. The motion passed. Senator Rucho, bill sponsor, was not available to explain the bill. The Chair recognized Representative Murry to explain the PCS. (Attachment IV) Representative Folwell sent forth an amendment. (Attachment V) The Chair moved to adopt the amendment for discussion. The motion carried. After a brief explanation of the amendment, the Chair moved for the adoption of the amendment, and with the majority being in favor, the amendment was adopted. The Chair recognized Representative Murry to continue to explain the bill. After some discussion Representative Collins moved for a favorable report as to House committee substitute bill, which changes the title, unfavorable as to Senate committee substitute bill and recommendation that the House committee substitute bill be re-referred to the committee on Finance. The motion passed.

There being no further business, the chair adjourned the meeting at 1:15 pm.

Respectfully submitted,

Jerry C. Dockham

Representative Jerry C. Dockham, Chair

Regina Irwin

Regina Irwin, Committee Assistant

Attachments

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2011-2012 SESSION

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

DAY & DATE: Tuesday, June 12, 2012

TIME: 1:00 pm

LOCATION: 1228/1327 LB

COMMENTS:

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 647	Mutual Insurance Holding Companies.	Senator Rucho
SB 656	Right to Choose Physical Therapist.	Senator Davis

Respectfully,

Representative Dockham, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **12 PM** o'clock on **June 06, 2011.**

☐ Principal Clerk
☐ Reading Clerk – House Chamber

Regina Irwin (Committee Assistant)

AGENDA

HOUSE COMMITTEE ON INSURANCE

June 12, 2012

Room 1228/1327

1:00 pm

OPENING REMARKS

Representative Jerry C. Dockham, Chairman
Insurance Committee

AGENDA ITEMS

SB 656 RIGHT TO CHOOSE PHYSICAL THERAPIST.
Senator Jim Davis, Sponsor

SB 647 MUTUAL INSURANCE HOLDING COMPANIES.
Senator Bob Rucho, Sponsor

ADJOURNMENT

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

June 12, 2012 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jessica Hall	National Multiple Sclerosis Society
Steven Sawyer	Medical Mutual of NC
Susanna Hailey	K & L Gates
DAVID BARNES	PS
DAN PETERS	CSS
Tim Bradley	NCDOJ
Rose Willis	NCDOJ
Debra Walker	NCDOI
Penny Griffin	School of Gov.
Lisa Pierce	Ragsdale Liggett
MARTY BOCOCK	AHIP
KEN WRIGHT	BCBS
Chip Baxter	NCMS

VISITOR REGISTRATION SHEET

INSURANCE — June 12, 2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John McMillan	MFAS
Daniel Baum	Troutman Sanders
Dave Hamm	SA

VISITOR REGISTRATION SHEET

INSURANCE — June 12, 2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kimberly Moore	NC Mutual Life Insurance Company
Susanna Davis	Gov Office
Louise Dockham	Guest / Rep. Dockham
Connie Cross	Guest / Rep. Dockham
Deborah J Rogan	NC Physical Therapy Association
DEAN McCALL	NC PHYSICAL THERAPY ASSN
W.H. Potter, Jr	NC PHYSICAL THERAPY ASS'N
[signature]	NWC
DAVID RICE	MFS
George Smith	WM
JOEL MAYNARD	GPM & ASSOC

VISITOR REGISTRATION SHEET

INSURANCE — June 12, 2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS

PLEASE PRINT

ATTACHMENT II

HOUSE PAGES

NAME OF COMMITTEE: INSURANCE **DATE:** June 12, 2012

1. **NAME:** Will Whisnant ✓
   County: Cleveland
   Sponsor: T. Moore
2. **NAME:** William Cheung ✓
   County: Alexander
   Sponsor: Hollo
3. **NAME:** Graham Blossom ✓
   County: New Hanover
   Sponsor: McComas
4. **NAME:** Sarah Ford ✓
   County: Wake
   Sponsor: Gill
5. **NAME:** Jenny Stevenson ✓
   County: Mecklenburg
   Sponsor: Tillis

SERGEANTS-AT-ARMS

1. **Name:** Young Bae ✓
2. **Name:** Jesse Hayes ✓
3. **Name:** John Brandon ✓
4. **Name:**
5. **Name:**

2012 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

By Representative Dockham (Chair) for the Committee on INSURANCE.

☒Committee Substitute for

SB 656 A BILL TO BE ENTITLED AN ACT TO ENSURE THAT PATIENTS HAVE THE RIGHT TO CHOOSE THEIR PHYSICAL THERAPISTS UNDER THEIR HEALTH BENEFIT PLANS.

☒ With a favorable report as to House committee substitute bill, unfavorable as to Senate committee substitute 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.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S D

SENATE BILL 656
Insurance Committee Substitute Adopted 6/9/11
PROPOSED HOUSE COMMITTEE SUBSTITUTE S656-CSRC-57 [v.1]

6/11/2012 1:15:28 PM

Short Title: Right to Choose Physical Therapist. (Public)

Sponsors:

Referred to:

April 20, 2011

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT PATIENTS HAVE THE RIGHT TO CHOOSE THEIR PHYSICAL THERAPISTS UNDER THEIR HEALTH BENEFIT PLANS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-30 reads as rewritten:

"**§ 58-50-30. Right to choose services of optometrist, podiatrist, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, chiropractor, physical therapist, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, licensed marriage and family therapist, or physician assistant.**

(a) Repealed by Session Laws 2001-297, s. 1, effective January 1, 2001.

(a1) 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 for coverage for, payment of, or reimbursement for any service rendered in connection with a condition or complaint that is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly licensed physical therapist, a duly licensed clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, a duly licensed marriage and family therapist, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to coverage of, payment of, or reimbursement for the services, whether the services be performed by a duly licensed physician, or a provider listed in this subsection, notwithstanding any provision contained in the plan or policy limiting access to the providers. The policyholder, insured, or beneficiary shall have the right to choose the provider of services notwithstanding any provision to the contrary in any other statute, subject to the utilization review, referral, and prior approval requirements of the plan that apply to all providers for that service; provided that:

(1) In the case of plans that require the use of network providers as a condition of obtaining benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network; and

(2) In the case of plans that require the use of network providers as a condition of obtaining a higher level of benefits under the plan or policy, the

policyholder, insured, or beneficiary must choose a provider of the services within the network in order to obtain the higher level of benefits.

(a2) Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly licensed physical therapist, a duly licensed clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, a duly licensed marriage and family therapist, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, or a provider listed in this subsection, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute; provided that for plans that require the use of network providers either as a condition of obtaining benefits under the plan or policy or to access a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network, subject to the requirements of the plan or policy.

...

(c4) For purposes of this section, a "duly licensed marriage and family therapist" is a person licensed by the North Carolina Marriage and Family Therapy Licensure Board pursuant to Article 18C of Chapter 90 of the General Statutes.

(c5) For purposes of this section, a "duly licensed physical therapist" is a person licensed by the North Carolina Board of Physical Therapy Examiners pursuant to Article 18B of Chapter 90 of the General Statutes.

...."

SECTION 2. G.S. 135-48.51(12) reads as rewritten:

"**§ 135-48.51. Coverage and operational mandates related to Chapter 58 of the General Statutes.**

The following provisions of Chapter 58 of the General Statutes apply to the State Health Plan:

...

(12) G.S. 58-50-30, Right to choose services of optometrist, podiatrist, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, physical therapist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, licensed marriage and family therapist, or physician assistant.

..."

SECTION 3. This act becomes effective October 1, 2012.

SENATE BILL 656:
Right to Choose Physical Therapist

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	June 11, 2012
Introduced by:	Sen. Davis	**Prepared by:**	Kory Goldsmith Committee Counsel
Analysis of:	PCS to Second Edition S656-CSRC-57		

SUMMARY: ***Senate Bill 656 adds physical therapists to the list of providers from which an individual has the right to choose the provider of services under a health benefit plan.***

The Proposed Committee Substitute corrects the effective date and conforms Section 2 of the bill to last year's changes to the State Health Plan.

CURRENT LAW:

G.S. §58-50-30 lists the various types of health care providers from which a policy holder, insured, or beneficiary ("insured") may choose under a health benefit plan, subscriber contract, or policy of insurance ("policy"). The services must be of a nature that the policy provides coverage of, or payment or reimbursement. If the policy requires use of network providers, the insured must choose a provider of services within the network. If the policy requires use of network providers as a condition of obtaining a higher level of benefits, the insured must choose a provider of services within network in order to obtain the higher level of benefits.

G.S. §58-50-30 also lists the provider types who are able to complete a certification of disability. When a policy provides for a certification of disability that is within the scope of the enumerated providers, the insured is entitled to benefits as long as one of the listed provider types has completed the certification of disability, notwithstanding any provisions contained in the policy. The insured has the right to choose the provider of services.

BILL ANALYSIS:

Section 1 of Senate Bill 656 amends G.S. §58-50-30 to add "a duly licensed physical therapist" to the list of health care providers from which an insured may choose under a policy. A"duly licensed physical therapist" is defined as a person licensed by the North Carolina Board of Physical Therapy Examiners pursuant to Article 18B of Chapter 90 of the General Statutes.

Section 2 makes a conforming change to G.S. 135-48.51(12), which makes G.S. §58-50-30 applicable to the State Health Plan.

EFFECTIVE DATE: The act becomes effective October 1, 2012.

Amy Jo Johnson, counsel to Senate Insurance, substantially contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S 2

SENATE BILL 656
Insurance Committee Substitute Adopted 6/9/11

Short Title: Right to Choose Physical Therapist. (Public)

Sponsors:

Referred to:

April 20, 2011

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT PATIENTS HAVE THE RIGHT TO CHOOSE THEIR PHYSICAL THERAPISTS UNDER THEIR HEALTH BENEFIT PLANS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-30 reads as rewritten:

"**§ 58-50-30. Right to choose services of optometrist, podiatrist, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, chiropractor, physical therapist, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, licensed marriage and family therapist, or physician assistant.**

(a) Repealed by Session Laws 2001-297, s. 1, effective January 1, 2001.

(a1) 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 for coverage for, payment of, or reimbursement for any service rendered in connection with a condition or complaint that is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly licensed physical therapist, a duly licensed clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, a duly licensed marriage and family therapist, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to coverage of, payment of, or reimbursement for the services, whether the services be performed by a duly licensed physician, or a provider listed in this subsection, notwithstanding any provision contained in the plan or policy limiting access to the providers. The policyholder, insured, or beneficiary shall have the right to choose the provider of services notwithstanding any provision to the contrary in any other statute, subject to the utilization review, referral, and prior approval requirements of the plan that apply to all providers for that service; provided that:

(1) In the case of plans that require the use of network providers as a condition of obtaining benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network; and

(2) In the case of plans that require the use of network providers as a condition of obtaining a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network in order to obtain the higher level of benefits.

(a2) Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly licensed physical therapist, a duly licensed clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, a duly licensed marriage and family therapist, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, or a provider listed in this subsection, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute; provided that for plans that require the use of network providers either as a condition of obtaining benefits under the plan or policy or to access a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network, subject to the requirements of the plan or policy.

...

(c4) For purposes of this section, a "duly licensed marriage and family therapist" is a person licensed by the North Carolina Marriage and Family Therapy Licensure Board pursuant to Article 18C of Chapter 90 of the General Statutes.

(c5) For purposes of this section, a "duly licensed physical therapist" is a person licensed by the North Carolina Board of Physical Therapy Examiners pursuant to Article 18B of Chapter 90 of the General Statutes.

...."

SECTION 2. G.S. 135-48.51(12), as enacted by S.L. 2011-85, reads as rewritten:

"(12) G.S. 58-50-30, Right to choose services of optometrist, podiatrist, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, physical therapist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, licensed marriage and family therapist, or physician assistant."

SECTION 3. Section 2 of this act becomes effective January 1, 2012. The remainder of this act becomes effective October 1, 2011.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: Senate Bill 656 (Second Edition)

SHORT TITLE: Right to Choose Physical Therapist.

SPONSOR(S): Senator Davis

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 2 of Senate Bill 656 (Second Edition) amends G.S. 135-48.51(12) to allow a plan member the right to choose the services of a physical therapist for services offered within the scope of practice for a duly licensed physical therapist.

EFFECTIVE DATE: January 1, 2012

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 no financial impact on the Plan based on the understanding that the Plan is already complying in practice with the intent of the proposed legislation.

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 based on the understanding that the Plan is already complying in practice with the intent of the proposed legislation.

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.

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 participate in the Standard plan or who elect dependent coverage. Total requirements for the Plan are estimated to be $2.87 billion for FY 2011-12 and $3.03 billion for FY 2012-13. 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 premiums from employees and retirees; and

2) The "Standard" 80/20 plan.

The Basic plan offers coverage to employees and retired employees on a noncontributory basis. The Standard plan offers coverage to employees and retired employees on a partially contributory basis. Coverage for dependents under both plans is offered on a fully contributory basis.

The following table provides a summary of most monthly premium rates for the Plan in FY 2012-13:

Coverage Type	PPO Basic		PPO Standard	
	Employee/ Retiree	Employer	Employee/ Retiree	Employer
Non-Medicare Active Employee/Retiree				
Employee	$0.00	$432.66	$22.76	$432.66
Employee + Child(ren)	$198.06	$432.66	$286.16	$432.66
Employee + Spouse	$510.32	$432.66	$629.64	$432.66
Employee + Family	$543.54	$432.66	$666.18	$432.66
Medicare Primary for Only Employee/Retiree				
Employee	$0.00	$336.25	$10.52	$336.25
Employee + Child(ren)	$198.06	$336.25	$273.92	$336.25
Employee + Spouse	$510.32	$336.25	$617.40	$336.25
Employee + Family	$543.54	$336.25	$653.94	$336.25

The employer share of premiums for retirees is paid from the Retiree Health Benefit Fund. During FY 2011-12, employers contribute 5.0% of active employee payroll into the Fund. Total contributions for the year are projected to be approximately $764 million.

Financial Condition

Projected Results for 2011-2013 Biennium – The following summarizes a financial projection prepared by the Plan's consulting actuary, Aon Hewitt, for the 2011-2013 biennium. It reflects the provisions of SL 2011-85 and SL 2011-96 and is based on financial experience through December, 2010.

	($ millions) Projected FY 2011-12	Projected FY 2012-13
Beginning Cash Balance	$226.8	$219.5
Receipts:		
Net Premium Collections	$2,769.9	$2,923.2
Early Retiree Reinsurance Program	$25.6	$0.0
Medicare Part D Subsidies	$60.1	$62.6
Investment Earnings	$2.2	$2.1
Total	$2,857.8	$2,987.9
Disbursements:		
Net Medical Claim Payment Expenses	$2,045.1	$2,179.7
Net Pharmacy Claim Payment Expenses	$639.6	$671.7
Administration and Claims-Processing Expenses	$180.5	$183.6
Total	$2,865.1	$3,035.0
Net Operating Income (Loss)	($7.3)	($47.0)

The projection assumes 9.5% annual claims growth trend. It incorporates $151 million in projected savings over the biennium from a new Pharmacy Benefit Manager (PBM) contract that was effective October 1, 2011. It assumes that the Plan maintains "grandfathered" status under the federal Affordable Care Act (ACA). It assumes the Plan experiences an increase of $33 million in claims over the biennium due to requirements in the ACA to cover additional dependents.

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, fraud detection, and other authorized actions by the State Treasurer, 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 9.5% annually according to the Plan's consulting actuary. Investment earnings are based upon a 1.0% return on available cash balances. The active population is projected to decline by 1% per year, the COBRA population is projected to remain constant, and the retired population is projected to increase by 1% per year.

Enrollment as of September 30, 2011

I. No. of Participants	Basic	Standard	Total	Percent of Total
Actives				
Employees	116,124	197,696	313,820	47.2%
Dependents	70,353	88,489	158,842	23.9%
Sub-total	186,477	286,185	472,662	71.1%
Retired				
Employees	25,109	141,696	166,805	25.1%
Dependents	5,459	13,709	19,168	2.9%
Sub-total	30,568	155,405	185,973	28.0%
Former Employees with Continuation Coverage				
Employees	1,255	1,289	2,544	0.4%
Dependents	528	350	878	0.1%
Sub-total	1,783	1,639	3,422	0.5%
Firefighters, Rescue Squad & National Guard				
Employees	3	4	7	0.0%
Dependents	3	1	4	0.0%
Sub-total	6	5	11	0.0%
Local Governments				
Employees	530	1,364	1,894	0.3%
Dependents	402	536	938	0.1%
Sub-total	932	1,900	2,832	0.4%
Total				
Employees	143,021	342,049	485,070	73.0%
Dependents	76,745	103,085	179,830	27.0%
Grand Total	**219,766**	**445,134**	**664,900**	**100%**
Percent of Total	**33.1%**	**66.9%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Total
Employee Only	104,153	284,789	388,942
Employee Child(ren)	21,354	29,930	51,284
Employee Spouse	6,653	15,312	21,965
Employee Family	10,861	12,018	22,879
Total	**143,021**	**342,049**	**485,070**

Percent Enrollment by Contract	Basic	Standard	Total
Employee Only	72.8%	83.3%	80.2%
Employee Child(ren)	14.9%	8.8%	10.6%
Employee Spouse	4.7%	4.5%	4.5%
Employee Family	7.6%	3.5%	4.7%
Total	**100.0%**	**100.0%**	**100.0%**

III. Enrollment by Sex	Basic	Standard	Total
Female	125,914	288,637	414,551
Male	93,852	156,497	250,349
Total	**219,766**	**445,134**	**664,900**

Percent Enrollment by Sex	Basic	Standard	Total
Female	57.3%	64.8%	62.3%
Male	42.7%	35.2%	37.7%
Total	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Total
19 & Under	49,389	60,779	110,168
20 to 29	24,898	36,748	61,646
30 to 44	52,875	73,944	126,819
45 to 54	42,716	67,407	110,123
55 to 64	43,858	92,724	136,582
65 & Over	6,030	113,532	119,562
Total	**219,766**	**445,134**	**664,900**

Percent Enrollment by Age	Basic	Standard	Total
19 & Under	22.5%	13.7%	16.6%
20 to 29	11.3%	8.3%	9.3%
30 to 44	24.1%	16.6%	19.1%
45 to 54	19.4%	15.1%	16.6%
55 to 64	20.0%	20.8%	20.5%
65 & Over	2.7%	25.5%	18.0%
Total	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	55,059	12,072	67,131
Medicare Eligible	111,746	7,096	118,842
Total	**166,805**	**19,168**	185,973

Percent Enrollment by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.0%	63.0%	36.1%
Medicare Eligible	67.0%	37.0%	63.9%
Total	**100.0%**	**100.0%**	100.0%

VI. Enrollment By Major Employer Groups	Employees	Dependents	Total
State Agencies	73,838	33,930	107,768
UNC System	50,223	30,672	80,895
Local Public Schools	174,370	86,182	260,552
Local Community Colleges	15,389	8,058	23,447
Other			
Local Goverments	1,894	938	2,832
COBRA	2,544	878	3,422
Nat. Guard, Fire & Rescue	7	4	11
Sub-total	318,265	160,662	478,927
Retirement System	166,805	19,168	185,973
Total	**485,070**	**179,830**	**664,900**

Percent Enrollment by Major Employer Groups	Employees	Dependents	Total
State Agencies	15.2%	18.9%	16.2%
UNC System	10.4%	17.1%	12.2%
Local Public Schools	35.9%	47.9%	39.2%
Local Community Colleges	3.2%	4.5%	3.5%
Other			
Local Goverments	0.4%	0.5%	0.4%
COBRA	0.5%	0.5%	0.5%
Nat. Guard, Fire & Rescue	0.0%	0.0%	0.0%
Sub-total	65.6%	89.3%	72.0%
Retirement System	34.4%	10.7%	28.0%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

Aon Hewitt, North Carolina State Health Plan, Financial Projections - January 2011 - 14b ($12 Generic) - Start September - No Premium Increase for Late Start, Total For All Plans - 9.5% Trend with Risk Adjustment, with Max GF Benefits except $12 Generic, with PBM Contract Savings, Additional Premium Charged To All Tiers - Active: 5% Std, 0% Basic; NMC Retiree 5% Std, 0% Basic; MC Retiree $10 Std, $0 Basic, No CWI, Non-Smoker Movement: Active: 25% single, 5% dep; NMC Retiree: 25% single, 5% dep; MC Retiree: 20% single, 5% dep, May 17, 2011.

-Actuarial Note, Hartman & Associates, Senate Bill 656, "Senate Bill 656 Proposed Committee Substitute S656-CSTK-24 [v.2]," June 8, 2011, an original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, Senate Bill 656, "Senate Bill 656 PCS S656-CSTK-24 [v.2], June 7, 2011, 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.

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DATE: June 8, 2012

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2012 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

By Representative Dockham (Chair) for the Committee on INSURANCE.

☒Committee Substitute for

SB 647 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR THE CREATION OF MUTUAL INSURANCE HOLDING COMPANIES.

☒ With a favorable report as to House committee substitute bill, which changes the title, unfavorable as to Senate committee substitute bill and recommendation that the House committee substitute bill be re-referred to the Committee on FINANCE.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House/Senate) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 647
. Insurance Committee Substitute Adopted 6/7/11
PROPOSED HOUSE COMMITTEE SUBSTITUTE S647-CSRG-25 [v.1]

6/11/2012 4:09:17 PM

Short Title: Mutual Insurance Holding Companies. (Public)

Sponsors:

Referred to:

April 19, 2011

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE CREATION OF MUTUAL INSURANCE HOLDING COMPANIES.

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 8. Mutual Insurance Holding Companies.

"**§ 58-10-275. Definitions.**

The following definitions apply in this Part:

(1) Affiliated. – Defined in G.S. 58-19-5.

(2) Control. – Defined in G.S. 58-19-5.

(3) Domestic mutual insurance company. – An insurance company organized on a mutual plan and incorporated under the laws of North Carolina.

(4) Interested person. – With respect to another person, includes any of the following:

a. Any affiliated person.

b. Any member of the immediate family of any natural person who is an affiliated person of such company.

c. Any person or partner or employee of any person who at any time since the beginning of the last two completed fiscal years of such company has acted as legal counsel for such company.

d. Any natural person whom the Commissioner by order shall have determined to be an interested person by reason of having had, at any time since the beginning of the last two completed fiscal years of such company, a material business or professional relationship with such company or with the principal executive officer of such company.

(5) Intermediate holding company. – A holding company that is a subsidiary of a mutual insurance holding company or part of a holding company system controlled by a mutual insurance holding company subject to the terms and conditions of Article 19 of this Chapter and that either directly or through a subsidiary intermediate holding company has one or more subsidiary reorganized insurance companies of which a majority of the voting shares of

the capital stock would otherwise have been required by this section to be at all times owned by the mutual insurance holding company.

(6) Limited application. – An application by a domestic mutual insurance company for reorganization to a mutual insurance holding company which will hold, at all times, one hundred percent (100%) of the stock of its insurance subsidiaries.

(7) Majority of the voting shares of the capital stock of the reorganized insurance company. – Shares of the capital stock of a reorganized insurance company which carry the right to cast a majority of the votes entitled to be cast by all of the outstanding shares of the capital stock of the reorganized insurance company for the election of directors and on all other matters submitted to a vote of the shareholders of the reorganized insurance company.

(8) Member of the immediate family. – Any parent, spouse of a parent, child, spouse of a child, spouse, brother, or sister, including step and adoptive relationships.

(9) Mutual insurance holding company. – A holding company organized on a mutual plan and incorporated under the laws of North Carolina, resulting from the reorganization of a domestic mutual insurance company pursuant to this Part, with one or more stock insurance holding company subsidiaries or stock insurance company subsidiaries.

(10) Plan of reorganization. – A plan to reorganize a domestic mutual insurance company by forming a mutual insurance holding company.

(11) Standard application. – An application by a domestic mutual insurance company for reorganization to a mutual insurance holding company which may sell interests in its subsidiaries to third parties.

(12) Stock. – Any security evidencing an equity interest in the issuing entity.

(13) Stock offering. – Any proposed sale, exchange, transfer, or other change of ownership of stock or of securities convertible into or exchangeable or exercisable for stock. For the purposes of this Article, "stock offering" shall not include any of the following:

a. An offering of preferred stock which is not convertible or exchangeable into common stock and which has no ordinary voting rights.

b. A transfer of stock among any of the following:

1. A mutual insurance holding company.

2. An insurance company subsidiary of a mutual insurance holding company.

3. An intermediate holding company subsidiary of a mutual insurance holding company.

4. An insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company.

(14) Subsidiary. – Defined in G.S. 58-19-5.

"**§ 58-10-280. General provisions.**

(a) A domestic mutual insurance company, upon approval of the Commissioner, may reorganize by forming an insurance holding company based upon a mutual plan and by continuing the corporate existence of the reorganizing insurance company as a stock insurance company. If the Commissioner, after a public comment period as provided in G.S. 58-10-285, or, if applicable, a public hearing, is satisfied that the interests of the policyholders are properly protected and that the plan of reorganization is fair and equitable to the policyholders, the Commissioner may approve the proposed plan of reorganization and may require as a condition

of approval such modifications of the proposed plan of reorganization as the Commissioner finds necessary for the protection of the policyholders' interests. The Commissioner may retain consultants as provided in G.S. 58-10-285 to assist in the review of the proposed plan. The Commissioner shall retain jurisdiction over a mutual insurance holding company organized under this Part to assure that policyholder interests are protected. All of the initial shares of the capital stock of the reorganized insurance company shall be issued to the mutual insurance holding company. The membership interests of the policyholders of the reorganized insurance company shall become membership interests in the mutual insurance holding company, pursuant to the terms and conditions of the plan of reorganization approved by the Commissioner. Policyholders of the reorganized insurance company shall be members of the mutual insurance holding company in accordance with the articles of incorporation and bylaws of the mutual insurance holding company. The mutual insurance holding company shall at all times own a majority of the voting shares of the capital stock of the reorganized insurance company.

(b) A domestic mutual insurance company, after approval by the Commissioner, may reorganize by merging its policyholders' membership interests into a mutual insurance holding company formed under subsection (a) of this section and continuing the corporate existence of the reorganizing insurance company as a stock insurance company subsidiary of the mutual insurance holding company. If the Commissioner is satisfied that the interests of the policyholders are properly protected and that the merger of interests is fair and equitable to the policyholders, the Commissioner may approve the proposed merger of interests and may require as a condition of approval such modifications of the proposed merger of interests as the Commissioner finds necessary for the protection of the policyholders' interests. The Commissioner may retain consultants as provided in G.S. 58-10-285. The Commissioner has jurisdiction over the mutual insurance holding company organized under this Part to assure that policyholder interests are protected. All of the initial shares of the capital stock of the reorganized insurance company shall be issued to the mutual insurance holding company. The membership interests of the policyholders of the reorganized insurance company shall, pursuant to the terms and conditions of the plan of reorganization approved by the Commissioner, become membership interests in the mutual insurance holding company. Policyholders of the reorganized insurance company shall be members of the mutual insurance holding company in accordance with subsection (a) of this section and the articles of incorporation and bylaws of the mutual insurance holding company. The mutual insurance holding company shall at all times own a majority of the voting shares of the capital stock of the reorganized insurance company.

(c) A mutual insurance holding company resulting from the reorganization of a domestic mutual insurance company that was organized under Articles 7 and 8 and other applicable provisions of this Chapter shall be incorporated under this Chapter. The articles of incorporation and any amendments to such articles of the mutual insurance holding company shall be subject to approval of the Commissioner in the same manner as those of a mutual insurance company.

(d) A mutual insurance holding company is an insurer subject to Article 30 of this Chapter and shall automatically be a party to any proceeding under Article 30 of this Chapter involving an insurance company which, as a result of a reorganization under subsection (a) or (b) of this section, is a subsidiary of the mutual insurance holding company. In any proceeding under Article 30 of this Chapter involving the reorganized insurance company, the assets of the mutual insurance holding company are deemed to be assets of the estate of the reorganized insurance company for purposes of satisfying the claims of the reorganized insurance company's policyholders. A mutual insurance holding company shall not dissolve or liquidate without the approval of the Commissioner or as ordered by the court pursuant to Article 30 of this Chapter.

(e) G.S. 58-10-10 and G.S. 58-10-12 are not applicable to a reorganization or merger of interests under this Part. G.S. 58-10-10 and G.S. 58-10-12 are applicable to demutualization of a mutual insurance holding company that resulted from the reorganization of a domestic mutual insurance company organized under this Chapter as if the mutual insurance holding company was a mutual insurance company.

(f) A membership interest in a domestic mutual insurance holding company shall not constitute a security as defined in Chapter 78A of the General Statutes.

(g) The majority of the voting shares of the capital stock of the reorganized insurance company, which is required by this section to be at all times owned by a mutual insurance holding company, shall not be conveyed, transferred, assigned, pledged, subjected to a security interest or lien, encumbered, or otherwise hypothecated or alienated by the mutual insurance holding company or intermediate holding company. Any conveyance, transfer, assignment, pledge, security interest, lien, encumbrance, or hypothecation or alienation of, in, or on the majority of the voting shares of the reorganized insurance company is a violation of this section and shall be void in inverse chronological order of the date of such conveyance, transfer, assignment, pledge, security interest, lien, encumbrance, or hypothecation or alienation, as to the shares necessary to constitute a majority of such voting shares. The majority of the voting shares of the capital stock of the reorganized insurance company shall not be subject to execution and levy as provided in Chapter 1 of the General Statutes. The shares of the capital stock of the surviving or new company resulting from a merger or consolidation of two or more reorganized insurance companies or two or more intermediate holding companies that were subsidiaries of the same mutual insurance holding company are subject to the same requirements, restrictions, and limitations to which the shares of the merging or consolidating reorganized insurance companies or intermediate holding companies were subject by this section prior to the merger or consolidation. The ownership of a majority of the voting shares of the capital stock of the reorganized insurance company that are required by this section to be at all times owned by a parent mutual insurance holding company includes indirect ownership through one or more intermediate holding companies in a corporate structure approved by the Commissioner. However, indirect ownership through one or more intermediate holding companies shall not result in the mutual insurance holding company owning less than the equivalent of a majority of the voting shares of the capital stock of the reorganized insurance company. The Commissioner shall have jurisdiction over an intermediate holding company as if it were a mutual insurance holding company.

(h) The applicant's articles of incorporation or bylaws, as appropriate, shall require a policyholder vote of approval of the reorganization by a two-thirds majority of the domestic mutual insurance company's policyholders voting on it in person, by proxy, or by mail at a meeting called for the purpose of voting on the reorganization.

"**§ 58-10-285. Application; contents; process.**

(a) An application shall be designated as either a limited application or a standard application. The filing of a limited application shall not preclude the subsequent filing of an application for approval of an initial sale of stock as provided in G.S. 58-10-315.

(b) The application shall be filed in triplicate with the Commissioner and shall include the following items:

(1) Designation as a limited or standard application.

(2) A plan of reorganization as set forth in G.S. 58-10-290.

(3) A plan to obtain the approval of the policyholders in accordance with this Part and the applicant's articles of incorporation and bylaws.

(4) A copy of the mutual insurance holding company's proposed articles of incorporation and bylaws specifying all membership rights.

(5) The names, addresses, and occupational information of all corporate officers and members of the initial mutual insurance holding company board of directors.

(6) Information sufficient to demonstrate that the financial condition of the applicant will not be diminished upon reorganization.

(7) A copy of the proposed articles of incorporation and bylaws for any insurance company subsidiary or intermediate holding company subsidiary.

(8) A "Form A" filing as described in Chapter 11 of Title 11 of the North Carolina Administrative Code.

(9) A statement that the application is in compliance with all pertinent North Carolina General Statutes and Administrative Rules and that the requirements for a plan of reorganization have been fulfilled.

(10) An index demonstrating wherein the application information supplied in compliance with this subsection is found.

(11) The applicable fee required by subsection (f) of this section.

(12) Any other information requested by the Commissioner at any time during the course of proceedings.

(c) Upon receipt and review by the Commissioner of all information provided pursuant to subsection (b) of this section, the Commissioner may establish a period during which the Department will receive and consider public comments on the proposed reorganization. The Commissioner may inform the public of the limited or standard application in a manner deemed appropriate by the Commissioner and may hold a public hearing concerning the application.

(d) The Commissioner may contract, at the expense of the person filing the application, with any attorneys, actuaries, economists, accountants, consultants, or other professional advisors not otherwise a part of the Commissioner's staff to assist the Commissioner in reviewing the application. These contracts are personal professional service contracts exempt from Articles 3 and 3C of Chapter 143 of the General Statutes.

(e) The expenses of mailing any notices and other materials required by this section shall be borne by the person filing the application.

(f) An applicant filing a limited application under this section shall submit with the application under subsection (b) of this section an application fee of two hundred fifty dollars ($250.00). An applicant filing a standard application under this section shall submit with the application under subsection (b) of this section an application fee of five hundred dollars ($500.00).

"**§ 58-10-290. Plan of reorganization.**

(a) A limited application plan of reorganization shall include the following provisions:

(1) Establishing a mutual insurance holding company with at least one stock insurance company subsidiary or one intermediary stock holding company with a stock insurance company subsidiary, the shares of which shall be held exclusively by the mutual insurance holding company.

(2) Protecting the interests of existing policyholders.

(3) Ensuring immediate membership in the mutual insurance holding company of all existing policyholders of the reorganizing domestic mutual insurance company.

(4) Describing a plan providing for membership interests of future policyholders.

(5) Describing the number of members of the board of directors of the mutual insurance holding company required to be policyholders.

(6) Demonstrating that, in the event of proceedings under Article 30 of this Chapter involving a stock insurance company subsidiary of the mutual insurance holding company which resulted from the reorganization of a

domestic mutual insurance company, the assets of the mutual insurance holding company will be available to satisfy the policyholder obligations of the stock insurance company.

(7) Describing how any accumulation or prospective accumulation of earnings by the mutual insurance holding company in excess of that determined by the board of directors of the mutual insurance holding company to be necessary shall inure to the exclusive benefit of the policyholders of its insurance company subsidiaries who are members.

(8) Describing the nature and content of the annual report and financial statement to be sent to each member.

(9) Describing any other relevant matters the applicant deems appropriate.

(b) A standard application plan of reorganization shall include the following provisions:

(1) Establishing a mutual insurance holding company with at least one stock insurance company subsidiary or one wholly owned intermediate stock holding company with a stock insurance company subsidiary, the shares of which shall be held exclusively by the wholly owned intermediate holding company.

(2) Protecting the interests of existing policyholders.

(3) Ensuring immediate membership in the mutual insurance holding company of all existing policyholders of the reorganizing domestic mutual insurance company.

(4) Providing for membership interests of future policyholders.

(5) Describing the number of members of the board of directors of the mutual insurance holding company required to be policyholders.

(6) Demonstrating that, in the event of proceedings under Article 30 of this Chapter involving a stock insurance company subsidiary of the mutual insurance holding company which resulted from the reorganization of a domestic mutual insurance company, the assets of the mutual insurance holding company will be available to satisfy the policyholder obligations of the stock insurance company.

(7) Describing how any accumulation or prospective accumulation of earnings by the mutual insurance holding company in excess of that determined by the board of directors of the mutual insurance holding company to be necessary shall inure to the exclusive benefit of the policyholders of its insurance company subsidiaries who are members.

(8) Describing the nature and content of the annual report and financial statement to be sent to each member.

(9) Describing the applicant's plan for a stock offering in accordance with the provisions of G.S. 58-10-315.

(10) Describing any other relevant matters the applicant deems appropriate.

(c) With regard to either a limited or standard application, the plan of reorganization submitted to the Commissioner shall demonstrate the following:

(1) Policyholder interests are properly preserved and protected.

(2) The plan is fair and equitable to policyholders.

(3) The financial condition of the applicant will not be diminished.

"**§ 58-10-295. Powers of the Commissioner.**

(a) The Commissioner shall at all times retain jurisdiction over the mutual insurance holding company, its intermediate holding company subsidiaries with stock insurance company subsidiaries, and its stock insurance company subsidiaries.

(b) Following any public comment period or hearing pursuant to G.S. 58-10-285, the Commissioner by order shall approve, conditionally approve, or deny an application. The

Commissioner may require, as a condition of approval of the proposed reorganization, modifications of the proposed plan of reorganization that the Commissioner finds necessary. The applicant shall accept the required modifications by filing appropriate amendments to the proposed plan of reorganization with the Commissioner within 30 days of the date of the Commissioner's order requiring the modifications. If the applicant does not accept the required modifications by failing to file the required amendments to the proposed plan of reorganization within 30 days, the proposed reorganization shall be deemed denied.

(c) An approval or conditional approval of a plan of reorganization shall expire if the reorganization is not completed within 210 days after the approval or conditional approval unless the time period is extended by the Commissioner upon a showing of good cause.

(d) The Commissioner may revoke approval or conditional approval of an applicant's plan of reorganization in the event the Commissioner finds the applicant has failed to comply with the plan of reorganization. The Commissioner may compel completion of a plan of reorganization unless the plan is abandoned in its entirety, in accordance with the applicant's provisions for governance.

(e) Upon completion of all elements of a plan of reorganization, the applicant shall provide a notice of completion to the Commissioner.

"**§ 58-10-300. Special financial requirements.**

(a) Mutual insurance holding companies and their insurance company subsidiaries and affiliates shall comply with the provisions of Article 19 of this Chapter except as expressly provided in this Part.

(b) When a mutual insurance holding company acquires or plans to acquire more than fifty percent (50%) of a stock insurance company, the mutual insurance holding company shall submit to the Commissioner a plan describing any membership interests of policyholders.

(c) Each mutual insurance holding company shall supply to the Commissioner, by April 1 of each year, an annual statement consisting of the following:

(1) An income statement.
(2) A balance sheet.
(3) A cash flow statement.
(4) Complete information on the status of any closed block formed as a part of a plan of reorganization.
(5) An investment plan covering all assets.
(6) A statement disclosing any intention to pledge, borrow against, alienate, hypothecate, or in any way encumber the assets of the mutual insurance holding company.

(d) At least fifty percent (50%) of the net worth of the mutual insurance holding company, based upon generally accepted accounting practices, shall be invested in insurance company subsidiaries. The Commissioner may waive the fifty percent (50%) limitation upon a showing of good cause.

(e) No policyholder who is a member of a mutual insurance holding company shall receive on account of such membership interest any payment of a policy credit, dividend, or other distribution unless the payment has been approved by the Commissioner. The Commissioner, if satisfied the proposed payment is fair and equitable to policyholders who are members, may approve the proposed payment and may require as a condition of the approval modification of the proposed payment that the Commissioner finds necessary for the protection of the policyholders.

(f) Mutual insurance holding companies shall comply with Part 3 of this Article and shall be considered a domestic insurer for the purposes of compliance with Part 3.

"**§ 58-10-305. Reorganization of domestic mutual insurer with mutual insurance holding company.**

A domestic mutual insurance company may apply to reorganize by merging its policyholders' membership interests into a mutual insurance holding company by filing with the Commissioner a joint application with the mutual insurance holding company complying with the provisions of G.S. 58-10-285.

"**§ 58-10-310. Mergers of mutual insurance holding companies.**

A mutual insurance holding company may apply to merge with another mutual insurance holding company by filing with the Commissioner a plan of merger and complying with the provisions of Article 19 of this Chapter.

"**§ 58-10-315. Stock offerings.**

(a) No stock offering by a mutual insurance holding company, an insurance company subsidiary of a mutual insurance holding company, an intermediate holding company subsidiary of a mutual insurance holding company, or an insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company shall occur without the prior approval of the Commissioner.

(b) Every application for approval of a stock offering shall contain the following information:

(1) A description of the stock intended to be offered by the applicant, including a description of all shareholder rights.

(2) The total number of shares authorized to be issued, the estimated number the applicant requests permission to offer, and the intended date or range of dates for the offer.

(3) A justification for a uniform planned offering price or a justification of the method by which the offering price will be determined.

(4) The name or names of any underwriter, syndicate member, or placement agent involved and, if known, the name or names of each entity, person, or group of persons to whom the stock offering is to be made who will control five percent (5%) of the total outstanding class of shares, and the manner in which the offer is to be tendered. If any such entity or person is a corporation or business organization, the name of each member of its board of directors or equivalent management team shall be provided along with the name of each member of the board of directors of the offeror. Copies of any filings with the United States Securities and Exchange Commission disclosing intended acquisitions of the stock shall be included in the application.

(5) A description of stock subscription rights to be afforded members of the mutual insurance holding company in conjunction with the stock offering.

(6) A detailed description of all expenses to be incurred in conjunction with the stock offering.

(7) An explanation of how funds raised by the stock offering are to be used.

(8) Any other information requested by the Commissioner.

(c) No application regarding a planned stock offering shall be approved unless the plan contains the following provisions:

(1) Prohibiting officers, directors, and insiders of the mutual insurance holding company and its subsidiaries and affiliates from purchase or ownership of shares of the stock offering, or issuance of stock options to or for the benefit of such officers, directors, and insiders, in excess of five percent (5%) of the stock offering. The Commissioner may waive this requirement upon a showing of good cause. This subdivision does not limit the rights of officers, directors, and insiders from exercising subscription rights that are generally accorded members of the mutual insurance holding company. However, pursuant to those subscription rights, the officers, directors, and insiders of the mutual insurance holding company and its subsidiaries and affiliates may

not purchase or own, in the aggregate, more than five percent (5%) of the stock offering.

(2) Requiring that, after the initial stock offering, a majority of the board of directors of the mutual insurance holding company be persons who are not interested persons of the mutual insurance holding company or of an affiliated person of the company. For purposes of this subdivision, a member of the mutual insurance holding company or a policyholder of any of its insurance company subsidiaries shall not be considered an "interested person" or an "affiliated person." The Commissioner may waive this requirement upon a showing of good cause.

(3) For the mutual insurance holding company to adopt articles of incorporation prohibiting any waiver of dividends from stock subsidiaries except under conditions specified in its articles of incorporation and after approval of the waiver by the board of directors of the mutual insurance holding company and the Commissioner.

(4) Requiring that, after the initial stock offering by an insurance company subsidiary of a mutual insurance holding company, an intermediate holding company subsidiary of a mutual insurance holding company, or an insurance company subsidiary of an intermediate holding company subsidiary of a mutual insurance holding company, the boards of directors of each insurance company or intermediate holding company include at least three directors who are not interested persons of the mutual insurance holding company. The Commissioner may waive this requirement upon a showing of good cause.

(5) Establishing, within the board of directors of the corporation offering stock, a pricing committee consisting exclusively of directors who are not members of management of the insurance company subsidiary whose responsibility is to evaluate and approve the price of any stock offering.

(d) An insurance company subsidiary of a mutual insurance holding company, an intermediate holding company subsidiary of a mutual insurance holding company, or an insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company may issue more than one class of stock, provided, however, that the issuer complies with all of the following requirements:

(1) At all times a majority of the voting stock is held by the mutual insurance holding company or its subsidiary.

(2) No class of common stock may possess greater dividend or other rights than the class held by the mutual insurance holding company or its subsidiary.

(e) The Commissioner may retain, at the expense of the person filing the application, any attorneys, actuaries, economists, accountants, consultants, or other professional advisors not otherwise a part of the Commissioner's staff to assist the Commissioner in reviewing the application. These contracts are personal professional service contracts exempt from Articles 3 and 3C of Chapter 143 of the General Statutes.

(f) The expenses of mailing any notices and other materials required by this section shall be borne by the person filing the application.

(g) Upon receipt and review by the Commissioner of all information provided under this section, the Commissioner may establish a period during which the Department will receive and consider public comments about the proposed offering. The Commissioner shall inform the public of the offering by posting information about the application in a manner deemed appropriate by the Commissioner. The Commissioner may hold a public hearing concerning the application or the proposed offering. Following any public comment period or

hearing, if applicable, the Commissioner may approve, conditionally approve, or deny the application. The Commissioner may approve the application if the following apply:

(1) The offering complies with this Part and other provisions of law.

(2) The method for establishing the price of a stock offering is consistent with generally accepted market or industry practices for establishing stock offering prices in similar transactions.

(3) The plan and offering will not unfairly impact the interests of members of the mutual insurance holding company.

Nothing in this subsection shall be deemed to prohibit the filing of a registration statement with the United States Securities and Exchange Commission before or concurrently with the giving of notice to members.

(h) Notwithstanding the provisions of subsections (a) through (g) of this section, stock offerings which are not an initial stock offering, and which are proposed by entities with a class of securities regularly traded on the New York Stock Exchange, the American Stock Exchange, or another exchange approved by the Commissioner, or designated on the National Association of Securities Dealers Automated Quotations national market system (NASDAQ), may be sold in accordance with the following procedure: if a mutual insurance holding company, an insurance company subsidiary of a mutual insurance holding company, an intermediate holding company, or an insurance company subsidiary of an intermediate holding company intends to make a stock offering which would be governed by the provisions of this subsection, that entity shall deliver to the Commissioner, not less than 60 days prior to the offering, a notice of the planned stock offering and all of the following information:

(1) The total number of shares intended to be offered.

(2) The intended date of sale.

(3) Evidence the stock is regularly traded on one of the public exchanges specified in this subsection.

(4) A record of the trading price and trading volume of the stock during the prior 52 weeks.

The Commissioner shall be deemed to have approved the sale unless, within 60 days following receipt of such notice, the Commissioner issues an objection to the sale. If the Commissioner issues an objection to the sale, the application process set forth in subsections (a) through (g) of this section shall be followed to determine whether the Commissioner approves of the proposed sale.

(i) Approval of a stock offering obtained under either subsection (g) or (h) of this section shall expire 120 days following the date of the approval or deemed approval, except as otherwise provided by order of the Commissioner.

(j) No prospectus, information, sales material, or sales presentation by the applicant, or by any representative, agent, or affiliate of the applicant, shall contain a representation that the Commissioner has endorsed the price, price range, or any other information relating to the stock.

(k) No company making a stock offering under this section shall engage in any of the following practices:

(1) Borrow funds from the mutual insurance holding company, or its subsidiaries and affiliates, to finance the purchase of any portion of a stock offering.

(2) Pay any commissions, "special fees," or any other special payments or extraordinary compensation to officers, directors, interested persons, and affiliates for arranging, promoting, aiding, or assisting in reorganization to a mutual insurance holding company or for arranging, promoting, aiding, assisting, or participating in the structuring and placement of a stock offering.

(3) Enter into an understanding or agreement transferring legal or beneficial ownership of stock to another person to avoid the requirements of this Part.

"**§ 58-10-320. Regulation of holding company system.**

(a) All material transactions, as that term is defined under Part 3 of this Article, between or among subsidiaries and affiliates of the mutual insurance holding company, must, after review and exercise of director duties by the directors of the mutual insurance holding company, be approved by a majority of the directors of the mutual insurance holding company as being fair and reasonable.

(b) If the Commissioner determines that activities within a mutual insurance holding company system have violated provisions of the General Statutes of North Carolina or the North Carolina Administrative Code or acted to circumvent requirements or prohibitions contained in the General Statutes or Administrative Code, the Commissioner may prohibit or order rescission of any transaction relating to those activities.

"**§ 58-10-325. Reporting of stock ownership and transactions.**

(a) Any director or officer of a mutual insurance holding company, its subsidiary, or affiliate, who acquires directly or indirectly the beneficial ownership of any security issued by any intermediate holding company or any insurance company subsidiary of an intermediate holding company or mutual insurance holding company shall, within 15 days following the transaction, file with the Commissioner a statement of the transaction on the form prescribed by the Commissioner.

(b) A mutual insurance holding company, and its subsidiaries and affiliates, shall file with the Commissioner, within 15 days of receipt, copies of Form 3, Form 4, and Schedule 13D, or any equivalent filings, such filings made under the federal Securities Exchange Act of 1934, as amended."

SECTION 2. This act is effective when it becomes law.

SENATE BILL 647:
Mutual Insurance Holding Companies

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	June 11, 2012
Introduced by:	Sen. Rucho	**Prepared by:**	Tim Hovis Committee Counsel
Analysis of:	PCS to Second Edition S647-CSRG-25		

SUMMARY: ***A "mutual insurance company" is a company that is owned by its policyholders. No stock is available for purchase. The proposed committee substitute (PCS) for Senate Bill 647 would authorize a domestic mutual insurance company, with the approval of two-thirds of its policyholders voting, to reorganize as a mutual insurance holding company. Members of the mutual insurance company would receive ownership interest in the mutual insurance holding company. The mutual insurance company would then be converted into a stock insurance company held by the holding company. In addition to approval by the policyholders, the Commissioner of Insurance must approve the reorganization as fair and equitable to the policyholders. Also, the holding company must at all times own a majority of the voting shares of the mutual insurance company. As a stock insurance company, the mutual insurer would be able to raise capital.***

Following reorganization, the Commissioner of Insurance would retain jurisdiction over the mutual insurance holding company, the mutual insurance company, and any stock insurance subsidiaries, including the approval of all stock offerings and mergers.

PROPOSED COMMITTEE SUBSTITUTE: The PCS deletes language exempting the mutual insurance holding company from restrictions on investment activities as provided under current law in the Insurance Holding Company System Regulatory Act. This language was deleted in an amendment previously adopted by the Committee.

BILL ANALYSIS: The PCS for Senate Bill 647 adds a new Part 8 to Article 10 of Chapter 58 of the General Statutes, entitled "*Mutual Insurance Holding Companies.*" Among its provisions, the bill creates the following new sections:

➢ ***G.S. 58-10-275. Definitions.***

The bill defines terms used in the act. Definitions include the following:

- "Domestic mutual insurance company" -- an insurance company organized on a mutual plan and incorporated under the laws of North Carolina.
- "Mutual insurance holding company" -- a holding company organized on a mutual plan and incorporated under the laws of North Carolina, resulting from the reorganization of a domestic mutual insurance company...with one or more stock insurance holding company subsidiaries or stock insurance company subsidiaries.
- "Limited application" -- an application for reorganization to a mutual insurance holding company which will hold one hundred percent of the stock of its insurance subsidiaries.
- "Standard application" -- an application for reorganization to a mutual insurance holding company which may sell interests in its subsidiaries to third parties.

➢ ***G.S. 58-10-280. General provisions.***

With the Commissioner's approval, the bill authorizes a domestic mutual insurance company to form an insurance holding company based upon a mutual plan and continue its corporate existence as a stock

insurance company subsidiary of the holding company. The membership interest of the policyholders in the mutual company shall, subject to the Commissioner's approval, become membership interests in the mutual insurance holding company. The Commissioner may require modification of the plan as necessary to protect the policyholders' interests. The Commissioner also retains jurisdiction over the holding company. The holding company shall at all times own a majority of the voting shares of stock of the reorganized stock insurance company. The policyholders of the mutual company must approve the reorganization by a two-thirds majority of those voting. In any delinquency proceeding under Chapter 58, the assets of the holding company are deemed to be assets of the reorganized mutual insurance company.

➢ ***G.S. 58-10-285. Application; contents; process.***

A limited or standard application, including a plan of reorganization, must be filed with the Commissioner. The Commissioner receives and considers public comment and may hold a public hearing. Applicants must pay to the Commissioner a fee of $250 for each limited application and $500 for each standard application under this section.

➢ ***G.S. 58-10-290. Plan of reorganization.***

A limited or standard plan of reorganization submitted to the Commissioner must include provisions as outlined and must demonstrate the following:

- Policyholder interests are properly preserved and protected
- Plan is fair and equitable
- The financial condition of the applicant will not be diminished.

➢ ***G.S. 58-10-295. Powers of the Commissioner.***

The Commissioner retains jurisdiction over the mutual insurance holding company, intermediate holding company subsidiaries with stock insurance subsidiaries, and stock insurance subsidiaries. Approval of a plan of operation may be conditioned on modifications deemed necessary by the Commissioner. If modifications are not made within 30 days, the plan is deemed to be denied. If the reorganization is not completed within 210 days of approval or conditional approval by the Commissioner, the approval expires unless the time period is extended by the Commissioner. The Commissioner may revoke approval if the applicant fails to comply with the plan of reorganization.

➢ ***G.S. 58-10-300. Special financial requirements.***

A mutual insurance holding company is subject to the provisions of the Insurance Holding Company System Regulatory Act, Article 19 of Chapter 58.

This section also requires a mutual insurance holding company to do the following:

- Upon acquisition or plan to acquire more than 50% of a stock insurance company, submit to the Commissioner of a plan describing the membership interests of policyholders.
- Invest at least 50% or more of its net worth in insurance company subsidiaries, unless waived by the Commissioner.
- File a report with the Commissioner disclosing all material transactions (acquisition and disposition of assets, nonrenewal and cancellation of reinsurance).

➢ ***G.S. 58-10-315. Stock offerings.***

The Commissioner must give prior approval of all stock offerings of a mutual insurance holding company, and its insurance company subsidiaries, intermediate holding company subsidiaries, and any insurance company subsidiaries of an intermediate holding company subsidiary of a mutual insurance holding company. Applications for approval of a stock offering must include a description of the stock, the total

number of shares to be issued, justification for offering price, and a description of rights afforded members of the mutual insurance holding company.

Planned stock offerings must:

- Prohibit officers, directors and insiders of the holding company and its subsidiaries and affiliates from purchase or ownership of shares in excess of 5% of the offering.
- Require that after the offering a majority of the Board of directors be persons who are not interested persons of the holding company or of an affiliated person of the company as defined under the Article.
- Provide for the holding company to adopt articles of incorporation prohibiting waiver of dividends from stock subsidiaries except under specified circumstances.
- Require that after the initial stock offering the boards of directors of each insurance company or intermediate holding company include at least three members who are not interested persons of the holding company. (This may be waived by the Commissioner.)
- Establish within the board of the offering corporation a pricing committee consisting exclusively of directors who are not members of management of the insurance company subsidiary.

Insurance company subsidiaries and intermediate holding company subsidiaries may only issue more than one class of stock if the mutual holding company retains at all times a majority of the voting stock and no class of common stock possesses a greater dividend or other rights than the mutual holding company's class of stock.

The Commissioner may establish a period for public comment on the proposed offering and may hold a public hearing. The offering may be approved if it: (1) complies with this Part; (2) the price is established by generally accepted market or industry practices; (3) the plan and offering will not unfairly impact the interests of mutual insurance holding company's members.

Approval of a stock offering under this section expires 120 days following approval, unless the Commissioner orders otherwise.

➢ ***G.S. 58-10-320. Regulation of holding company system.***

All material transactions (acquisition and disposition of assets, nonrenewal and cancellation of reinsurance) between or among subsidiaries and affiliates of a mutual insurance holding company must be approved by a majority of the board of directors of the mutual holding company. Also, if the Commissioner determines that a mutual holding company's activities have violated the General Statutes or the Administrative Code, the Commissioner may prohibit or order rescission of the transaction.

➢ ***G.S. 58-10-325. Reporting of stock ownership and transactions.***

Directors and officers of a mutual insurance holding company or its subsidiaries or affiliates who acquire beneficial ownership of any security issued by any intermediate holding company or any insurance company subsidiary must file a statement with the Commissioner within 15 days of the transaction.

EFFECTIVE DATE: The PCS for Senate Bill 647 is effective when it becomes law.

S647-SMRG-54(CSRG-25) v3

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 647

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

S647-ARG-28 [v.4]

Comm. Sub. [YES]
Amends Title [NO]
Second Edition S647-CSRG-25

Date _____,2012

Rep._____

moves to amend the bill on page 1, line 3,
by rewriting the line to read:
"COMPANIES AND TO CHANGE THE TIME PERIOD FOR FIRE CODE INSPECTIONS OF PUBLIC BUILDINGS.";

and on page 11, line 25,
by rewriting the lines to read:
"**SECTION 2.** G.S. 58-31-40 reads as rewritten:
'**§ 58-31-40. Commissioner to inspect State property.**
(a) The Commissioner ~~shall, at least once every year~~ shall, as often as is required in the fire code adopted by the North Carolina Building Code Council or more often if the Commissioner considers it necessary, visit, inspect, and thoroughly examine every State property to analyze and determine its protection from fire, including the property's occupants or contents. The Commissioner shall notify in writing the agency or official in charge of the property of any defect noted by the Commissioner or any improvement considered by the Commissioner to be necessary, and a copy of that notice shall be forwarded by the Commissioner to the Department of Administration.
(b) No agency or person authorized or directed by law to select a plan or erect a building comprising 20,000 square feet or more for the use of any county, city, or school district shall receive and approve of the plan until it is submitted to and approved by the Commissioner as to the safety of the proposed building from fire, including the property's occupants or contents.

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

S647-ARG-28 [v.4]

(c) Repealed by Session Laws 2009-474, s. 1, effective October 1, 2009.'
SECTION 3. This act is effective when it becomes law."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

SENATE BILL 647
Insurance Committee Substitute Adopted 6/7/11

Short Title: Mutual Insurance Holding Companies. (Public)

Sponsors:

Referred to:

April 19, 2011

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE CREATION OF MUTUAL INSURANCE HOLDING COMPANIES.

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 8. Mutual Insurance Holding Companies.

"**§ 58-10-275. Definitions.**

The following definitions apply in this Part:

(1) Affiliated. – Defined in G.S. 58-19-5.

(2) Control. – Defined in G.S. 58-19-5.

(3) Domestic mutual insurance company. – An insurance company organized on a mutual plan and incorporated under the laws of North Carolina.

(4) Interested person. – With respect to another person, includes any of the following:

a. Any affiliated person.

b. Any member of the immediate family of any natural person who is an affiliated person of such company.

c. Any person or partner or employee of any person who at any time since the beginning of the last two completed fiscal years of such company has acted as legal counsel for such company.

d. Any natural person whom the Commissioner by order shall have determined to be an interested person by reason of having had, at any time since the beginning of the last two completed fiscal years of such company, a material business or professional relationship with such company or with the principal executive officer of such company.

(5) Intermediate holding company. – A holding company that is a subsidiary of a mutual insurance holding company or part of a holding company system controlled by a mutual insurance holding company subject to the terms and conditions of Article 19 of this Chapter and that either directly or through a subsidiary intermediate holding company has one or more subsidiary reorganized insurance companies of which a majority of the voting shares of the capital stock would otherwise have been required by this section to be at all times owned by the mutual insurance holding company.

(6) Limited application. – An application by a domestic mutual insurance company for reorganization to a mutual insurance holding company which will hold, at all times, one hundred percent (100%) of the stock of its insurance subsidiaries.

(7) Majority of the voting shares of the capital stock of the reorganized insurance company. – Shares of the capital stock of a reorganized insurance company which carry the right to cast a majority of the votes entitled to be cast by all of the outstanding shares of the capital stock of the reorganized insurance company for the election of directors and on all other matters submitted to a vote of the shareholders of the reorganized insurance company.

(8) Member of the immediate family. – Any parent, spouse of a parent, child, spouse of a child, spouse, brother, or sister, including step and adoptive relationships.

(9) Mutual insurance holding company. – A holding company organized on a mutual plan and incorporated under the laws of North Carolina, resulting from the reorganization of a domestic mutual insurance company pursuant to this Part, with one or more stock insurance holding company subsidiaries or stock insurance company subsidiaries.

(10) Plan of reorganization. – A plan to reorganize a domestic mutual insurance company by forming a mutual insurance holding company.

(11) Standard application. – An application by a domestic mutual insurance company for reorganization to a mutual insurance holding company which may sell interests in its subsidiaries to third parties.

(12) Stock. – Any security evidencing an equity interest in the issuing entity.

(13) Stock offering. – Any proposed sale, exchange, transfer, or other change of ownership of stock or of securities convertible into or exchangeable or exercisable for stock. For the purposes of this Article, "stock offering" shall not include any of the following:

a. An offering of preferred stock which is not convertible or exchangeable into common stock and which has no ordinary voting rights.

b. A transfer of stock among any of the following:

1. A mutual insurance holding company.

2. An insurance company subsidiary of a mutual insurance holding company.

3. An intermediate holding company subsidiary of a mutual insurance holding company.

4. An insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company.

(14) Subsidiary. – Defined in G.S. 58-19-5.

"**§ 58-10-280. General provisions.**

(a) A domestic mutual insurance company, upon approval of the Commissioner, may reorganize by forming an insurance holding company based upon a mutual plan and by continuing the corporate existence of the reorganizing insurance company as a stock insurance company. If the Commissioner, after a public comment period as provided in G.S. 58-10-285, or, if applicable, a public hearing, is satisfied that the interests of the policyholders are properly protected and that the plan of reorganization is fair and equitable to the policyholders, the Commissioner may approve the proposed plan of reorganization and may require as a condition of approval such modifications of the proposed plan of reorganization as the Commissioner finds necessary for the protection of the policyholders' interests. The Commissioner may retain

consultants as provided in G.S. 58-10-285 to assist in the review of the proposed plan. The Commissioner shall retain jurisdiction over a mutual insurance holding company organized under this Part to assure that policyholder interests are protected. All of the initial shares of the capital stock of the reorganized insurance company shall be issued to the mutual insurance holding company. The membership interests of the policyholders of the reorganized insurance company shall become membership interests in the mutual insurance holding company, pursuant to the terms and conditions of the plan of reorganization approved by the Commissioner. Policyholders of the reorganized insurance company shall be members of the mutual insurance holding company in accordance with the articles of incorporation and bylaws of the mutual insurance holding company. The mutual insurance holding company shall at all times own a majority of the voting shares of the capital stock of the reorganized insurance company.

(b) A domestic mutual insurance company, after approval by the Commissioner, may reorganize by merging its policyholders' membership interests into a mutual insurance holding company formed under subsection (a) of this section and continuing the corporate existence of the reorganizing insurance company as a stock insurance company subsidiary of the mutual insurance holding company. If the Commissioner is satisfied that the interests of the policyholders are properly protected and that the merger of interests is fair and equitable to the policyholders, the Commissioner may approve the proposed merger of interests and may require as a condition of approval such modifications of the proposed merger of interests as the Commissioner finds necessary for the protection of the policyholders' interests. The Commissioner may retain consultants as provided in G.S. 58-10-285. The Commissioner has jurisdiction over the mutual insurance holding company organized under this Part to assure that policyholder interests are protected. All of the initial shares of the capital stock of the reorganized insurance company shall be issued to the mutual insurance holding company. The membership interests of the policyholders of the reorganized insurance company shall, pursuant to the terms and conditions of the plan of reorganization approved by the Commissioner, become membership interests in the mutual insurance holding company. Policyholders of the reorganized insurance company shall be members of the mutual insurance holding company in accordance with subsection (a) of this section and the articles of incorporation and bylaws of the mutual insurance holding company. The mutual insurance holding company shall at all times own a majority of the voting shares of the capital stock of the reorganized insurance company.

(c) A mutual insurance holding company resulting from the reorganization of a domestic mutual insurance company that was organized under Articles 7 and 8 and other applicable provisions of this Chapter shall be incorporated under this Chapter. The articles of incorporation and any amendments to such articles of the mutual insurance holding company shall be subject to approval of the Commissioner in the same manner as those of a mutual insurance company.

(d) A mutual insurance holding company is an insurer subject to Article 30 of this Chapter and shall automatically be a party to any proceeding under Article 30 of this Chapter involving an insurance company which, as a result of a reorganization under subsection (a) or (b) of this section, is a subsidiary of the mutual insurance holding company. In any proceeding under Article 30 of this Chapter involving the reorganized insurance company, the assets of the mutual insurance holding company are deemed to be assets of the estate of the reorganized insurance company for purposes of satisfying the claims of the reorganized insurance company's policyholders. A mutual insurance holding company shall not dissolve or liquidate without the approval of the Commissioner or as ordered by the court pursuant to Article 30 of this Chapter.

(e) G.S. 58-10-10 and G.S. 58-10-12 are not applicable to a reorganization or merger of interests under this Part. G.S. 58-10-10 and G.S. 58-10-12 are applicable to demutualization of

a mutual insurance holding company that resulted from the reorganization of a domestic mutual insurance company organized under this Chapter as if the mutual insurance holding company was a mutual insurance company.

(f) A membership interest in a domestic mutual insurance holding company shall not constitute a security as defined in Chapter 78A of the General Statutes.

(g) The majority of the voting shares of the capital stock of the reorganized insurance company, which is required by this section to be at all times owned by a mutual insurance holding company, shall not be conveyed, transferred, assigned, pledged, subjected to a security interest or lien, encumbered, or otherwise hypothecated or alienated by the mutual insurance holding company or intermediate holding company. Any conveyance, transfer, assignment, pledge, security interest, lien, encumbrance, or hypothecation or alienation of, in, or on the majority of the voting shares of the reorganized insurance company is a violation of this section and shall be void in inverse chronological order of the date of such conveyance, transfer, assignment, pledge, security interest, lien, encumbrance, or hypothecation or alienation, as to the shares necessary to constitute a majority of such voting shares. The majority of the voting shares of the capital stock of the reorganized insurance company shall not be subject to execution and levy as provided in Chapter 1 of the General Statutes. The shares of the capital stock of the surviving or new company resulting from a merger or consolidation of two or more reorganized insurance companies or two or more intermediate holding companies that were subsidiaries of the same mutual insurance holding company are subject to the same requirements, restrictions, and limitations to which the shares of the merging or consolidating reorganized insurance companies or intermediate holding companies were subject by this section prior to the merger or consolidation. The ownership of a majority of the voting shares of the capital stock of the reorganized insurance company that are required by this section to be at all times owned by a parent mutual insurance holding company includes indirect ownership through one or more intermediate holding companies in a corporate structure approved by the Commissioner. However, indirect ownership through one or more intermediate holding companies shall not result in the mutual insurance holding company owning less than the equivalent of a majority of the voting shares of the capital stock of the reorganized insurance company. The Commissioner shall have jurisdiction over an intermediate holding company as if it were a mutual insurance holding company.

(h) The applicant's articles of incorporation or bylaws, as appropriate, shall require a policyholder vote of approval of the reorganization by a two-thirds majority of the domestic mutual insurance company's policyholders voting on it in person, by proxy, or by mail at a meeting called for the purpose of voting on the reorganization.

"**§ 58-10-285. Application; contents; process.**

(a) An application shall be designated as either a limited application or a standard application. The filing of a limited application shall not preclude the subsequent filing of an application for approval of an initial sale of stock as provided in G.S. 58-10-315.

(b) The application shall be filed in triplicate with the Commissioner and shall include the following items:

(1) Designation as a limited or standard application.

(2) A plan of reorganization as set forth in G.S. 58-10-290.

(3) A plan to obtain the approval of the policyholders in accordance with this Part and the applicant's articles of incorporation and bylaws.

(4) A copy of the mutual insurance holding company's proposed articles of incorporation and bylaws specifying all membership rights.

(5) The names, addresses, and occupational information of all corporate officers and members of the initial mutual insurance holding company board of directors.

(6) Information sufficient to demonstrate that the financial condition of the applicant will not be diminished upon reorganization.
(7) A copy of the proposed articles of incorporation and bylaws for any insurance company subsidiary or intermediate holding company subsidiary.
(8) A "Form A" filing as described in Chapter 11 of Title 11 of the North Carolina Administrative Code.
(9) A statement that the application is in compliance with all pertinent North Carolina General Statutes and Administrative Rules and that the requirements for a plan of reorganization have been fulfilled.
(10) An index demonstrating wherein the application information supplied in compliance with this subsection is found.
(11) The applicable fee required by subsection (f) of this section.
(12) Any other information requested by the Commissioner at any time during the course of proceedings.

(c) Upon receipt and review by the Commissioner of all information provided pursuant to subsection (b) of this section, the Commissioner may establish a period during which the Department will receive and consider public comments on the proposed reorganization. The Commissioner may inform the public of the limited or standard application in a manner deemed appropriate by the Commissioner and may hold a public hearing concerning the application.

(d) The Commissioner may contract, at the expense of the person filing the application, with any attorneys, actuaries, economists, accountants, consultants, or other professional advisors not otherwise a part of the Commissioner's staff to assist the Commissioner in reviewing the application. These contracts are personal professional service contracts exempt from Articles 3 and 3C of Chapter 143 of the General Statutes.

(e) The expenses of mailing any notices and other materials required by this section shall be borne by the person filing the application.

(f) An applicant filing a limited application under this section shall submit with the application under subsection (b) of this section an application fee of two hundred fifty dollars ($250.00). An applicant filing a standard application under this section shall submit with the application under subsection (b) of this section an application fee of five hundred dollars ($500.00).

"**§ 58-10-290. Plan of reorganization.**

(a) A limited application plan of reorganization shall include the following provisions:
(1) Establishing a mutual insurance holding company with at least one stock insurance company subsidiary or one intermediary stock holding company with a stock insurance company subsidiary, the shares of which shall be held exclusively by the mutual insurance holding company.
(2) Protecting the interests of existing policyholders.
(3) Ensuring immediate membership in the mutual insurance holding company of all existing policyholders of the reorganizing domestic mutual insurance company.
(4) Describing a plan providing for membership interests of future policyholders.
(5) Describing the number of members of the board of directors of the mutual insurance holding company required to be policyholders.
(6) Demonstrating that, in the event of proceedings under Article 30 of this Chapter involving a stock insurance company subsidiary of the mutual insurance holding company which resulted from the reorganization of a domestic mutual insurance company, the assets of the mutual insurance holding company will be available to satisfy the policyholder obligations of the stock insurance company.

(7) Describing how any accumulation or prospective accumulation of earnings by the mutual insurance holding company in excess of that determined by the board of directors of the mutual insurance holding company to be necessary shall inure to the exclusive benefit of the policyholders of its insurance company subsidiaries who are members.

(8) Describing the nature and content of the annual report and financial statement to be sent to each member.

(9) Describing any other relevant matters the applicant deems appropriate.

(b) A standard application plan of reorganization shall include the following provisions:

(1) Establishing a mutual insurance holding company with at least one stock insurance company subsidiary or one wholly owned intermediate stock holding company with a stock insurance company subsidiary, the shares of which shall be held exclusively by the wholly owned intermediate holding company.

(2) Protecting the interests of existing policyholders.

(3) Ensuring immediate membership in the mutual insurance holding company of all existing policyholders of the reorganizing domestic mutual insurance company.

(4) Providing for membership interests of future policyholders.

(5) Describing the number of members of the board of directors of the mutual insurance holding company required to be policyholders.

(6) Demonstrating that, in the event of proceedings under Article 30 of this Chapter involving a stock insurance company subsidiary of the mutual insurance holding company which resulted from the reorganization of a domestic mutual insurance company, the assets of the mutual insurance holding company will be available to satisfy the policyholder obligations of the stock insurance company.

(7) Describing how any accumulation or prospective accumulation of earnings by the mutual insurance holding company in excess of that determined by the board of directors of the mutual insurance holding company to be necessary shall inure to the exclusive benefit of the policyholders of its insurance company subsidiaries who are members.

(8) Describing the nature and content of the annual report and financial statement to be sent to each member.

(9) Describing the applicant's plan for a stock offering in accordance with the provisions of G.S. 58-10-315.

(10) Describing any other relevant matters the applicant deems appropriate.

(c) With regard to either a limited or standard application, the plan of reorganization submitted to the Commissioner shall demonstrate the following:

(1) Policyholder interests are properly preserved and protected.

(2) The plan is fair and equitable to policyholders.

(3) The financial condition of the applicant will not be diminished.

"**§ 58-10-295. Powers of the Commissioner.**

(a) The Commissioner shall at all times retain jurisdiction over the mutual insurance holding company, its intermediate holding company subsidiaries with stock insurance company subsidiaries, and its stock insurance company subsidiaries.

(b) Following any public comment period or hearing pursuant to G.S. 58-10-285, the Commissioner by order shall approve, conditionally approve, or deny an application. The Commissioner may require, as a condition of approval of the proposed reorganization, modifications of the proposed plan of reorganization that the Commissioner finds necessary. The applicant shall accept the required modifications by filing appropriate amendments to the

proposed plan of reorganization with the Commissioner within 30 days of the date of the Commissioner's order requiring the modifications. If the applicant does not accept the required modifications by failing to file the required amendments to the proposed plan of reorganization within 30 days, the proposed reorganization shall be deemed denied.

(c) An approval or conditional approval of a plan of reorganization shall expire if the reorganization is not completed within 210 days after the approval or conditional approval unless the time period is extended by the Commissioner upon a showing of good cause.

(d) The Commissioner may revoke approval or conditional approval of an applicant's plan of reorganization in the event the Commissioner finds the applicant has failed to comply with the plan of reorganization. The Commissioner may compel completion of a plan of reorganization unless the plan is abandoned in its entirety, in accordance with the applicant's provisions for governance.

(e) Upon completion of all elements of a plan of reorganization, the applicant shall provide a notice of completion to the Commissioner.

"**§ 58-10-300. Special financial requirements.**

(a) Mutual insurance holding companies and their insurance company subsidiaries and affiliates shall comply with the provisions of Article 19 of this Chapter except as expressly provided in this Part. Mutual insurance holding companies' investments in subsidiaries, including intermediate holding companies, shall not be subject to any of the restrictions on investment activities set forth in G.S. 58-19-10.

(b) When a mutual insurance holding company acquires or plans to acquire more than fifty percent (50%) of a stock insurance company, the mutual insurance holding company shall submit to the Commissioner a plan describing any membership interests of policyholders.

(c) Each mutual insurance holding company shall supply to the Commissioner, by April 1 of each year, an annual statement consisting of the following:

(1) An income statement.
(2) A balance sheet.
(3) A cash flow statement.
(4) Complete information on the status of any closed block formed as a part of a plan of reorganization.
(5) An investment plan covering all assets.
(6) A statement disclosing any intention to pledge, borrow against, alienate, hypothecate, or in any way encumber the assets of the mutual insurance holding company.

(d) At least fifty percent (50%) of the net worth of the mutual insurance holding company, based upon generally accepted accounting practices, shall be invested in insurance company subsidiaries. The Commissioner may waive the fifty percent (50%) limitation upon a showing of good cause.

(e) No policyholder who is a member of a mutual insurance holding company shall receive on account of such membership interest any payment of a policy credit, dividend, or other distribution unless the payment has been approved by the Commissioner. The Commissioner, if satisfied the proposed payment is fair and equitable to policyholders who are members, may approve the proposed payment and may require as a condition of the approval modification of the proposed payment that the Commissioner finds necessary for the protection of the policyholders.

(f) Mutual insurance holding companies shall comply with Part 3 of this Article and shall be considered a domestic insurer for the purposes of compliance with Part 3.

"**§ 58-10-305. Reorganization of domestic mutual insurer with mutual insurance holding company.**

A domestic mutual insurance company may apply to reorganize by merging its policyholders' membership interests into a mutual insurance holding company by filing with the

Commissioner a joint application with the mutual insurance holding company complying with the provisions of G.S. 58-10-285.

"**§ 58-10-310. Mergers of mutual insurance holding companies.**

A mutual insurance holding company may apply to merge with another mutual insurance holding company by filing with the Commissioner a plan of merger and complying with the provisions of Article 19 of this Chapter.

"**§ 58-10-315. Stock offerings.**

(a) No stock offering by a mutual insurance holding company, an insurance company subsidiary of a mutual insurance holding company, an intermediate holding company subsidiary of a mutual insurance holding company, or an insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company shall occur without the prior approval of the Commissioner.

(b) Every application for approval of a stock offering shall contain the following information:

(1) A description of the stock intended to be offered by the applicant, including a description of all shareholder rights.

(2) The total number of shares authorized to be issued, the estimated number the applicant requests permission to offer, and the intended date or range of dates for the offer.

(3) A justification for a uniform planned offering price or a justification of the method by which the offering price will be determined.

(4) The name or names of any underwriter, syndicate member, or placement agent involved and, if known, the name or names of each entity, person, or group of persons to whom the stock offering is to be made who will control five percent (5%) of the total outstanding class of shares, and the manner in which the offer is to be tendered. If any such entity or person is a corporation or business organization, the name of each member of its board of directors or equivalent management team shall be provided along with the name of each member of the board of directors of the offeror. Copies of any filings with the United States Securities and Exchange Commission disclosing intended acquisitions of the stock shall be included in the application.

(5) A description of stock subscription rights to be afforded members of the mutual insurance holding company in conjunction with the stock offering.

(6) A detailed description of all expenses to be incurred in conjunction with the stock offering.

(7) An explanation of how funds raised by the stock offering are to be used.

(8) Any other information requested by the Commissioner.

(c) No application regarding a planned stock offering shall be approved unless the plan contains the following provisions:

(1) Prohibiting officers, directors, and insiders of the mutual insurance holding company and its subsidiaries and affiliates from purchase or ownership of shares of the stock offering, or issuance of stock options to or for the benefit of such officers, directors, and insiders, in excess of five percent (5%) of the stock offering. The Commissioner may waive this requirement upon a showing of good cause. This subdivision does not limit the rights of officers, directors, and insiders from exercising subscription rights that are generally accorded members of the mutual insurance holding company. However, pursuant to those subscription rights, the officers, directors, and insiders of the mutual insurance holding company and its subsidiaries and affiliates may not purchase or own, in the aggregate, more than five percent (5%) of the stock offering.

(2) Requiring that, after the initial stock offering, a majority of the board of directors of the mutual insurance holding company be persons who are not interested persons of the mutual insurance holding company or of an affiliated person of the company. For purposes of this subdivision, a member of the mutual insurance holding company or a policyholder of any of its insurance company subsidiaries shall not be considered an "interested person" or an "affiliated person." The Commissioner may waive this requirement upon a showing of good cause.

(3) For the mutual insurance holding company to adopt articles of incorporation prohibiting any waiver of dividends from stock subsidiaries except under conditions specified in its articles of incorporation and after approval of the waiver by the board of directors of the mutual insurance holding company and the Commissioner.

(4) Requiring that, after the initial stock offering by an insurance company subsidiary of a mutual insurance holding company, an intermediate holding company subsidiary of a mutual insurance holding company, or an insurance company subsidiary of an intermediate holding company subsidiary of a mutual insurance holding company, the boards of directors of each insurance company or intermediate holding company include at least three directors who are not interested persons of the mutual insurance holding company. The Commissioner may waive this requirement upon a showing of good cause.

(5) Establishing, within the board of directors of the corporation offering stock, a pricing committee consisting exclusively of directors who are not members of management of the insurance company subsidiary whose responsibility is to evaluate and approve the price of any stock offering.

(d) An insurance company subsidiary of a mutual insurance holding company, an intermediate holding company subsidiary of a mutual insurance holding company, or an insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company may issue more than one class of stock, provided, however, that the issuer complies with all of the following requirements:

(1) At all times a majority of the voting stock is held by the mutual insurance holding company or its subsidiary.

(2) No class of common stock may possess greater dividend or other rights than the class held by the mutual insurance holding company or its subsidiary.

(e) The Commissioner may retain, at the expense of the person filing the application, any attorneys, actuaries, economists, accountants, consultants, or other professional advisors not otherwise a part of the Commissioner's staff to assist the Commissioner in reviewing the application. These contracts are personal professional service contracts exempt from Articles 3 and 3C of Chapter 143 of the General Statutes.

(f) The expenses of mailing any notices and other materials required by this section shall be borne by the person filing the application.

(g) Upon receipt and review by the Commissioner of all information provided under this section, the Commissioner may establish a period during which the Department will receive and consider public comments about the proposed offering. The Commissioner shall inform the public of the offering by posting information about the application in a manner deemed appropriate by the Commissioner. The Commissioner may hold a public hearing concerning the application or the proposed offering. Following any public comment period or hearing, if applicable, the Commissioner may approve, conditionally approve, or deny the application. The Commissioner may approve the application if the following apply:

(1) The offering complies with this Part and other provisions of law.

(2) The method for establishing the price of a stock offering is consistent with generally accepted market or industry practices for establishing stock offering prices in similar transactions.

(3) The plan and offering will not unfairly impact the interests of members of the mutual insurance holding company.

Nothing in this subsection shall be deemed to prohibit the filing of a registration statement with the United States Securities and Exchange Commission before or concurrently with the giving of notice to members.

(h) Notwithstanding the provisions of subsections (a) through (g) of this section, stock offerings which are not an initial stock offering, and which are proposed by entities with a class of securities regularly traded on the New York Stock Exchange, the American Stock Exchange, or another exchange approved by the Commissioner, or designated on the National Association of Securities Dealers Automated Quotations national market system (NASDAQ), may be sold in accordance with the following procedure: if a mutual insurance holding company, an insurance company subsidiary of a mutual insurance holding company, an intermediate holding company, or an insurance company subsidiary of an intermediate holding company intends to make a stock offering which would be governed by the provisions of this subsection, that entity shall deliver to the Commissioner, not less than 60 days prior to the offering, a notice of the planned stock offering and all of the following information:

(1) The total number of shares intended to be offered.

(2) The intended date of sale.

(3) Evidence the stock is regularly traded on one of the public exchanges specified in this subsection.

(4) A record of the trading price and trading volume of the stock during the prior 52 weeks.

The Commissioner shall be deemed to have approved the sale unless, within 60 days following receipt of such notice, the Commissioner issues an objection to the sale. If the Commissioner issues an objection to the sale, the application process set forth in subsections (a) through (g) of this section shall be followed to determine whether the Commissioner approves of the proposed sale.

(i) Approval of a stock offering obtained under either subsection (g) or (h) of this section shall expire 120 days following the date of the approval or deemed approval, except as otherwise provided by order of the Commissioner.

(j) No prospectus, information, sales material, or sales presentation by the applicant, or by any representative, agent, or affiliate of the applicant, shall contain a representation that the Commissioner has endorsed the price, price range, or any other information relating to the stock.

(k) No company making a stock offering under this section shall engage in any of the following practices:

(1) Borrow funds from the mutual insurance holding company, or its subsidiaries and affiliates, to finance the purchase of any portion of a stock offering.

(2) Pay any commissions, "special fees," or any other special payments or extraordinary compensation to officers, directors, interested persons, and affiliates for arranging, promoting, aiding, or assisting in reorganization to a mutual insurance holding company or for arranging, promoting, aiding, assisting, or participating in the structuring and placement of a stock offering.

(3) Enter into an understanding or agreement transferring legal or beneficial ownership of stock to another person to avoid the requirements of this Part.

"**§ 58-10-320. Regulation of holding company system.**

(a) All material transactions, as that term is defined under Part 3 of this Article, between or among subsidiaries and affiliates of the mutual insurance holding company, must, after review and exercise of director duties by the directors of the mutual insurance holding company, be approved by a majority of the directors of the mutual insurance holding company as being fair and reasonable.

(b) If the Commissioner determines that activities within a mutual insurance holding company system have violated provisions of the General Statutes of North Carolina or the North Carolina Administrative Code or acted to circumvent requirements or prohibitions contained in the General Statutes or Administrative Code, the Commissioner may prohibit or order rescission of any transaction relating to those activities.

"**§ 58-10-325. Reporting of stock ownership and transactions.**

(a) Any director or officer of a mutual insurance holding company, its subsidiary, or affiliate, who acquires directly or indirectly the beneficial ownership of any security issued by any intermediate holding company or any insurance company subsidiary of an intermediate holding company or mutual insurance holding company shall, within 15 days following the transaction, file with the Commissioner a statement of the transaction on the form prescribed by the Commissioner.

(b) A mutual insurance holding company, and its subsidiaries and affiliates, shall file with the Commissioner, within 15 days of receipt, copies of Form 3, Form 4, and Schedule 13D, or any equivalent filings, such filings made under the federal Securities Exchange Act of 1934, as amended."

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

Legislative Fiscal Note

BILL NUMBER: Senate Bill 647 (Second Edition)

SHORT TITLE: Mutual Insurance Holding Companies.

SPONSOR(S): Senator Rucho

FISCAL IMPACT

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

	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16
REVENUES	***See Assumptions and Methodology***				
EXPENDITURES	***See Assumptions and Methodology***				
POSITIONS (cumulative):	***See Assumptions and Methodology***				

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Insurance

EFFECTIVE DATE: Effective when it becomes law

BILL SUMMARY:

Senate Bill 647 adds a new Part 8 to Article 10 of Chapter 58 of the General Statutes, entitled "*Mutual Insurance Holding Companies.*" Among its provisions, the bill creates the following new sections:

➢ ***G.S. 58-10-275. Definitions.***

The bill defines terms used in the act. Definitions include the following:

- "Domestic mutual insurance company" -- an insurance company organized on a mutual plan and incorporated under the laws of North Carolina.
- "Mutual insurance holding company" -- a holding company organized on a mutual plan and incorporated under the laws of North Carolina, resulting from the reorganization of a domestic mutual insurance company...with one or more stock insurance holding company subsidiaries or stock insurance company subsidiaries.
- "Limited application" -- an application for reorganization to a mutual insurance holding company which will hold one hundred percent of the stock of its insurance subsidiaries.

- "Standard application" -- an application for reorganization to a mutual insurance holding company which may sell interests in its subsidiaries to third parties.

➢ ***G.S. 58-10-280. General provisions.***

With the Commissioner's approval, the bill authorizes a domestic mutual insurance company to form an insurance holding company based upon a mutual plan and continue its corporate existence as a stock insurance company subsidiary of the holding company. The membership interest of the policyholders in the mutual company shall, subject to the Commissioner's approval, become membership interests in the mutual insurance holding company. The Commissioner may require modification of the plan as necessary to protect the policyholders' interests. The Commissioner also retains jurisdiction over the holding company. The holding company shall at all times own a majority of the voting shares of stock of the reorganized stock insurance company. The policyholders of the mutual company must approve the reorganization by a two-thirds majority of those voting. In any delinquency proceeding under Chapter 58, the assets of the holding company are deemed to be assets of the reorganized mutual insurance company.

➢ ***G.S. 58-10-285. Application; contents; process.***

A limited or standard application, including a plan of reorganization, must be filed with the Commissioner. The Commissioner receives and considers public comment and may hold a public hearing. Applicants must pay to the Commissioner a fee of $250 for each limited application and $500 for each standard application under this section.

➢ ***G.S. 58-10-290. Plan of reorganization.***

A limited or standard plan of reorganization submitted to the Commissioner must include provisions as outlined and must demonstrate the following:

- Policyholder interests are properly preserved and protected
- Plan is fair and equitable
- The financial condition of the applicant will not be diminished.

➢ ***G.S. 58-10-295. Powers of the Commissioner.***

The Commissioner retains jurisdiction over the mutual insurance holding company, intermediate holding company subsidiaries with stock insurance subsidiaries, and stock insurance subsidiaries. Approval of a plan of operation may be conditioned on modifications deemed necessary by the Commissioner. If modifications are not made within 30 days, the plan is deemed to be denied. If the reorganization is not completed within 210 days of approval or conditional approval by the Commissioner, the approval expires unless the time period is extended by the Commissioner. The Commissioner may revoke approval if the applicant fails to comply with the plan of reorganization.

➢ ***G.S. 58-10-300. Special financial requirements.***

A mutual insurance holding company is subject to the provisions of the Insurance Holding Company System Regulatory Act, Article 19 of Chapter 58, but is not subject to the restrictions on investment activities by domestic insurers as provided in G.S. 58-19-10 of the Act. (G.S. 58-19-10 regulates the investment activities of domestic insurers, not insurance holding companies.)

This section also requires a mutual insurance holding company to do the following:

- Upon acquisition or plan to acquire more than 50% of a stock insurance company, submit to the Commissioner of a plan describing the membership interests of policyholders.
- Invest at least 50% or more of its net worth in insurance company subsidiaries, unless waived by the Commissioner.
- File a report with the Commissioner disclosing all material transactions (acquisition and disposition of assets, nonrenewal and cancellation of reinsurance).

➢ ***G.S. 58-10-315. Stock offerings.***

The Commissioner must give prior approval of all stock offerings of a mutual insurance holding company, and its insurance company subsidiaries, intermediate holding company subsidiaries, and any insurance company subsidiaries of an intermediate holding company subsidiary of a mutual insurance holding company. Applications for approval of a stock offering must include a description of the stock, the total number of shares to be issued, justification for offering price, and a description of rights afforded members of the mutual insurance holding company.

Planned stock offerings must:

- Prohibit officers, directors and insiders of the holding company and its subsidiaries and affiliates from purchase or ownership of shares in excess of 5% of the offering.
- Require that after the offering a majority of the Board of directors be persons who are not interested persons of the holding company or of an affiliated person of the company as defined under the Article.
- Provide for the holding company to adopt articles of incorporation prohibiting waiver of dividends from stock subsidiaries except under specified circumstances.
- Require that after the initial stock offering the boards of directors of each insurance company or intermediate holding company include at least three members who are not interested persons of the holding company. (This may be waived by the Commissioner.)
- Establish within the board of the offering corporation a pricing committee consisting exclusively of directors who are not members of management of the insurance company subsidiary.

Insurance company subsidiaries and intermediate holding company subsidiaries may only issue more than one class of stock if the mutual holding company retains at all times a majority of the voting stock and no class of common stock possesses a greater dividend or other rights than the mutual holding company's class of stock.

The Commissioner may establish a period for public comment on the proposed offering and may hold a public hearing. The offering may be approved if it: (1) complies with this Part; (2) the price is established by generally accepted market or industry practices; (3) the plan and offering will not unfairly impact the interests of mutual insurance holding company's members.

Approval of a stock offering under this section expires 120 days following approval, unless the Commissioner orders otherwise.

- ***G.S. 58-10-320. Regulation of holding company system.***

All material transactions (acquisition and disposition of assets, nonrenewal and cancellation of reinsurance) between or among subsidiaries and affiliates of a mutual insurance holding company must be approved by a majority of the board of directors of the mutual holding company. Also, if the Commissioner determines that a mutual holding company's activities have violated the General Statutes or the Administrative Code, the Commissioner may prohibit or order rescission of the transaction.

- ***G.S. 58-10-325. Reporting of stock ownership and transactions.***

Directors and officers of a mutual insurance holding company or its subsidiaries or affiliates who acquire beneficial ownership of any security issued by any intermediate holding company or any insurance company subsidiary must file a statement with the Commissioner within 15 days of the transaction.

Source: Research Division (June 8, 2011)

ASSUMPTIONS AND METHODOLOGY:

Revenue

With the Commissioner's approval, Senate Bill 647 authorizes a domestic mutual insurance company to form an insurance holding company based upon a mutual plan and continue its corporate existence as a stock insurance company subsidiary of the holding company. Also, Senate Bill 647 requires applicants seeking to form an insurance holding company to pay the Commissioner a fee of $250 for each limited application and $500 for each standard application under this section.

DOI reports that there are approximately 33 mutual insurance companies. Each of these companies could decide to submit an application. If these companies were to submit an application, DOI reports that it is uncertain as to whether these companies would choose the limited or standard application. The Department of Insurance (DOI) is not able to estimate the number or type of applications that it would receive under this bill.

Fiscal Research is not able to estimate the number of applications that would be filed under this bill or the revenue that would be generated. With that said—if the 33 mutual insurance companies were to submit a limited application, then $8,250 of revenue would be generated. If the 33 companies were to submit a standard limited application, then $16,500 of revenue would be generated. Within this scenario, Fiscal Research anticipates that the revenue generated from this bill could range from $0 to $16,550.

Any revenue that is generated from Senate Bill 647 would be deposited into the General Fund.

Expenditures

Senate Bill 647 allows DOI to hire experts to review the application or to review stock offerings. Because this expense would be billed to the applicable companies, Fiscal Research estimates that the reviews of applications or stock offering would have no fiscal impact on DOI or the State.

Under Senate Bill 647, DOI would also have to conduct a review of the financial condition of the mutual holding company's financial statements that would be filed annually as well as any transactions and filings that would have to be submitted pursuant to Article 19. DOI estimates that it would not be able to absorb the additional workload required by these reviews and would need an additional position.

Fiscal Research is not able to concur with DOI's assessment. Fiscal Research is not able to estimate the number of applications—and how many of these applications will be limited or standard—that DOI would receive under this bill. Therefore, it is not possible to determine whether or not DOI would require additional resources to administer this bill.

SOURCES OF DATA: Department of Insurance

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Tazra Mitchell

APPROVED BY: Lynn Muchmore, Director
Fiscal Research Division

DATE: June 8, 2011



Signed Copy Located in the NCGA Principal Clerk's Offices

MINUTES

HOUSE COMMITTEE ON INSURANCE

June 19, 2012

The House Committee on Insurance met in Room 1228 of the Legislative Building on June 19, 2012, at 1:00 pm. The following members were present: Representatives Dockham, Chair, Blust, Brown, Bryant, Burr, Collins, Floyd, Graham, Hamilton, Hurley, Insko, Jackson, McElraft, McGuirt, Mills, Murry, Pierce, Shepard, Stevens, Warren, Wilkins, and Wray. Tim Hovis, Kory Goldsmith, Amy Jo Johnson, and Bill Patterson, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes. (Attachment I)

Representative Dockham, Chair, called the meeting to order at 1:00 pm. He introduced the pages and the Sergeant of Arms staff. (Attachment II) The following bills were considered:

HB 1044, entitled, AN ACT TO ALLOW MEMBERS OF THE MILITARY WHO HAVE TAKEN A COMPARABLE MOTORCYCLE SAFETY PROGRAM PROVIDED BY FEDERALLY CERTIFIED INSTRUCTORS TO RECEIVE THE SAME MOTORCYCLE INSURANCE DISCOUNT AS CITIZENS WHO COMPLETE THE MOTORCYCLE SAFETY INSTRUCTION PROGRAM, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON MILITARY AFFAIRS. A Proposed Committee Substitute bill was presented. (Attachment III) Representative Brown moved to adopt the PCS for consideration. The motion passed. The PCS corrects language in the effective date. The Chair recognized Representative Sheppard, bill sponsor, to explain the bill. House Bill 1044 would allow insurers to charge a reduced motorcycle insurance rate for members of the military who have successfully completed a motorcycle safety program taught by a federally certified instructor that is comparable to the programs currently offered by the community colleges. Representative Floyd moved for a favorable report as to the committee substitute bill, unfavorable as to the original bill. The motion passed.

SB 836, entitled, A BILL TO BE ENTITLED AN ACT TO IMPROVE THE RATE-MAKING PROCESS BY REQUIRING THE DEPARTMENT OF INSURANCE TO ACCEPT PUBLIC COMMENT ON ALL PROPERTY INSURANCE RATE FILINGS, BY PROVIDING THE COMMISSIONER WITH THE POWER TO SPECIFY THE APPROPRIATE RATE LEVEL OR LEVELS BETWEEN THE CURRENT RATE AND THE FILED RATE UPON A FINDING THAT A RATE FILING DOES NOT COMPLY WITH APPLICABLE LAW, BY PROVIDING THAT THE COST OF REINSURANCE BE INCLUDED AS A FACTOR IN RATE MAKING AND REQUIRING CERTAIN SUPPORTING INFORMATION ON

REINSURANCE COSTS IN A FILING, BY REQUIRING THAT THE RATE BUREAU CREATE A RATING PLAN FOR A PROPERTY INSURANCE POLICY THAT EXCLUDES COVERAGE FOR THE PERILS OF WINDSTORM AND HAIL, AND BY REQUIRING THAT THE RATE BUREAU AND THE DEPARMENT OF INSURANCE STUDY THE FAIRNESS AND EFFICACY OF THE CURRENT PROPERTY INSURANCE GEOGRAPHIC RATE TERRITORIES, AS RECOMMENDED BY THE LEGISLATIVE RESEARCH COMMISSION'S COMMITTEE ON PROPERTY INSURANCE RATE MAKING. The Chair recognized Senator Brown, bill sponsor, to explain the bill. (Attachment IV) Senate Bill 836 requires all property insurance rate filings to be open to the public and requires the Department to receive public comments regarding the filing. It gives the Commissioner the authority to specify a rate between the existing rate and the rate proposed by the Bureau; provides that rates *may* reflect the cost of reinsurance purchased by insurers to protect against catastrophic exposure within the State. Expected reinsurance recoveries and NC exposure to catastrophic events relative to other states' exposure are among the factors that may be considered. The bill directs the Bureau to develop a policy for residential property insurance coverage without wind and hail coverage, and directs the rate Bureau and the Department to study current geographic territories established by the Bureau and report to the 2013 General Assembly. Representative Stevens moved for a favorable report. The motion passed.

There being no further business, the chair adjourned the meeting at 1:10 pm.

Respectfully submitted,

Jerry C. Dockham

Representative Jerry C. Dockham, Chair

Regina Irwin

Regina Irwin, Committee Assistant

Attachments

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2011-2012 SESSION

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

DAY & DATE: Tuesday, June 19, 2012

TIME: 1:00 pm

LOCATION: 1228/1327 LB

COMMENTS:

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 1044	Motorcycle Insurance Discount/Military.	Representative Shepard Representative Cook
SB 836	Improve Property Insurance Rate Making.	Senator Brown

Respectfully,

Representative Dockham, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **4 PM** o'clock on June **13, 2011**.

☐ Principal Clerk
☐ Reading Clerk – House Chamber

Regina Irwin (Committee Assistant)

AGENDA

HOUSE COMMITTEE ON INSURANCE

June 19, 2012

Room 1228/1327

1:00 pm

OPENING REMARKS

Representative Jerry C. Dockham, Chairman
Insurance Committee

AGENDA ITEMS

HB 1044 **MOTORCYCLE INSURANCE DISCOUNT/MILITARY.**
Representative Phillip Shepard, Sponsor
Representative Bill Cook, Sponsor

SB 836 **IMPROVE PROPERTY INSURANCE RATE MAKING.**
Senator Harry Brown

ADJOURNMENT

ATTACHMENT I

VISITOR REGISTRATION SHEET

INSURANCE — June 19, 2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bill Trott	Young Moore
RAY EVANS	NORTH CAROLINA RATE BUREAU
Ted Bore	Bore & Asso.
Tom Thompson	NC-20
Willo Kelly	NC-20
Grant Logan	NMRs
Steve Woodson	NLFB
Bryan Heekle	NCDOI
Fred Fuller	NCDOI
Bob Mack	↓
Rose Williams	

VISITOR REGISTRATION SHEET

INSURANCE — June 19, 2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Elise Quick	Troutman Sanders
Daniel Baum	Troutman Sanders
John Tucker	Moore & Van Allen
Patrick Hannan	Liberty Mutual
Ira Piercy	Pagedale Liggett
Harry Kyle	NUC
Dave Hare	Staff
Hannah Rice	N/A constituent
Ionapearl Reid-Eaton	N/A constituent
David McKeown	NCAR
Tyler Newman	BASF

VISITOR REGISTRATION SHEET

INSURANCE — June 19, 2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Conoley	BBCC
KATY EISENBERG	MWC
Ashleigh Thornton	MWC
Bo Heath	MWC
J Bode	BCS
Michelle Frazier	MFTS
John McMillan	MFTS
Kathleen Kirby	URAN
Robert Pasahal	Young Moore
Susan Valauri	NW
Tim Lucas	NC Rate Bureau

PLEASE PRINT

ATTACHMENT II

HOUSE PAGES

NAME OF COMMITTEE: INSURANCE DATE: June 19, 2012

1. NAME: Jackson Kaplan
County: Wake
Sponsor: Tillis

2. NAME: Alexandra Warren
County: Rowan
Sponsor: Folwell

3. NAME: Michael Bean
County: Wake
Sponsor: Dollar

4. NAME: Olivia Knox
County: Mecklenburg
Sponsor: Tillis

5. NAME: Megan Rader
County: Alexander
Sponsor: Hollo

SERGEANTS-AT-ARMS

1. Name: Wayne Davis
2. Name:
3. Name: Martha Pancik
4. Name:
5: Name:

2012 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

By Representative Dockham (Chair) for the Committee on INSURANCE.

☐ Committee Substitute for

HB 1044 A BILL TO BE ENTITLED AN ACT TO ALLOW MEMBERS OF THE MILITARY WHO HAVE TAKEN A COMPARABLE MOTORCYCLE SAFETY PROGRAM PROVIDED BY FEDERALLY CERTIFIED INSTRUCTORS TO RECEIVE THE SAME MOTORCYCLE INSURANCE DISCOUNT AS CITIZENS WHO COMPLETE THE MOTORCYCLE SAFETY INSTRUCTION PROGRAM, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON MILITARY AFFAIRS.

☒ 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.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 1044
PROPOSED COMMITTEE SUBSTITUTE H1044-PCS80395-RC-67

Short Title: Motorcycle Insurance Discount/Military. (Public)

Sponsors:

Referred to:

May 23, 2012

A BILL TO BE ENTITLED

AN ACT TO ALLOW MEMBERS OF THE MILITARY WHO HAVE TAKEN A COMPARABLE MOTORCYCLE SAFETY PROGRAM PROVIDED BY FEDERALLY CERTIFIED INSTRUCTORS TO RECEIVE THE SAME MOTORCYCLE INSURANCE DISCOUNT AS CITIZENS WHO COMPLETE THE MOTORCYCLE SAFETY INSTRUCTION PROGRAM, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON MILITARY AFFAIRS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-36-65(m) reads as rewritten:

"(m) Notwithstanding any other provision of law, with respect to motorcycle insurance under the jurisdiction of the Bureau, any member of the Bureau may apply for and use in this State, subject to the Commissioner's approval, a downward deviation in the rates of insureds who show proof of satisfactory completion of the Motorcycle Safety Instruction ~~Program.~~ Program or a comparable motorcycle safety program provided by federally certified instructors for members of the military."

SECTION 2. This act becomes effective October 1, 2012, and applies to policies issued or renewed on or after that date.

HOUSE BILL 1044:
Motorcycle Insurance Discount/Military

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	June 18, 2012
Introduced by:	Reps. Shepard, Cook	**Prepared by:**	Kory Goldsmith Committee Counsel
Analysis of:	PCS to First Edition H1044-CSRC-67		

SUMMARY: ***House Bill 1044 would allow insurers to charge a reduced motorcycle insurance rate for members of the military who have successfully completed a motorcycle safety program taught by a federally certified instructor that is comparable to the programs currently offered by the community colleges.***

The PCS corrects language in the effective date.

CURRENT LAW: G.S. 58-36-65 directs the North Carolina Rate Bureau ("Bureau) to file with the Commissioner of Insurance ("Commissioner") a Safe Driver Incentive Plan which allows for downward deviations in rates for safe driving records and surcharges for driving records with at-fault accidents and moving traffic violations. Subsection (m) allows an insurer to apply for and, subject to approval by the Commissioner, use a downward deviation in motorcycle insurance rates for individuals who have successfully completed the Motorcycle Safety Instruction Program offered by a community college.

BILL ANALYSIS: The bill would allow a similar downward deviation in motorcycle insurance rates for members of the military who have taken and passed a motorcycle safety program that is comparable to the program offered by the community colleges and that is taught by a federally certified instructor. No insurer, under current law or under the proposed change, is required to provide the discount.

EFFECTIVE DATE: The act becomes effective October 1, 2012, and would apply to policies issued or renewed on or after that date.

BACKGROUND: House Bill 1044 came as a recommendation of the House Select Committee on Military Affairs. The Committee found that the statutory motorcycle insurance discount allowed for individuals who complete a motorcycle safety program through the community college system does not apply to military service members who complete a motorcycle safety course through the federal government.

H1044-SMRC-72(CSRC-67) v1

HOUSE BILL 1044

Short Title:	Motorcycle Insurance Discount/Military.	(Public)
Sponsors:	Representatives Shepard and Cook (Primary Sponsors). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Insurance.	

May 23, 2012

A BILL TO BE ENTITLED

AN ACT TO ALLOW MEMBERS OF THE MILITARY WHO HAVE TAKEN A COMPARABLE MOTORCYCLE SAFETY PROGRAM PROVIDED BY FEDERALLY CERTIFIED INSTRUCTORS TO RECEIVE THE SAME MOTORCYCLE INSURANCE DISCOUNT AS CITIZENS WHO COMPLETE THE MOTORCYCLE SAFETY INSTRUCTION PROGRAM, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON MILITARY AFFAIRS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-36-65(m) reads as rewritten:

"(m) Notwithstanding any other provision of law, with respect to motorcycle insurance under the jurisdiction of the Bureau, any member of the Bureau may apply for and use in this State, subject to the Commissioner's approval, a downward deviation in the rates of insureds who show proof of satisfactory completion of the Motorcycle Safety Instruction ~~Program.~~ Program or a comparable motorcycle safety program provided by federally certified instructors for members of the military."

SECTION 2. This act becomes effective October 1, 2012, and applies to policies in force on or after that date.

2012 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☒Committee Substitute for
SB 836 A BILL TO BE ENTITLED AN ACT TO IMPROVE THE RATE-MAKING PROCESS BY REQUIRING THE DEPARTMENT OF INSURANCE TO ACCEPT PUBLIC COMMENT ON ALL PROPERTY INSURANCE RATE FILINGS, BY PROVIDING THE COMMISSIONER WITH THE POWER TO SPECIFY THE APPROPRIATE RATE LEVEL OR LEVELS BETWEEN THE CURRENT RATE AND THE FILED RATE UPON A FINDING THAT A RATE FILING DOES NOT COMPLY WITH APPLICABLE LAW, BY PROVIDING THAT THE COST OF REINSURANCE BE INCLUDED AS A FACTOR IN RATE MAKING AND REQUIRING CERTAIN SUPPORTING INFORMATION ON REINSURANCE COSTS IN A FILING, BY REQUIRING THAT THE RATE BUREAU CREATE A RATING PLAN FOR A PROPERTY INSURANCE POLICY THAT EXCLUDES COVERAGE FOR THE PERILS OF WINDSTORM AND HAIL, AND BY REQUIRING THAT THE RATE BUREAU AND THE DEPARTMENT OF INSURANCE STUDY THE FAIRNESS AND EFFICACY OF THE CURRENT PROPERTY INSURANCE GEOGRAPHIC RATE TERRITORIES, AS RECOMMENDED BY THE LEGISLATIVE RESEARCH COMMISSION'S COMMITTEE ON PROPERTY INSURANCE RATE MAKING.

☒ 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 _____.

ATTACHMENT IV

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S 3

SENATE BILL 836
Insurance Committee Substitute Adopted 6/6/12
Third Edition Engrossed 6/11/12

Short Title: Improve Property Insurance Rate Making. (Public)

Sponsors:

Referred to:

May 22, 2012

A BILL TO BE ENTITLED

AN ACT TO IMPROVE THE RATE-MAKING PROCESS BY REQUIRING THE DEPARTMENT OF INSURANCE TO ACCEPT PUBLIC COMMENT ON ALL PROPERTY INSURANCE RATE FILINGS, BY PROVIDING THE COMMISSIONER WITH THE POWER TO SPECIFY THE APPROPRIATE RATE LEVEL OR LEVELS BETWEEN THE CURRENT RATE AND THE FILED RATE UPON A FINDING THAT A RATE FILING DOES NOT COMPLY WITH APPLICABLE LAW, BY PROVIDING THAT THE COST OF REINSURANCE BE INCLUDED AS A FACTOR IN RATE MAKING AND REQUIRING CERTAIN SUPPORTING INFORMATION ON REINSURANCE COSTS IN A FILING, BY REQUIRING THAT THE RATE BUREAU CREATE A RATING PLAN FOR A PROPERTY INSURANCE POLICY THAT EXCLUDES COVERAGE FOR THE PERILS OF WINDSTORM AND HAIL, AND BY REQUIRING THAT THE RATE BUREAU AND THE DEPARMENT OF INSURANCE STUDY THE FAIRNESS AND EFFICACY OF THE CURRENT PROPERTY INSURANCE GEOGRAPHIC RATE TERRITORIES, AS RECOMMENDED BY THE LEGISLATIVE RESEARCH COMMISSION'S COMMITTEE ON PROPERTY INSURANCE RATE MAKING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-36-15(b) reads as rewritten:

"(b) A filing by the Rate Bureau shall be open to public inspection immediately upon submission to the Commissioner. All property insurance rate filings shall be open to the public except as provided in this Article where necessary to maintain the confidentiality of certain testimony. At least 30 days before a notice of hearing issues, the Department shall receive comments from the public regarding a property insurance rate filing. The comments may be provided to the Department by e-mail, mail, or in person at a time and place set by the Department. All public comments shall be shared with the Rate Bureau in a timely manner."

SECTION 2. 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. Once begun, hearings must proceed without undue delay. At the hearing the burden of proving that the proposed rates are not excessive, inadequate, or unfairly discriminatory is on the Bureau. 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. In the event the Commissioner finds that the proposed rates are excessive, the Commissioner shall specify the overall rates, between the existing rates and the rates proposed by the Bureau filing, that may be used by the members of the Bureau instead of the rates proposed by the Bureau filing. In any such order, the Commissioner shall make findings of fact based on the evidence presented in the filing and at the hearing. Any order issued after a hearing shall be issued within 45 days after the completion of the hearing. If no order is issued within 45 days after the completion of the hearing, the filing shall be deemed to be approved."

SECTION 3. G.S. 58-36-10 is amended by adding a new subdivision to read:

"(7) Property insurance rates established under this Article may include a provision to reflect the cost of reinsurance to protect against catastrophic exposure within this State. Amounts to be paid to reinsurers, ceding commissions paid or to be paid to insurers by reinsurers, expected reinsurance recoveries, North Carolina exposure to catastrophic events relative to other states' exposure, and any other relevant information may be considered when determining the provision to reflect the cost of reinsurance."

SECTION 4. Article 36 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-36-42. Development of policy form or endorsement for residential property insurance that does not include coverage for perils of windstorm or hail.**

With respect to residential property insurance under its jurisdiction, the Bureau shall develop an optional policy form or endorsement to be filed with the Commissioner for approval that provides residential property insurance coverage without coverage for the perils of windstorm or hail. Insurers that sell such policies shall comply with the provisions of G.S. 58-44-60 and through such compliance shall be deemed to have given notice to all insured and persons claiming benefits under such policies that such policies do not include coverage for the perils of windstorm or hail."

SECTION 5. G.S. 58-44-60 reads as rewritten:

"**§ 58-44-60. Notice to property insurance policyholder about flood, earthquake, mudslide, mudflow, ~~and landslide~~landslide, and windstorm or hail insurance coverage.**

(a) Every insurer that sells residential or commercial property insurance policies that do not provide coverage for the perils of flood, earthquake, mudslide, mudflow, ~~or landslide~~ landslide, or windstorm or hail shall, upon the issuance and renewal of each policy, identify to the policyholder which of these perils are not covered under the policy. The insurer shall print the following warning, citing which peril is not covered, in Times New Roman 16-point font or other equivalent font and include it in the policy on a separate page immediately before the declarations page:

"WARNING: THIS PROPERTY INSURANCE POLICY DOES NOT PROTECT YOU AGAINST LOSSES FROM [FLOODS], [EARTHQUAKES], [MUDSLIDES], [MUDFLOWS], ~~[LANDSLIDES].~~ [LANDSLIDES], [WINDSTORM OR HAIL]. YOU SHOULD CONTACT YOUR INSURANCE COMPANY OR AGENT TO DISCUSS YOUR OPTIONS FOR OBTAINING COVERAGE FOR THESE LOSSES. THIS IS NOT A COMPLETE LISTING OF ALL OF THE CAUSES OF LOSSES NOT COVERED UNDER YOUR POLICY. YOU SHOULD READ YOUR ENTIRE POLICY TO UNDERSTAND WHAT IS COVERED AND WHAT IS NOT COVERED."

(b) As used in this section, "insurer" includes an entity that sells property insurance under Articles 21, 45, or 46 of this Chapter."

SECTION 6. The North Carolina Rate Bureau, with the assistance of the Department of Insurance, shall study the current geographic territories established by the Bureau for rating purposes. The study shall address the following issues:

(1) Whether risks of the same class and essentially the same hazard are charged premiums that are commensurate with the risk of loss, actuarially correct, and not unfairly discriminatory.

(2) Whether geographic territories in the beach and coastal areas (as defined in G.S. 58-45-5) currently meet the standards and mandates set forth in G.S. 58-36-10(6).

(3) Whether current technology and statistical data sources make possible any practical and cost-effective alternative to the geographic territory system for property insurance rate setting.

The Bureau shall submit a final report, including any recommendations for changes to the geographic territories or alternatives to the geographic territory rating system, to the 2013 General Assembly.

SECTION 7. Sections 4 and 5 of this act become effective December 1, 2012. Sections 6 and 7 of this act are effective when this act becomes law. The remainder of this act becomes effective July 1, 2012.

SENATE BILL 836:
Improve Property Insurance Rate Making

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	June 18, 2012
Introduced by:	Sen. Brown	**Prepared by:**	Tim Hovis
Analysis of:	Third Edition		Committee Counsel

SUMMARY: ***Senate Bill 836 makes changes to the property insurance rate making process. The bill's provisions are based upon recommendations of the LRC Committee on Property Insurance Rate Making.***

[As introduced, this bill was identical to H1053, as introduced by Rep. Dockham, which is currently in House Insurance.]

BACKGROUND: Article 36 of Chapter 58 requires the N.C. Rate Bureau to file jointly for all insurers the proposed rates and rating plans for insurance against loss to residential real property. Within 50 days of the filing, the Commissioner may give written notice to the Bureau specifying in what respect the Commissioner believes the filing fails to comply with the Article and fixing a date for a hearing. If no notice of hearing is issued by the Commissioner within 50 days, the rate is deemed to be approved. If notice is given, the hearing must be held not less than 30 days from the date of the notice. The burden of proving that the rate meets the necessary standard of not being "excessive, inadequate, or unfairly discriminatory" is on the Rate Bureau. When deciding upon a rate, due consideration must be given to a number of factors, including actual and prospective loss and expense experience within the State, the hazards of catastrophe, and a reasonable margin for underwriting profit.

BILL ANALYSIS: **Section 1** would require that all property insurance rate filings be open to the public. This section also requires the Department to receive public comments regarding the filing at least thirty days before a notice of hearing is issued by the Commissioner.

There is currently no statutory requirement for a public comment period.

Section 2 of the bill would give to the Commissioner, upon a finding that the proposed rate in a filing is excessive, the authority to specify a rate between the existing rate and the rate proposed by the Bureau.

Under current law, the Commissioner may only accept or reject the rate submitted by the Bureau and lacks the authority to set a rate between the current rate and the proposed rate.

Section 3 provides that property insurance rates may reflect the cost of reinsurance purchased by insurers to protect against catastrophic exposure within the State. This section provides that expected reinsurance recoveries and NC exposure to catastrophic events relative to other states' exposure, as well as amounts paid to reinsurers, may be considered when determining the provision to reflect the cost of reinsurance.

Sections 4 of the bill directs the Bureau to develop a policy for residential property insurance coverage without coverage for the perils of windstorm and hail. **Section 5** requires notice to policyholders that windstorm and hail coverage is not included in these policies.

Some homeowners in beach and coastal areas of the State have indicated a willingness to personally assume the risk of loss due to wind and hail in hopes of being able to afford coverage insuring them against other risks.

Section 6 directs the Rate Bureau, with the assistance of the Department, to study current geographic territories established by the Bureau for rating purposes to ensure that risks of the same class and hazard

are charged actuarially correct premiums commensurate with the risk of loss. The Bureau is also directed to look at alternatives to the current territorial system. The Bureau is directed to report to the 2013 General Assembly.

EFFECTIVE DATE: Sections 4 and 5 of Senate Bill 836 become effective December 1, 2012. Section 6 and 7 are effective when the bill becomes law. The remainder of the bill becomes effective July 1, 2012.

S836-SMRG-55(e3) v2

MINUTES

HOUSE COMMITTEE ON INSURANCE

June 26, 2012

The House Committee on Insurance met in Room 1228 of the Legislative Building on June 26, 2012, at 1:00 pm. The following members were present: Representatives Dockham, Chair, Blust, Brown, Bryant, Collins, Current, Floyd, Folwell, Graham, Hamilton, Howard, Hurley, Insko, Jackson, McElraft, McGuirt, Murry, Pierce, Shepard, Steen, Stevens, Warren, Wilkins, and Wray. Tim Hovis, Amy Jo Johnson, and David Vanderweide, Staff Counsels, were in attendance. A Visitor Registration list is attached and made part of these minutes. (Attachment I)

Representative Dockham, Chair, called the meeting to order at 1:00 pm. He introduced the pages and the Sergeant of Arms staff. (Attachment II) The following bills were considered:

SB 738, entitled, A BILL TO BE ENTITLED AN ACT TO REQUIRE THAT A PERSON THAT HOLDS CERTAIN ALCOHOLIC BEVERAGE CONTROL PERMITS HAVE AT LEAST ONE MILLION DOLLARS IN LIABILITY INSURANCE. The Chair informed the committee that Senate Bill 738 received a favorable report on June 14, 2011, however was not reported out. Representative Dockham thanked Senator Goolsby for allowing his bill to be used as a vehicle for a Proposed House Committee Substitute bill. Representative Steen moved to reconsider the vote by which SB 738 received a favorable report. The motion passed. The Chair presented a Proposed House Committee Substitute bill. (Attachment III) Representative Blust moved to adopt the PCS for consideration. The motion passed. The Chair recognized Mr. Tim Hovis, Staff Counsel, to explain the Proposed House Committee Substitute bill. The PCS for Senate Bill 738 provides that the North Carolina Bail Agents Association shall provide pre-licensing education and continuing education for bail bondsmen and runners. Courses and course instructors will continue to be approved by the Commissioners, as required under current law. (Attachment IV) Mr. Mark Black, Attorney at Law P.C., NC Bail Agents Association and Ms. Rose Vaughn Williams, Legislative Counsel, NC Department of Insurance, spoke in support of the Proposed House Committee Substitute bill. After some discussion Representative Wray moved for a favorable report as to House committee substitute bill, which changes the title, unfavorable as to Senate committee substitute bill. The motion passed.

HB 244, entitled, AN ACT TO AUTHORIZE STERLING MONTESSORI ACADEMY AND CHARTER SCHOOL, THE CASA ESPERANZA MONTESSORI CHARTER SCHOOL, AND KESTREL HEIGHTS SCHOOL TO ELECT TO PARTICIPATE IN THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES AND TO PROVIDE PROTECTIONS FOR WHISTLE-BLOWERS ALLEGING FRAUD OR OTHER MISCONDUCT RELATED TO THE STATE HEALTH PLAN. The Chair recognized Ms. Amy Jo Johnson, Staff Counsel, to explain the Senate Committee Substitute bill. (Attachment V) House Bill 244 would authorize, notwithstanding the time limitation in G.S. 135-45.5, the Boards of Directors of Sterling Montessori Charter School, Casa Esperanza Montessori Charter School, and the Kestral Heights School to elect to become participating employing units in the State Health Plan. The Senate Committee Substitute bill would

encourage individuals to report wrongdoings involving the State Health Plan, prohibit retaliation against reporting persons, and provide those persons with a cause of action should retaliation occur. Mr. David Vanderweide was available to answer questions regarding the fiscal impact on the State Health Plan. (Attachment VI) After some discussion Representative Floyd recommended that the House do not concur. The motion passed.

There being no further business, the chair adjourned the meeting at 1:30 pm.

Respectfully submitted,

Jerry C. Dockham

Representative Jerry C. Dockham, Chair

Regina Irwin

Regina Irwin, Committee Assistant

Attachments

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2011-2012 SESSION

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

DAY & DATE: Tuesday, June 26, 2012

TIME: 1:00 pm

LOCATION: 1228/1327 LB

COMMENTS: Added HB 244

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 244	State Health Plan/Add Schools; Whistleblowers.	Representative Murry
SB 738	Liability Insurance Required for ABC Permits.	Senator Goolsby

Respectfully,

Representative Dockham, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **11 AM** o'clock on **June 26, 2011**.

☐ Principal Clerk
☐ Reading Clerk – House Chamber

Regina Irwin (Committee Assistant)

AGENDA

HOUSE COMMITTEE ON INSURANCE

June 26, 2012

Room 1228/1327

1:00 pm

OPENING REMARKS

Representative Jerry C. Dockham, Chairman
Insurance Committee

AGENDA ITEMS

HB 244 STATE HEALTH PLAN/ADD SCHOOLS; WHISTLEBLOWERS.
Representative Tom Murry, Sponsor

SB 738 LIABILITY INSURANCE REQUIRED FOR ABC PERMITS.
Senator Thom Goolsby, Sponsor

ADJOURNMENT

ATTACHMENT I

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

June 26, 2012 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chuck Stone	SEANC
Michelle Frazier	MFTS
Katherine Joyce	NCASA
[illegible]	BMCE
Amy Whited	NCMS
Ed [illegible]	Brooks Pierce
DAVID RECE	MFS
Lori Ann Harris	LHHA

VISITOR REGISTRATION SHEET

INSURANCE — June 26, 2012

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mark Jarrett	RAHC
Sarah Wolfe	McGuire Woods
Chris Valauri	Valauri Group, LLC
Rose Williams	NCDOI
Angela Forzel	NCDOI
[illegible]	VMRS
Susan Valauri	NW
Mark Black	NCBAA
Doug Dozier	NCBAA
Mike Mann	NCBAA
Melissa Seiler	NCBAA

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

June 26, 2012 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chip Baggett	NCMS
Matt Meinig	NCLM
Graham Dean	NCLM
Jessica Hall	NMSS
Abby Emanuelson	NMSS
Whitney Christenson	NCRLA
T. Jerry Williams	MISC.
Susanna Hailey	K&L Gates
Penny Griffin	School Bd.
W H Potter Jr	NCDOS & NCPTA
HUGH TILSON	NCHA
Barbara Canada	BBC&C

VISITOR REGISTRATION SHEET

INSURANCE
Name of Committee

June 26, 2012
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Leslie Holley	The Longmire Group
Matt Howell	NCSBA
ZEB ALLEY	NMRS
Oliver Fleming	Rep. Brubakers Intern
Paul Meyer	NCLM

ATTACHMENT II

House Committee Pages / Sergeants at Arms

NAME OF COMMITTEE INSURANCE

DATE: 6-26-12 Room: 1228

*Name: OWEN LEVY ✓

County: GASTON

Sponsor: WEST

*Name: SAMUEL JONES ✓

County: GUILFORD

Sponsor: INGLE

*Name: MARY LEVINER LAVINER

ounty: RICHMOND

Sponsor: TILLIS

*Name: ASHLEY HINES ✓

County: RICHMOND

Sponsor: TILLIS

*Name: DERRICK McNEILL ✓

County: MOORE

Sponsor: TILLIS

House Sgt-At Arms:

✓

1. Name: LARRY ELLIOTT
2. Name: JOE CROOK ✓
3. Name: BILL BASS ✓
4. Name:
5. Name:
6. Name:

2012 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

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

☒ Committee Substitute for
SB 738 A BILL TO BE ENTITLED AN ACT TO REQUIRE THAT A PERSON THAT HOLDS CERTAIN ALCOHOLIC BEVERAGE CONTROL PERMITS HAVE AT LEAST ONE MILLION DOLLARS IN LIABILITY INSURANCE.

☒ With a favorable report as to House committee substitute bill, which changes the title, unfavorable as to Senate committee substitute 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.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S D

SENATE BILL 738
Insurance Committee Substitute Adopted 6/7/11
Third Edition Engrossed 6/8/11
PROPOSED HOUSE COMMITTEE SUBSTITUTE S738-CSRG-27 [v.2]

6/26/2012 9:38:00 AM

Short Title: Sole Source Ed. Requirements/Bail Bondsmen. (Public)

Sponsors:

Referred to:

April 20, 2011

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE PRE-LICENSING AND CONTINUING EDUCATION OF BAIL BONDSMEN AND RUNNERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-71-71 reads as rewritten:

"**§ 58-71-71. Examination; educational requirements; penalties.**

(a) In order to be eligible to take the examination required to be licensed as a runner or bail bondsman under G.S. 58-71-70, each person shall complete at least 12 hours of education as provided by the North Carolina Bail Agents Association in subjects pertinent to the duties and responsibilities of a runner or bail bondsman, including all laws and regulations related to being a runner or bail bondsman.

(b) Each year every licensee shall complete at least three hours of continuing education as provided by the North Carolina Bail Agents Association in subjects related to the duties and responsibilities of a runner or bail bondsman before renewal of the license. This continuing education shall not include a written or oral examination. A person who receives his first license on or after January 1 of any year does not have to comply with this subsection until the period between his first and second license renewals.

(c) Any person licensed as a runner or bail bondsman before January 1, 1994, is not subject to the prelicensing education requirement of this section, but is subject to the continuing education requirement of this section. A licensed runner or bail bondsman who is 65 years of age or older and who has been licensed as a runner or bail bondsman for 15 years or more is exempt from both the prelicensing education and continuing education requirements of this section.

(d) Educational courses offered by the North Carolina Bail Agents Association under this section must be approved by the Commissioner before they may be offered. Before approving a course, the Commissioner must be satisfied that ~~it~~ the course will enhance the professional competence and professional responsibility of bail bondsmen and runners. ~~No person shall~~The North Carolina Bail Agents Association shall not offer, sponsor, or conduct any course under this section unless the Commissioner has ~~authorized that person~~given authorization to do so.

(e) The license of any person who fails to comply with the continuing education requirements under this section shall lapse. The Commissioner may, for good cause shown,

grant extensions of time to licensees to comply with these requirements. Any licensee who, after obtaining an extension under this subsection, offers evidence satisfactory to the Commissioner that the licensee has satisfactorily completed the required continuing professional education courses is in compliance with this section.

(f) The Commissioner may adopt rules for the effective administration of this section."

SECTION 2. This act becomes effective October 1, 2012.

SENATE BILL 738:
Sole Source Ed. Requirements/Bail Bondsmen

2011-2012 General Assembly

Committee:	House Insurance	**Date:**	June 25, 2012
Introduced by:	Sen. Goolsby	**Prepared by:**	Tim Hovis
Analysis of:	PCS to Third Edition S738-CSRG-27		Committee Counsel

SUMMARY: ***The proposed committee substitute (PCS) for Senate Bill 738 provides that the North Carolina Bail Agents Association shall provide pre-licensing education and continuing education for bail bondsmen and runners.***

CURRENT LAW: Article 71 of Chapter 58 gives to the Commissioner of Insurance the authority to regulate bail bondsmen and runners.

G.S. 58-71-71 provides that applicants to take the examination to be licensed as a bail bondsman or runner must complete at least 12 hours of education prior to taking the examination. After successful completion of the examination and receipt of his or her license, licensees must complete at least three hours of continuing education each year.

G.S. 58-71-71 provides that educational courses under must be approved by the Commissioner. In addition, under G.S. 58-71-72, instructors of pre-licensing and continuing education courses must have a certificate of authority issued by the Commissioner.

BILL ANALYSIS: The PCS for Senate Bill 738 provides that the North Carolina Bail Agents Association shall provide pre-licensing education and continuing education for bail bondsmen and runners. Courses and course instructors will continue to be approved by the Commissioner, as required under current law.

EFFECTIVE DATE: The bill becomes effective October 1, 2012.

S738-SMRG-56(CSRG-27) v4

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S 3

SENATE BILL 738
Insurance Committee Substitute Adopted 6/7/11
Third Edition Engrossed 6/8/11

Short Title: Liability Insurance Required for ABC Permits. (Public)

Sponsors: --

Referred to:

April 20, 2011

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT A PERSON THAT HOLDS CERTAIN ALCOHOLIC BEVERAGE CONTROL PERMITS HAVE AT LEAST ONE MILLION DOLLARS IN LIABILITY INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 18B-123 reads as rewritten:

"**§ 18B-123. Limitation on damages.**

The total amount of damages that may be awarded to all aggrieved parties pursuant to any claims for relief under this Article is limited to no more than ~~five hundred thousand dollars ($500,000)~~ one million dollars ($1,000,000) per occurrence. When all claims arising out of an occurrence exceed ~~five hundred thousand dollars ($500,000),~~one million dollars ($1,000,000), each claim shall abate in the proportion it bears to the total of all claims."

SECTION 2. Article 1 of Chapter 18B of the General Statutes is amended by adding a new section to read:

"**§ 18B-123.1. Liability insurance required.**

A person holding an ABC permit or permits issued pursuant to G.S. 18B-1001(1), (3), (5), and (10) shall maintain in full force and effect a policy of liability insurance in an amount of not less than one million dollars ($1,000,000). A person that has a lapse in coverage under such policy or cancels a policy required by this section shall have any ABC permits issued to them summarily revoked by the Commission upon notification of such lapse by the policyholder or issuer. The revocation authorized by this section is not subject to the provisions of Chapter 150B of the General Statutes. The requirement of liability insurance under this section does not replace or eliminate any other remedy an aggrieved party may have in the law or at common law."

SECTION 3. Article 1 of Chapter 18B of the General Statutes is amended by adding a new section to read:

"**§ 18B-123.2. Notification of lapse or cancellation required.**

An insurance company that issues a policy of liability insurance under G.S. 18B-123.1 to a person who holds an ABC permit or permits issued pursuant to G.S. 18B-1001(1), (3), (5), and (10) shall notify the Commission within 10 days of the cancellation or lapse of the liability insurance policy."

SECTION 4. This act becomes effective December 1, 2011, and applies to all ABC permits issued, registered, or renewed on or after that date.

2012 COMMITTEE REPORT

HOUSE OF REPRESENTATIVES

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

By Representative Dockham (Chair) for the Committee on INSURANCE.

☒ Senate Committee Substitute for

HB 244 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE STERLING MONTESSORI ACADEMY AND CHARTER SCHOOL, THE CASA ESPERANZA MONTESSORI CHARTER SCHOOL, AND KESTREL HEIGHTS SCHOOL TO ELECT TO PARTICIPATE IN THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES AND TO PROVIDE PROTECTIONS FOR WHISTLE-BLOWERS ALLEGING FRAUD OR OTHER MISCONDUCT RELATED TO THE STATE HEALTH PLAN.

☒ With recommendation that the House do not concur.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the bill/resolution is placed on the Calendar of _____.

_____ On motion of Representative _____, Committee Amendment No.(s) ___ is/are adopted by EV (_____).

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H 4

HOUSE BILL 244
Committee Substitute Favorable 6/7/11
Senate Insurance Committee Substitute Adopted 6/6/12
Fourth Edition Engrossed 6/7/12

Short Title: State Health Plan/Add Schools; Whistleblowers. (Public)

Sponsors:

Referred to:

March 8, 2011

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE STERLING MONTESSORI ACADEMY AND CHARTER SCHOOL, THE CASA ESPERANZA MONTESSORI CHARTER SCHOOL, AND KESTREL HEIGHTS SCHOOL TO ELECT TO PARTICIPATE IN THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES AND TO PROVIDE PROTECTIONS FOR WHISTLE-BLOWERS ALLEGING FRAUD OR OTHER MISCONDUCT RELATED TO THE STATE HEALTH PLAN.

The General Assembly of North Carolina enacts:

SECTION 1. Notwithstanding the time limitation contained in G.S. 135-48.54(a), the Boards of Directors of (i) Sterling Montessori Academy and Charter School, located in Morrisville, North Carolina, (ii) the Casa Esperanza Montessori Charter School, located in Raleigh, North Carolina, and (iii) Kestrel Heights School, located in Durham, North Carolina, may elect to become participating employing units in the State Health Plan for Teachers and State Employees in accordance with Article 3B of Chapter 135 of the General Statutes. The election authorized by this section shall be made no later than 30 days after the effective date of this act and shall be made in accordance with all other requirements of G.S. 135-48.54.

SECTION 2. Article 1 of Chapter 22B of the General Statutes is amended by adding a new section to read as follows:

"**§ 22B-4. Prohibition on contract provisions restricting whistle-blowing related to State Health Plan.**

A provision in any contract is void and against public policy if it prohibits an employee's or contractor's ability to report wrongdoing under G.S. 135-48.15 related to the State Health Plan."

SECTION 3. Part 1 of Article 3B of Chapter 135 of the General Statutes is amended by adding a new section to read as follows:

"**§ 135-48.15. Whistle-blower protections related to the State Health Plan.**

(a) Statement of Public Policy. – It is the policy of this State that persons shall be encouraged to report verbally or in writing to the State Health Plan, Attorney General, or other appropriate authority evidence of activity related to the State Health Plan and involving the following:

(1) A violation of State or federal law, rule, or regulation.
(2) Fraud.
(3) Misappropriation of State resources.
(4) Gross mismanagement, a gross waste of monies, or gross abuse of authority.

Further, it is the policy of this State that persons shall be free of intimidation or harassment when reporting matters of public concern related to the State Health Plan, including offering testimony to or testifying before appropriate legislative panels.

(b) Protection From Retaliation. – No employer shall sue, discharge, threaten, or otherwise discriminate against an employee regarding the employee's compensation, terms, conditions, location, or privileges of employment because the employee, or a person acting on behalf of the employee, reports or is about to report, verbally or in writing, any activity described in subsection (a) of this section, unless the employee knows or has reason to believe that the report is inaccurate. No other employee of an employer shall retaliate against another employee because the employee, or a person acting on behalf of the employee, reports or is about to report, verbally or in writing, any activity described in subsection (a) of this section. No person shall sue, terminate a contract, threaten, or otherwise discriminate against a reporting person regarding the reporting person's compensation or terms of contract because the reporting person, or a person acting on behalf of the reporting person, reports or is about to report, verbally or in writing, any activity described in subsection (a) of this section, unless the reporting person knows or has reason to believe that the report is inaccurate.

(c) Relief for Violation. – Any person injured by a violation of subsection (b) of this section may maintain an action in superior court for damages, an injunction, or other remedies provided in this section against the person who committed the violation within one year after the occurrence of the alleged violation of this Article.

(d) Remedies. – A court, in rendering a judgment in an action brought pursuant to this section, may order an injunction, damages, reinstatement of the employee, the payment of back wages or payments owed under a contract, full reinstatement of fringe benefits and seniority rights, costs, reasonable attorneys' fees, or any combination of these. If an application for a permanent injunction is granted, the person maintaining the action shall be awarded costs and reasonable attorneys' fees. If in an action for damages the court finds that the person maintaining the action was injured by a willful violation of subsection (b) of this section, the court shall award as damages three times the amount of actual damages plus costs and reasonable attorneys' fees against the individual or individuals found to be in violation of subsection (b) of this section.

(e) Unrelated Unfavorable Action. – It shall not be a violation of this Article for a person to discharge or take any other unfavorable action with respect to an employee who has engaged in protected activity as set forth under this Article if the person proves by the greater weight of the evidence that it would have taken the same unfavorable action in the absence of the protected activity of the employee."

SECTION 4. Sections 2 and 3 of this act become effective October 1, 2012, and apply to causes of action arising on or after that date. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: House Bill 244 (Fourth Edition)

SHORT TITLE: State Health Plan/Add Schools; Whistleblowers.

SPONSOR(S): Representative Murry

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 of the bill permits the Boards of Directors of Sterling Montessori Academy and Charter School, Casa Esperanza Montessori Charter School, and Kestrel Heights School, which are public charter schools, to become participating employers under the Plan within 30 days after the act becomes law. Under G.S. 135-48.54, an election to join the Plan by the board of a charter school is irrevocable and shall require all eligible employees of the charter school to participate.

Section 2 of the bill amends G.S. 22B to prohibit contract provisions restricting whistleblowing related to the Plan.

Section 3 of the bill enacts a new statute, G.S. 135-48.15, which includes a statement of public policy on whistleblower protection and provides for protection from retaliation and for remedies.

EFFECTIVE DATE: Section 1 becomes effective when it becomes law. Sections 2 and 3 become effective on October 1, 2012.

ESTIMATED IMPACT ON STATE:

The consulting actuary for the State Health Plan for Teachers and State Employees, Aon Hewitt, estimates a financial loss to the Plan of $438,055 for FY 2012-2013 if Sterling Montessori, Casa Esperanza, and Kestrel Heights charter schools all elect to participate in the Plan.

Aon Hewitt noted that by solely comparing the Plan's current average plan membership and the combined charter schools' submitted employee and dependent demographic data, each charter school group should produce less in expected claims, on average, as compared to the Plan's covered group. However, absent historical claims experience data from either school to substantiate this assessment, Aon Hewitt noted that there is no basis to rule out the risk of either school group having higher average claims costs than the current plan members. Therefore, for the purposes of estimating the combined schools' potential cost impact to the Plan, Aon Hewitt assumed potential claims for each school would be 150% greater on average

due to expected adverse selection of costlier plan members entering the Plan. Even with this assumption, and given the small size of each respective school, Aon Hewitt estimates the projected costs would have a negligible impact on the Plan.

Hartman & Associates, consulting actuary for the General Assembly's Fiscal Research Division, estimates that the financial impact on the Plan would not be material upon Sterling Montessori, Casa Esperanza, and Kestrel Heights charter schools electing to participate in the Plan.

Hartman and Associates noted that the employee and dependent demographics of the combined schools' groups would be expected to produce similar costs as compared to the Plan's membership, and that given the minimal number of prospective employees and dependents to be enrolled, there is not expected to be a significant financial impact as a percent of total claims. Hartman & Associates, however, also noted the lack of available historical claims experience from either School to assess potential adverse selection against the Plan.

The additional cost impact of the bill, projected by either consulting actuary, would be expected to impact total claims growth by approximately one and one-half hundredths of one percent (0.015%) for the 2012-2013 fiscal year based on the highest estimate of additional cost (i.e., $438,055).

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.

Authorized Charter Schools: As of December 2010, there were 59 charter schools with 3,524 enrolled active employees and dependents participating in the Plan.

Data submitted by the Schools: Aon Hewitt and Hartman and Associates based their respective analyses in part on a Distribution of Participants schedule submitted by each school. The schedules below reflect the age and sex demographic data for employees and dependents for each of the respective schools. None of the schools provided complete claims experience data due to a refusal of their respective incumbent carriers to release claims information on each School's participants.

Distribution of Participants – Sterling Montessori

	Active Employees			Dependents of Active Employees			Retired Employees			Dependents of Retired Employees		
Ages	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	0	0	0	0	0	0			0			0
5-9	0	0	0	1	0	1			0			0
10-14	0	0	0	1	3	4			0			0
15-19	0	0	0	1	3	4			0			0
20-24	0	0	0	1	1	2			0			0
25-29	0	4	4	0	0	0			0			0
30-34	4	7	11	0	0	0			0			0
35-39	2	8	10	0	0	0			0			0
40-44	1	17	18	1	1	2			0			0
45-49	1	7	8	0	2	2			0			0
50-54	1	9	10	1	0	1			0			0
55-59	1	1	2	1	0	1			0			0
60-64	1	0	1	0	0	0			0			0
65-69	0	2	2	0	0	0			0			0
70-74	0	1	1	0	0	0			0			0
75-79	0	0	0	0	0	0			0			0
>79	0	0	0	0	0	0			0			0
Unknown	0	0	0	0	0	0			0			0
TOTAL	11	56	67	7	10	17	0	0	0	0	0	0

Distribution of Participants – Casa Esperanza

Ages	Active Employees			Dependents of Active Employees			Retired Employees			Dependents of Retired Employees		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4			0		1	1			0			0
5-9			0	3	1	4			0			0
10-14			0		4	4			0			0
15-19			0			0			0			0
20-24		1	1	1	1	2			0			0
25-29	1	6	7			0			0			0
30-34		7	7			0			0			0
35-39		11	11			0			0			0
40-44	1	5	6			0			0			0
45-49		3	3	1		1			0			0
50-54		6	6			0			0			0
55-59		2	2			0			0			0
60-64		2	2	1		1			0			0
65-69			0			0			0			0
70-74			0			0			0			0
75-79			0			0			0			0
>79			0			0			0			0
Unknown			0			0			0			0
TOTAL	2	43	45	6	7	13	0	0	0	0	0	0

Distribution of Participants – Kestrel Heights

Ages	Active Employees			Dependents of Active Employees			Retired Employees			Dependents of Retired Employees		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	0	0	0	1	0	1			0			0
5-9	0	0	0	1	0	1			0			0
10-14	0	0	0	2	3	5			0			0
15-19	0	0	0	3	1	4			0			0
20-24	0	2	2	1	1	2			0			0
25-29	1	2	3	0	0	0			0			0
30-34	3	4	7	0	0	0			0			0
35-39	3	4	7	0	0	0			0			0
40-44	5	1	6	0	0	0			0			0
45-49	3	3	6	0	3	3			0			0
50-54	2	1	3	0	1	1			0			0
55-59	1	1	2	0	0	0			0			0
60-64	1	2	3	0	0	0			0			0
65-69	0	1	1	0	0	0			0			0
70-74	0	0	0	0	0	0			0			0
75-79	0	0	0	0	0	0			0			0
>79	0	0	0	0	0	0			0			0
Unknown	0	0	0	0	0	0			0			0
TOTAL	19	21	40	8	9	17	0	0	0	0	0	0

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.

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 participate in the Standard plan or who elect dependent coverage. Total requirements for the Plan are estimated to be $2.87 billion for FY 2011-12 and $3.03 billion for FY 2012-13. 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 premiums from employees and retirees; and

2) The "Standard" 80/20 plan.

The Basic plan offers coverage to employees and retired employees on a noncontributory basis. The Standard plan offers coverage to employees and retired employees on a partially contributory basis. Coverage for dependents under both plans is offered on a fully contributory basis.

The following table provides a summary of most monthly premium rates for the Plan in FY 2012-13:

Coverage Type	PPO Basic		PPO Standard	
	Employee/ Retiree	Employer	Employee/ Retiree	Employer
Non-Medicare Active Employee/Retiree				
Employee	$0.00	$432.66	$22.76	$432.66
Employee + Child(ren)	$198.06	$432.66	$286.16	$432.66
Employee + Spouse	$510.32	$432.66	$629.64	$432.66
Employee + Family	$543.54	$432.66	$666.18	$432.66
Medicare Primary for Only Employee/Retiree				
Employee	$0.00	$336.25	$10.52	$336.25
Employee + Child(ren)	$198.06	$336.25	$273.92	$336.25
Employee + Spouse	$510.32	$336.25	$617.40	$336.25
Employee + Family	$543.54	$336.25	$653.94	$336.25

The employer share of premiums for retirees is paid from the Retiree Health Benefit Fund. During FY 2011-12, employers contribute 5.0% of active employee payroll into the Fund. Total contributions for the year are projected to be approximately $764 million.

Financial Condition

Projected Results for 2011-2013 Biennium – The following summarizes a financial projection prepared by the Plan's consulting actuary, Aon Hewitt, for the 2011-2013 biennium. It reflects the provisions of SL 2011-85 and SL 2011-96 and is based on financial experience through December, 2010.

	($ millions) Projected FY 2011-12	Projected FY 2012-13
Beginning Cash Balance	$226.8	$219.5
Receipts:		
Net Premium Collections	$2,769.9	$2,923.2
Early Retiree Reinsurance Program	$25.6	$0.0
Medicare Part D Subsidies	$60.1	$62.6
Investment Earnings	$2.2	$2.1
Total	$2,857.8	$2,987.9
Disbursements:		
Net Medical Claim Payment Expenses	$2,045.1	$2,179.7
Net Pharmacy Claim Payment Expenses	$639.6	$671.7
Administration and Claims-Processing Expenses	$180.5	$183.6
Total	$2,865.1	$3,035.0
Net Operating Income (Loss)	($7.3)	($47.0)

The projection assumes 9.5% annual claims growth trend. It incorporates $151 million in projected savings over the biennium from a new Pharmacy Benefit Manager (PBM) contract that was effective October 1, 2011. It assumes that the Plan maintains "grandfathered" status under the federal Affordable Care Act (ACA). It assumes the Plan experiences an increase of $33 million in claims over the biennium due to requirements in the ACA to cover additional dependents.

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, fraud detection, and other authorized actions by the State Treasurer, 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 9.5% annually according to the Plan's consulting actuary. Investment earnings are based upon a 1.0% return on available cash balances. The active population is projected to decline by 1% per year, the COBRA population is projected to remain constant, and the retired population is projected to increase by 1% per year.

Enrollment as of September 30, 2011

I. No. of Participants	Basic	Standard	Total	Percent of Total
Actives				
Employees	116,124	197,696	313,820	47.2%
Dependents	70,353	88,489	158,842	23.9%
Sub-total	186,477	286,185	472,662	71.1%
Retired				
Employees	25,109	141,696	166,805	25.1%
Dependents	5,459	13,709	19,168	2.9%
Sub-total	30,568	155,405	185,973	28.0%
Former Employees with Continuation Coverage				
Employees	1,255	1,289	2,544	0.4%
Dependents	528	350	878	0.1%
Sub-total	1,783	1,639	3,422	0.5%
Firefighters, Rescue Squad & National Guard				
Employees	3	4	7	0.0%
Dependents	3	1	4	0.0%
Sub-total	6	5	11	0.0%
Local Governments				
Employees	530	1,364	1,894	0.3%
Dependents	402	536	938	0.1%
Sub-total	932	1,900	2,832	0.4%
Total				
Employees	143,021	342,049	485,070	73.0%
Dependents	76,745	103,085	179,830	27.0%
Grand Total	**219,766**	**445,134**	**664,900**	**100%**
Percent of Total	**33.1%**	**66.9%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Total
Employee Only	104,153	284,789	388,942
Employee Child(ren)	21,354	29,930	51,284
Employee Spouse	6,653	15,312	21,965
Employee Family	10,861	12,018	22,879
Total	**143,021**	**342,049**	**485,070**

Percent Enrollment by Contract	Basic	Standard	Total
Employee Only	72.8%	83.3%	80.2%
Employee Child(ren)	14.9%	8.8%	10.6%
Employee Spouse	4.7%	4.5%	4.5%
Employee Family	7.6%	3.5%	4.7%
Total	**100.0%**	**100.0%**	**100.0%**

III. Enrollment by Sex	Basic	Standard	Total
Female	125,914	288,637	414,551
Male	93,852	156,497	250,349
Total	**219,766**	**445,134**	**664,900**

Percent Enrollment by Sex	Basic	Standard	Total
Female	57.3%	64.8%	62.3%
Male	42.7%	35.2%	37.7%
Total	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Total
19 & Under	49,389	60,779	110,168
20 to 29	24,898	36,748	61,646
30 to 44	52,875	73,944	126,819
45 to 54	42,716	67,407	110,123
55 to 64	43,858	92,724	136,582
65 & Over	6,030	113,532	119,562
Total	**219,766**	**445,134**	**664,900**

Percent Enrollment by Age	Basic	Standard	Total
19 & Under	22.5%	13.7%	16.6%
20 to 29	11.3%	8.3%	9.3%
30 to 44	24.1%	16.6%	19.1%
45 to 54	19.4%	15.1%	16.6%
55 to 64	20.0%	20.8%	20.5%
65 & Over	2.7%	25.5%	18.0%
Total	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	55,059	12,072	67,131
Medicare Eligible	111,746	7,096	118,842
Total	**166,805**	**19,168**	185,973

Percent Enrollment by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.0%	63.0%	36.1%
Medicare Eligible	67.0%	37.0%	63.9%
Total	**100.0%**	**100.0%**	100.0%

VI. Enrollment By Major Employer Groups	Employees	Dependents	Total
State Agencies	73,838	33,930	107,768
UNC System	50,223	30,672	80,895
Local Public Schools	174,370	86,182	260,552
Local Community Colleges	15,389	8,058	23,447
Other			
Local Goverments	1,894	938	2,832
COBRA	2,544	878	3,422
Nat. Guard, Fire & Rescue	7	4	11
Sub-total	318,265	160,662	478,927
Retirement System	166,805	19,168	185,973
Total	**485,070**	**179,830**	**664,900**

Percent Enrollment by Major Employer Groups	Employees	Dependents	Total
State Agencies	15.2%	18.9%	16.2%
UNC System	10.4%	17.1%	12.2%
Local Public Schools	35.9%	47.9%	39.2%
Local Community Colleges	3.2%	4.5%	3.5%
Other			
Local Goverments	0.4%	0.5%	0.4%
COBRA	0.5%	0.5%	0.5%
Nat. Guard, Fire & Rescue	0.0%	0.0%	0.0%
Sub-total	65.6%	89.3%	72.0%
Retirement System	34.4%	10.7%	28.0%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

Aon Hewitt, North Carolina State Health Plan, Financial Projections - January 2011 - 14b ($12 Generic) - Start September - No Premium Increase for Late Start, Total For All Plans - 9.5% Trend with Risk Adjustment, with Max GF Benefits except $12 Generic, with PBM Contract Savings, Additional Premium Charged To All Tiers - Active: 5% Std, 0% Basic; NMC Retiree 5% Std, 0% Basic; MC Retiree $10 Std, $0 Basic, No CWI, Non-Smoker Movement: Active: 25% single, 5% dep; NMC Retiree: 25% single, 5% dep; MC Retiree: 20% single, 5% dep, May 17, 2011.

-Actuarial Note, Hartman & Associates, House Bill 244, "House Bill 244 Proposed Committee Substitute H244-CSRG-18 [v.2]: An Act to Authorize Sterling Montessori Academy and the Casa Esperanza Montessori Charter School to Elect to Participate in the State Health Plan for Teachers and State Employees," June 1, 2011, an original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Hartman & Associates, House Bill 1213, "House Bill 1213: An Act to Authorize Kestrel Heights School to Elect to Participate in the State Health Plan for Teachers and State Employees," June 6, 2012, an original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, House Bill 244, " House Bill 244 Proposed Committee Substitute H244-CSRG-18 [v.2] State Health Plan/Add Sterling Montessori Academy," June 1, 2011, 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.

-Actuarial Note, Aon Hewitt, House Bill 1213, " House Bill 1213 State Health Plan / Add Kestrel Heights School," June 15, 2012, 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.

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DATE: June 22, 2012



Signed Copy Located in the NCGA Principal Clerk's Offices

Box #	Year	Chamber	Committee
7	2011-2012	House	Judiciary
7	2011-2012	House	Judiciary - Subcommittee A
7	2011-2012	House	Judiciary - Subcommittee B (through June 11, 2012)