

2011-2012

**SENATE
INSURANCE**

MINUTES

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2010 Legislative Building
733-5745

Legislative Assistant: Carolyn
Gooden

Co-Chairman

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2106 Legislative Building
733-5776

Legislative Assistant: Debbie
Lown

Vice Chairman

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312 Legislative Office Building
301-1446

Legislative Assistant: Karen
Johns, Gayle Gunn, Tory Apply

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1026 Legislative Building
733-3460

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Spears

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Senator Floyd McKissick
520 Legislative Office Building
733-4599
Legislative Assistant: Rosita Littlejohn

SENATE INSURANCE COMMITTEE
Tuesday, March 22, 2011 at 9:30 AM
Room 1027, Legislative Building

MINUTES

The Senate Insurance Committee met at 9:30 AM on March 22, 2011, in Room 1027 of the Legislative Building. Sixteen members of the committee were present. Senator Meredith presided. Sarah Heard of Greenville served as a page.

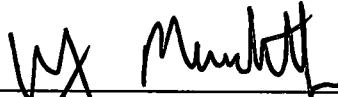
S.B. 265- Transfer State Health Plan to State Treasurer

Senator Apodaca was recognized to explain the bill and moved to adopt the proposed committee substitute (PCS) for discussion. The motion carried. The PCS for Senate Bill 265 provides funding for the State Health Plan for 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. Senator Garrou was recognized to ask if the bill would be voted upon today. Senator Meredith responded that the committee would move forward with discussions and see how far they got. Senator Apodaca was recognized to explain the PCS. Ryan Blackledge, of NCGA Bill Drafting, was recognized to give an overview of the language of the bill. Mark Trogden, of NCGA Fiscal Research, was recognized to explain the actuarial note of S.B. 265. Chairmen Meredith recognized Ryan Blackledge, NCGA Bill Drafting, to discuss Part II of the bill overview. Senator Apodaca was recognized to discuss the process of transferring the bill to the Treasurer's office. Senator Doug Berger was recognized to ask Mark Trogden a question regarding employee co-pay and premiums. Mark Trogden was recognized to respond to Senator D. Berger's question. Senator D. Berger was recognized again to ask how this plan compared to the Governor's plan. Senator Apodaca was recognized to answer. Senator East was recognized to ask how citizens could apply for a waiver process for the Affordable Health Care Act. Staff responded they would research and get back to Senator East. Senator Garrou was recognized to ask if the committee would hear from the Treasurer's office or State Employees Association of North Carolina. Tony Solari, Director of Government Relations in the office of the State Treasurer, was recognized to explain the Treasurer's involvement in the legislation. Ardis Watkins, Legislative Liaison for SEANC, was recognized to explain the organizations feelings regarding S.B. 265. Senator Garrou was recognized to question why the B.M.I and tobacco requirements were removed from the new plan. Senator Apodaca was recognized and answered that it was intrusive to people and SEANC was not in favor of it. Senator Garrou was recognized to ask if the plan would reduce the cost of families with dependents. Senator Apodaca was recognized to say no. Senator Garrou was recognized to ask the difference between permanent and temporary employees. Mark Trogden was recognized to answer that temporary employees do not qualify for coverage. Senator Garrou was recognized to ask if mail order prescriptions were included in the plan. Senator Apodaca was recognized to answer that they could not move to mail order prescriptions only. Senator Berger was recognized to ask Ardis Watkins of SEANC if their organization supported the premium increase. Ardis responded that there were pieces of the legislation that were popular and unpopular with members. Senator Rucho was recognized to ask what is being done to ensure fiscal survivability to this health plan. Senator Apodaca was recognized to answer that it will be maintained better under these conditions. Senator

Rucho was recognized to ask what else is being done to increase young healthy folks into the system. Senator Apodaca was recognized to respond nothing at this time. He then invited Dr. Jack Walker to speak regarding the initiatives. Dr. Jack Walker, Director of BCBS was then recognized to discuss initiative programs. Senator McKissick was recognized to make comments on the PCS. Dr. Walk was recognized to speak regarding wellness issues.

Senator Hise moved for a favorable report and the motion carried. A copy of the PCS, the summary, and the actuarial note is attached.

The meeting adjourned at 10:52 AM.



Senator Wesley Meredith, Presiding Chair
Senate Insurance Committee



Nicole McGuinness, Committee Clerk



Debbie Lown, Committee Clerk

**Senate Insurance Committee
Tuesday, March 22, 2011, 10:00 AM
1027 LB**

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 265 Transfer State Health Plan to State Treasurer.

**Senator Hartsell
Senator Brunstetter
Senator Apodaca**

Presentations

Other Business

Adjournment

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

INSURANCE COMMITTEE REPORT

**Senator Tom Apodaca, Co-Chair
Senator Wesley Meredith, Co-Chair**

Tuesday, March 22, 2011

Senator MEREDITH,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B.	265	Transfer State Health Plan to State Treasurer.
		Draft Number: 35127-ME-4
		Sequential Referral: None
		Recommended Referral: None
		Long Title Amended: No

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2011

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SENATE BILL 265
PROPOSED COMMITTEE SUBSTITUTE S265-PCS35127-ME-4

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:



* S 2 6 5 - P C S 3 5 1 2 7 - H E - 4 *

	<u>FY 2011-2012</u>		<u>FY 2012-2013</u>	
	<u>Basic</u>	<u>Standard</u>	<u>Basic</u>	<u>Standard</u>
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.

- 1 h. Increase prescription drug co-payments as required under
2 G.S. 135-45.6(b)(1) as amended by this section.
- 3 i. Except as otherwise provided in this act, co-payments and
4 coinsurance for coverage not otherwise listed in this subdivision shall
5 remain as applicable in the 2010-2011 benefit year.
- 6 (2) Standard Plan (80/20):
- 7 a. Increase the in-network annual deductible to seven hundred dollars
8 (\$700.00) for member-only coverage and to one thousand four
9 hundred dollars (\$1,400) for the member-only out-of-network annual
10 deductible. The aggregate maximum annual deductible for
11 employee-child and employee-family coverage shall be three times
12 the member-only annual deductibles.
- 13 b. Increase the in-network coinsurance maximum to three thousand two
14 hundred ten dollars (\$3,210) for member-only coverage and to six
15 thousand four hundred twenty dollars (\$6,420) for member-only
16 out-of-network maximum coinsurance. The aggregate maximum
17 coinsurance for employee-child and employee-family coverage shall
18 be three times the member-only coinsurance maximums.
- 19 c. Increase the in-network urgent care co-payment to eighty-seven
20 dollars (\$87.00) per covered individual.
- 21 d. Increase the in-network primary care co-payment to thirty dollars
22 (\$30.00) per covered individual.
- 23 e. Increase the in-network specialist co-payment to seventy dollars
24 (\$70.00) per covered individual, except that for mental health and
25 substance abuse services, chiropractic services, and physical therapy,
26 occupational therapy, and speech therapy services, the in-network
27 specialist co-payment shall be fifty-two dollars (\$52.00) per covered
28 individual.
- 29 f. Increase the in-network and out-of-network inpatient co-payment to
30 two hundred thirty-three dollars (\$233.00) per covered individual.
- 31 g. Increase the in-network and out-of-network emergency room
32 co-payment to two hundred thirty-three dollars (\$233.00) per covered
33 individual.
- 34 h. Increase prescription drug co-pays as required under
35 G.S. 135-45.6(b)(1) as amended by this act.
- 36 i. Except as otherwise provided in this act, co-payments and
37 coinsurance for coverage not otherwise listed in this subdivision shall
38 remain as applicable in the 2010-2011 benefit year.

39 **SECTION 1.3.(b)** G.S. 135-45.6(b)(1) reads as rewritten:

40 "(1) The Plan will pay allowable charges for each outpatient prescription drug
41 less a copayment to be paid by each covered individual equal to the
42 following amounts: pharmacy charges up to ten dollars (\$10.00) for each
43 generic prescription, ~~thirty-five dollars (\$35.00)~~ forty dollars (\$40.00) for
44 each preferred branded prescription without a generic equivalent, and
45 ~~fifty-five dollars (\$55.00)~~ sixty-four dollars (\$64.00) for each nonpreferred
46 branded prescription. For each branded prescription drug with a generic
47 equivalent drug, the member shall pay the generic co-payment plus the
48 difference between the Plan's gross allowed cost for the generic prescription
49 and the Plan's cost for the branded prescription drug."

50

51 **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

- 1 of the State-supported retirement programs, provided the death of the
2 former plan member occurred prior to October 1, 1986.
- 3 (5) ~~Employees of the General Assembly, not otherwise covered by this section,~~
4 ~~as determined by the Legislative Services Commission, except for legislative~~
5 ~~interns and pages.~~
- 6 (6) ~~Members of the General Assembly.~~
- 7 (7) ~~Notwithstanding the provisions of subsection (e) of this section, employees~~
8 ~~on official leave of absence while completing a full-time program in school~~
9 ~~administration in an approved program as a Principal Fellow in accordance~~
10 ~~with Article 5C of Chapter 116 of the General Statutes.~~
- 11 (8) ~~Notwithstanding the provisions of G.S. 135-45.12 employees formerly~~
12 ~~covered by the provisions of this section, other than retired employees, who~~
13 ~~have been employed for 12 or more months by an employing unit, or who~~
14 ~~have completed a contract term of employment of 10 or 11 months and~~
15 ~~whose employing unit is a local school administrative unit, and whose jobs~~
16 ~~are eliminated because of a reduction, in total or in part, in the funds used to~~
17 ~~support the job or its responsibilities, provided the employees were covered~~
18 ~~by the Plan at the time of separation from service resulting from a job~~
19 ~~elimination. Employees covered by this subsection shall be covered for a~~
20 ~~period of up to 12 months following a separation from service because of a~~
21 ~~job elimination. An employee formerly covered by the provisions of this~~
22 ~~section shall not be eligible for coverage under this subdivision if the~~
23 ~~employee is provided health benefit coverage on a non-contributory basis by~~
24 ~~a subsequent employer.~~
- 25 (9) ~~Any member enrolled pursuant to subdivision (1) or (2) of this subsection~~
26 ~~who is on approved leave of absence with pay or receiving workers'~~
27 ~~compensation.~~
- 28 (10) ~~Employees on approved Family and Medical Leave.~~
- 29 (a1) Partially Contributory Coverage. – The following persons are eligible for coverage
30 under the Plan, on a partially contributory basis, subject to the provisions of G.S. 135-45.4:
- 31 (1) All permanent full-time employees of an employing unit who meet either of
32 the following conditions:
- 33 a. Paid from general or special State funds.
- 34 b. Paid from non-State funds and in a group for which his or her
35 employing unit has agreed to provide coverage.
- 36 Employees of State agencies, departments, institutions, boards, and
37 commissions not otherwise covered by the Plan who are employed in
38 permanent job positions on a recurring basis and who work 30 or more hours
39 per week for nine or more months per calendar year are covered by the
40 provisions of this subdivision.
- 41 (2) Permanent hourly employees who work at least one-half of the workdays of
42 each pay period.
- 43 (3) Retired teachers, State employees, members of the General Assembly, and
44 retired State law enforcement officers who retired under the Law
45 Enforcement Officers' Retirement System prior to January 1, 1985. Except
46 as otherwise provided in this subdivision, on and after January 1, 1988, a
47 retiring employee or retiree must have completed at least five years of
48 contributory retirement service with an employing unit prior to retirement
49 from any State-supported retirement system in order to be eligible for group
50 benefits under this Part as a retired employee or retiree. For employees first
51 hired on and after October 1, 2006, and members of the General Assembly

- 1 first taking office on and after February 1, 2007, future coverage as retired
2 employees and retired members of the General Assembly is subject to a
3 requirement that the future retiree have 20 or more years of retirement
4 service credit in order to be covered by the provisions of this subdivision.
5 (4) Employees of the General Assembly, not otherwise covered by this section,
6 as determined by the Legislative Services Commission, except for legislative
7 interns and pages.
8 (5) Members of the General Assembly.
9 (6) Notwithstanding the provisions of subsection (e) of this section, employees
10 on official leave of absence while completing a full-time program in school
11 administration in an approved program as a Principal Fellow in accordance
12 with Article 5C of Chapter 116 of the General Statutes.
13 (7) Notwithstanding the provisions of G.S. 135-45.12, employees formerly
14 covered by the provisions of this subsection, other than retired employees,
15 who have been employed for 12 or more months by an employing unit, or
16 who have completed a contract term of employment of 10 or 11 months and
17 whose employing unit is a local school administrative unit, and whose jobs
18 are eliminated because of a reduction, in total or in part, in the funds used to
19 support the job or its responsibilities, provided the employees were covered
20 by the Plan at the time of separation from service resulting from a job
21 elimination. Employees covered by this subsection shall be covered for a
22 period of up to 12 months following a separation from service because of a
23 job elimination. An employee formerly covered by the provisions of this
24 subsection shall not be eligible for coverage under this subdivision if the
25 employee is provided health benefit coverage on a noncontributory basis by
26 a subsequent employer.
27 (8) Any member enrolled pursuant to subdivision (1) or (2) of this subsection
28 who is on approved leave of absence with pay or receiving workers'
29 compensation.
30 (9) Employees on approved Family and Medical Leave.
31 (b) Partially Contributory. One-Half Contributory Coverage. – The following persons
32 are eligible for coverage under the Plan Plan, on a partially one-half contributory basis basis,
33 subject to the provisions of G.S. 135-45.4:
34 (1) A school employee in a job-sharing position as ~~defined in G.S. 135-45.4.~~
35 described in G.S. 115C-326.5. If these employees elect to participate in the
36 Plan, the employing unit shall pay fifty percent (50%) of the Plan's total
37 ~~noncontributory employer~~ premiums. Individual employees shall pay the
38 balance of the total ~~noncontributory~~ premiums not paid by the employing
39 unit.
40 (2) ~~Subject to the provisions of G.S. 135-45.4, employees~~ Employees and
41 members of the General Assembly with 10 but less than 20 years of
42 retirement service credit provided the employees were first hired on or after
43 October 1, 2006, and the members first took office on or after February 1,
44 2007. For such future retirees, the State shall pay fifty percent (50%) of the
45 Plan's total ~~noncontributory employer~~ premiums. Individual retirees shall
46 pay the balance of the total ~~noncontributory~~ premiums not paid by the State.
47 (c) ~~Fully Contributory. Contributory Coverage.~~ – The following ~~person~~ persons shall be
48 eligible for coverage under the Plan, on a fully contributory basis, subject to the provisions of
49 G.S. 135-45.4:
50 (1) Former members of the General Assembly who enroll before October 1,
51 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.
- 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

1 in whole or in part by contributions of the State shall enroll the retiree in the active group and
2 pay the cost for the hospital-medical benefits if that retiree is employed in a position that would
3 require the employer to pay hospital-medical benefits if the individual had not been retired.

4 **SECTION 1.8.(b)** Effective July 1, 2011, the State's employer contribution rates
5 budgeted for retirement and related benefits as percentage of covered salaries for the 2011-2012
6 fiscal year are: (i) ten and sixty-one hundredths percent (10.61%) – Teachers and State
7 Employees; (ii) fifteen and sixty-one hundredths percent (15.61%) – State Law Enforcement
8 Officers; (iii) twelve and thirty-six hundredths percent (12.36%) – University Employees'
9 Optional Retirement System; (iv) twelve and thirty-six hundredths percent (12.36%) –
10 Community College Optional Retirement Program; (v) twenty and eleven hundredths percent
11 (20.11%) – Consolidated Judicial Retirement System; and (vi) five and zero hundredths percent
12 (5.00%) – Legislative Retirement System. Each of the foregoing contribution rates includes
13 five and zero hundredths percent (5.00%) for hospital and medical benefits. The rate for
14 Teachers and State Employees, State Law Enforcement Officers, Community College Optional
15 Retirement Program, and for the University Employees' Optional Retirement Program includes
16 fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for Teachers
17 and State Employees and State Law Enforcement Officers include sixteen hundredths percent
18 (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers includes five
19 percent (5%) for Supplemental Retirement Income.

20 **SECTION 1.8.(c)** Effective July 1, 2012, the State's employer contribution rates
21 budgeted for retirement and related benefits as percentage of covered salaries for the 2012-2013
22 fiscal year are: (i) ten and ninety-one hundredths percent (10.91%) – Teachers and State
23 Employees; (ii) fifteen and ninety-one hundredths percent (15.91%) – State Law Enforcement
24 Officers; (iii) twelve and sixty-six hundredths percent (12.66%) – University Employees'
25 Optional Retirement System; (iv) twelve and sixty-six hundredths percent (12.66%) –
26 Community College Optional Retirement Program; (v) twenty and forty-one hundredths
27 percent (20.41%) – Consolidated Judicial Retirement System; and (vi) five and thirty
28 hundredths percent (5.30%) – Legislative Retirement System. Each of the foregoing
29 contribution rates includes five and thirty hundredths percent (5.30%) for hospital and medical
30 benefits. The rate for Teachers and State Employees, State Law Enforcement Officers,
31 Community College Optional Retirement Program, and for the University Employees' Optional
32 Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income
33 Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include
34 sixteen hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law
35 Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

36 **SECTION 1.8.(d)** Effective July 1, 2011, the maximum annual employer
37 contributions, payable monthly, by the State for each covered employee or retiree for the
38 2011-2012 fiscal year to the State Health Plan for Teachers and State Employees are: (i)
39 Medicare-eligible employees and retirees – three thousand seven hundred sixty-eight dollars
40 (\$3,768) and (ii) non-Medicare-eligible employees and retirees – four thousand nine hundred
41 fifty-two dollars (\$4,952).

42 **SECTION 1.8.(e)** Effective July 1, 2012, the maximum annual employer
43 contributions, payable monthly, by the State for each covered employee or retiree for the
44 2012-2013 fiscal year to the State Health Plan for Teachers and State Employees are: (i)
45 Medicare-eligible employees and retirees – three thousand nine hundred sixty-five dollars
46 (\$3,965) and (ii) non-Medicare-eligible employees and retirees – five thousand two hundred
47 eleven dollars (\$5,211).

48
49 **REMOVE SPECIAL EXEMPTION FROM PUBLIC RECORDS LAW FOR STATE**
50 **HEALTH PLAN CONTRACTS**

51 **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.

1 **SECTION 2.4.(e)** G.S. 135-43.7 [contract disputes] is recodified as G.S. 135-48.35
2 under Part 3 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of
3 this act.

4
5 **RECODIFY PORTIONS OF PART 2 OF EXISTING STATE HEALTH PLAN**
6 **ARTICLE**

7 **SECTION 2.5.(a)** G.S. 135-44 [Board of Trustees] is recodified as G.S. 135-48.20
8 under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of
9 this act.

10 **SECTION 2.5.(b)** G.S. 135-44.1 [officers, quorum, meetings] is recodified as
11 G.S. 135-48.21 under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by
12 Section 2.3 of this act.

13 **SECTION 2.5.(c)** G.S. 135-44.2, as amended by Section 2.1 of this act, [Executive
14 Administrator] is recodified as G.S. 135-48.22 under Part 2 of Article 3B of Chapter 135 of the
15 General Statutes, as created by Section 2.3 of this act.

16 **SECTION 2.5.(d)** Subdivision (26) of G.S. 135-44.4 [member education] is
17 recodified as G.S. 135-48.56, to be entitled "Education of covered active and retired
18 employees.", under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by
19 Section 2.3 of this act.

20 **SECTION 2.5.(e)** G.S. 135-44.5 [trust funds] is recodified as G.S. 135-48.5 under
21 Part 1 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this
22 act.

23 **SECTION 2.5.(f)** G.S. 135-44.6(d) [firefighter premiums] is recodified as
24 G.S. 135-48.58, to be entitled "Premiums for firefighters, rescue squad workers, and members
25 of National Guard.", under Part 5 of Article 3B of Chapter 135 of the General Statutes, as
26 created by Section 2.3 of this act. G.S. 135-44.6(e) [interest on late payments] is recodified as
27 G.S. 135-48.55, to be entitled "Interest charged to charter schools on late premiums.", under
28 Part 5 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this
29 act.

30 **SECTION 2.5.(g)** G.S. 135-44.7 [administrative review] is recodified as
31 G.S. 135-48.24 under Part 2 of Article 3B of Chapter 135 of the General Statutes, as created by
32 Section 2.3 of this act.

33 **SECTION 2.5.(h)** G.S. 135-44.8 [rules] is recodified as G.S. 135-48.25 under Part
34 2 of Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.

35
36 **RECODIFY PORTIONS OF PART 3 OF EXISTING STATE HEALTH PLAN**
37 **ARTICLE**

38 **SECTION 2.6.(a)** Subsections (a) and (e) of G.S. 135-45 [undertaking] are
39 recodified as subsections (a) and (b) of G.S. 135-48.2 under Part 1 of Article 3B of Chapter 135
40 of the General Statutes, as created by Section 2.3 of this act. G.S. 135-45(c) [firefighter
41 coverage in public interest] is recodified as G.S. 135-48.8, to be entitled "Statements of public
42 interest.", under Part 1 of Article 3B of Chapter 135 of the General Statutes, as created by
43 Section 2.3 of this act. Subsection (d) of G.S. 135-45 [contracts with claim processors] is
44 recodified as G.S. 135-48.32, to be entitled "Contracts to provide benefits.", under Part 3 of
45 Article 3B of Chapter 135 of the General Statutes, as created by Section 2.3 of this act.
46 Subsection (d1) of G.S. 135-45 [contracting provisions] is recodified as G.S. 135-48.33, to be
47 entitled "Contracting provisions; large contract review by Attorney General, auditing, no cost
48 plus contracts.", under Part 3 of Article 3B of Chapter 135 of the General Statutes, as created
49 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 Statutes, 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 and the Executive 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 unrepresented 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.

1 **"§ 135-48.8. Statements of public interest.**

2 The State of North Carolina deems it to be in the public interest for North Carolina
3 firefighters, rescue squad workers, and members of the National Guard, and certain of their
4 dependents, who are not eligible for any other type of comprehensive group health insurance or
5 other comprehensive group health benefits, and who have been without any form of group
6 health insurance or other comprehensive group health benefit coverage for at least six
7 consecutive months, to be given the opportunity to participate in the benefits provided by the
8 State Health Plan for Teachers and State Employees. Coverage under the Plan shall be
9 voluntary for eligible firefighters, rescue squad workers, and members of the National Guard
10 who elect participation in the Plan for themselves and their eligible dependents.

11 **"§ 135-48.9: Reserved for future codification purposes.**

12 **"§ 135-48.10. Confidentiality of information and medical records; provider contracts.**

13 (a) Any information ~~as herein described in this section which~~ that is in the possession of
14 ~~the Executive Administrator and the Board of Trustees of the State Health Plan for Teachers~~
15 ~~and State Employees or its Claims Processor under the Plan or the Predecessor Plan shall be~~
16 confidential and shall be exempt from the provisions of Chapter 132 of the General Statutes or
17 any other provision requiring information and records held by State agencies to be made public
18 or accessible to the public. This section shall apply to all information concerning individuals,
19 including the fact of coverage or noncoverage, whether or not a claim has been filed, medical
20 information, whether or not a claim has been paid, and any other information or materials
21 concerning a plan participant. ~~Provided, however, such~~ This information ~~may may, however,~~ be
22 released to the State Auditor, or to the Attorney General, ~~or to the persons designated under~~
23 ~~G.S. 135-43.3 in furtherance of their statutory duties and responsibilities, or to such persons or~~
24 ~~organizations as may be designated and approved by the Executive Administrator and Board of~~
25 ~~Trustees of the Plan, but any~~ State Treasurer. Any information so released shall remain
26 confidential as stated above and any party obtaining such information shall assume the same
27 level of responsibility for maintaining such confidentiality as that of ~~the Executive~~
28 ~~Administrator and Board of Trustees of the State Health Plan for Teachers and State~~
29 ~~Employees.~~

30 (b) ~~Notwithstanding the provisions of this Article, the Executive Administrator and~~
31 ~~Board of Trustees of the State Health Plan for Teachers and State Employees may contract with~~
32 ~~providers of institutional and professional medical care and services to establish preferred~~
33 ~~provider networks. The~~ The terms of a contract between the Plan and its third party
34 administrator or between the Plan and its pharmacy benefit manager are a public record under
35 Chapter 132 of the General Statutes. No provision of law, however, shall be construed to
36 prevent or restrict the release of any information in a Plan contract to the State Treasurer, the
37 State Auditor, the Attorney General, the Director of the State Budget, the Plan's Board of
38 Trustees, and the Plan's Executive Administrator, and the Committee on Employee Hospital
39 and Medical Benefits Administrator solely and exclusively for their use in the furtherance of
40 their duties and responsibilities, ~~and to the Department of Health and Human Services solely~~
41 ~~for the purpose of implementing the transition of NC Health Choice from the Plan to the~~
42 ~~Department of Health and Human Services. The design, adoption, and implementation of the~~
43 ~~preferred provider contracts, networks, and optional alternative comprehensive health benefit~~
44 ~~plans, and programs available under the optional alternative plans, as authorized under~~
45 ~~G.S. 135-45 are not subject to the requirements of Article 3 of Chapter 143 of the General~~
46 ~~Statutes. However, the Executive Administrator and Board of Trustees shall: (i) submit all~~
47 ~~proposed statewide and agency term contracts for supplies, materials, printing, equipment, and~~
48 ~~contractual services that exceed one million dollars (\$1,000,000) authorized by this subsection~~
49 ~~to the Attorney General or the Attorney General's designee for review as provided in~~
50 ~~G.S. 114-8.3; and (ii) include in all proposed contracts to be awarded by the Executive~~
51 ~~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 of Trustees and shall serve as its Chair.

(e)(d) Three 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.

(d)(e) Three 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)(f) Three 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.

(f)(g) Each appointing authority may remove any member appointed by that appointing authority.

(g)(h) 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)(i) No member of the Board of Trustees may serve more than three consecutive two-year terms.

(i)(j) Meetings of the Board of Trustees may be called by the Executive Administrator, the Chair, or by any three members.

"§ 135-48.21. 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 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.

(c) Meetings may be called by the Chair, or at the written request of three members.

"§ 135-48.22. 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."~~

"§ 135-48.23: Reserved for future codification purposes.

"§ 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.

- (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 Attorney General, auditing, no cost plus contracts.

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,~~

1 implement such an agreement, which shall supersede all other provisions of the Plan to the
2 contrary related to its payment of claims for Medicare-eligible members.

3 "Part 4. Eligibility and Enrollment.

4 "**§ 135-48.40. Categories of eligibility.**

5 (a) Noncontributory Coverage. – The following persons are eligible for coverage under
6 the Plan, on a noncontributory basis, subject to the provisions of ~~G.S. 135-45.4:~~
7 G.S. 135-48.43:

8 ~~(3)~~(1) Retired teachers, State employees, members of the General Assembly, and
9 retired State law enforcement officers who retired under the Law
10 Enforcement Officers' Retirement System prior to January 1, 1985. Except
11 as otherwise provided in this subdivision, on and after January 1, 1988, a
12 retiring employee or retiree must have completed at least five years of
13 contributory retirement service with an employing unit prior to retirement
14 from any State-supported retirement system in order to be eligible for group
15 benefits under this Part as a retired employee or retiree. For employees first
16 hired on and after October 1, 2006, and members of the General Assembly
17 first taking office on and after February 1, 2007, future coverage as retired
18 employees and retired members of the General Assembly is subject to a
19 requirement that the future retiree have 20 or more years of retirement
20 service credit in order to be covered by the provisions of this subdivision.

21 ~~(4)~~(2) Surviving spouses of:

- 22 a. Deceased retired employees, provided the death of the former plan
23 member occurred prior to October 1, 1986; and
24 b. Deceased teachers, State employees, and members of the General
25 Assembly who are receiving a survivor's alternate benefit under any
26 of the State-supported retirement programs, provided the death of the
27 former plan member occurred prior to October 1, 1986.

28 (b) Partially Contributory Coverage. – The following persons are eligible for coverage
29 under the Plan, on a partially contributory basis, subject to the provisions of ~~G.S. 135-45.4:~~
30 G.S. 135-48.43:

31 (1) All permanent full-time employees of an employing unit who meet either of
32 the following conditions:

- 33 a. Paid from general or special State funds.
34 b. Paid from non-State funds and in a group for which his or her
35 employing unit has agreed to provide coverage.

36 Employees of State agencies, departments, institutions, boards, and
37 commissions not otherwise covered by the Plan who are employed in
38 permanent job positions on a recurring basis and who work 30 or more hours
39 per week for nine or more months per calendar year are covered by the
40 provisions of this subdivision.

41 (2) Permanent hourly employees who work at least one-half of the workdays of
42 each pay period.

43 (3) Retired teachers, State employees, members of the General Assembly, and
44 retired State law enforcement officers who retired under the Law
45 Enforcement Officers' Retirement System prior to January 1, 1985. Except
46 as otherwise provided in this subdivision, on and after January 1, 1988, a
47 retiring employee or retiree must have completed at least five years of
48 contributory retirement service with an employing unit prior to retirement
49 from any State-supported retirement system in order to be eligible for group
50 benefits under this Part as a retired employee or retiree. For employees first
51 hired on and after October 1, 2006, and members of the General Assembly

- 1 first taking office on and after February 1, 2007, future coverage as retired
2 employees and retired members of the General Assembly is subject to a
3 requirement that the future retiree have 20 or more years of retirement
4 service credit in order to be covered by the provisions of this subdivision.
- 5 (4) Employees of the General Assembly, not otherwise covered by this section,
6 as determined by the Legislative Services Commission, except for legislative
7 interns and pages.
- 8 (5) Members of the General Assembly.
- 9 (6) Notwithstanding the provisions of subsection (e) of this section, employees
10 on official leave of absence while completing a full-time program in school
11 administration in an approved program as a Principal Fellow in accordance
12 with Article 5C of Chapter 116 of the General Statutes.
- 13 (7) Notwithstanding the provisions of ~~G.S. 135-45.12,~~ G.S. 135-48.44,
14 employees formerly covered by the provisions of this section, other than
15 retired employees, who have been employed for 12 or more months by an
16 employing unit, or who have completed a contract term of employment of 10
17 or 11 months and whose employing unit is a local school administrative unit,
18 and whose jobs are eliminated because of a reduction, in total or in part, in
19 the funds used to support the job or its responsibilities, provided the
20 employees were covered by the Plan at the time of separation from service
21 resulting from a job elimination. Employees covered by this subsection shall
22 be covered for a period of up to 12 months following a separation from
23 service because of a job elimination. An employee formerly covered by the
24 provisions of this section shall not be eligible for coverage under this
25 subdivision if the employee is provided health benefit coverage on a
26 non-contributory basis by a subsequent employer.
- 27 (8) Any member enrolled pursuant to subdivision (1) or (2) of this subsection
28 who is on approved leave of absence with pay or receiving workers'
29 compensation.
- 30 (9) Employees on approved Family and Medical Leave.
- 31 (c) One-Half Contributory Coverage. – The following persons are eligible for coverage
32 under the Plan, on a one-half contributory basis, subject to the provisions of ~~G.S. 135-45.4:~~
33 G.S. 135-48.43:
- 34 (1) A school employee in a job-sharing position as described in
35 G.S. 115C-326.5. If these employees elect to participate in the Plan, the
36 employing unit shall pay fifty percent (50%) of the Plan's total employer
37 premiums. Individual employees shall pay the balance of the total premiums
38 not paid by the employing unit.
- 39 (2) Employees and members of the General Assembly with 10 but less than 20
40 years of retirement service credit provided the employees were first hired on
41 or after October 1, 2006, and the members first took office on or after
42 February 1, 2007. For such future retirees, the State shall pay fifty percent
43 (50%) of the Plan's total employer premiums. Individual retirees shall pay
44 the balance of the total premiums not paid by the State.
- 45 (d) Fully Contributory Coverage. – The following persons shall be eligible for coverage
46 under the Plan, on a fully contributory basis, subject to the provisions of ~~G.S. 135-45.4:~~
47 G.S. 135-48.43:
- 48 (1) Former members of the General Assembly who enroll before October 1,
49 1986.
- 50 (2) For enrollments after September 30, 1986, former members of the General
51 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:
- Operating such a vending facility;
 - 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
 - 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(e)(7)~~. G.S. 135-48.40(d)(7).

1 (c) No person shall be eligible for coverage as a dependent if eligible as an employee or
2 retired employee, except when a spouse is eligible on a fully contributory basis. In addition, no
3 person shall be eligible for coverage as a dependent of more than one employee or retired
4 employee at the same time.

5 (d) Former employees who are receiving disability retirement benefits or disability
6 income benefits pursuant to Article 6 of Chapter 135 of the General Statutes or who are
7 approved for those benefits but not in receipt of the benefits due to lump-sum payouts of
8 vacation and bonus leave, provided the former employee has at least five years of contributory
9 retirement service with an employing unit of a State-supported retirement system, shall be
10 eligible for the benefit provisions of this Plan, as set forth in this Part, on a noncontributory
11 basis. Such coverage shall terminate as of the end of the month in which such former employee
12 is no longer eligible for disability retirement benefits or disability income benefits pursuant to
13 Article 6 of this Chapter.

14 (e) Employees on official leave of absence without pay may elect to continue this group
15 coverage at group cost provided that they pay the full employee and employer contribution
16 through the employing unit during the leave period.

17 (f) For the support of the benefits made available to any member vested at the time of
18 retirement, their spouses or surviving spouses, and the surviving spouses of employees who are
19 receiving a survivor's alternate benefit under G.S. 135-5(m) of those associations listed in
20 G.S. 135-27(a), licensing and examining boards under G.S. 135-1.1, the North Carolina State
21 Art Society, Inc., and the North Carolina Symphony Society, Inc., each association,
22 organization or board shall pay to the Plan the full cost of providing these benefits under this
23 section as determined by ~~the Board of Trustees of the State Health Plan for Teachers and State~~
24 ~~Employees.~~ In addition, each association, organization or board shall pay to the Plan an amount
25 equal to the cost of the benefits provided under this section to presently retired members of
26 each association, organization or board since such benefits became available at no cost to the
27 retired member. This subsection applies only to those individuals employed prior to July 1,
28 1983, as provided in G.S. 135-27(d).

29 (g) An eligible surviving spouse and any eligible surviving dependent child of a
30 deceased retiree, teacher, State employee, member of the General Assembly, former member of
31 the General Assembly, or Disability Income Plan beneficiary shall be eligible for group
32 benefits under this section without waiting periods for preexisting conditions provided
33 coverage is elected within 90 days after the death of the former plan member. Coverage may be
34 elected at a later time, but will be subject to the 12-month waiting period for preexisting
35 conditions and will be effective the first day of the month following receipt of the application.

36 (h) No person shall be eligible for coverage as an employee or retired employee or as a
37 dependent of an employee or retired employee upon a finding by the ~~Executive Administrator~~
38 ~~or Board of Trustees~~ State Treasurer or by a court of competent jurisdiction that the employee
39 or dependent knowingly and willfully made or caused to be made a false statement or false
40 representation of a material fact in a claim for reimbursement of medical services under the
41 Plan or in any representation or attestation to the Plan.

42 ~~The Executive Administrator and Board of Trustees~~ State Treasurer may make an
43 exception to the provisions of this subsection when persons subject to this subsection have had
44 a cessation of coverage for a period of five years and have made a full and complete restitution
45 to the Plan for all fraudulent claim amounts. Nothing in this subsection shall be construed to
46 obligate the ~~Executive Administrator and Board of Trustees~~ State Treasurer to make an
47 exception as allowed for under this subsection.

48 (i) Any employee receiving benefits pursuant to Article 6 of this Chapter when the
49 employee has less than five years of retirement membership service, or an employee on leave
50 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~~

1 ~~and Board of Trustees~~ State Treasurer for optional alternative plans offered
2 under the Plan.

- 3 (4) Members of the General Assembly, beginning with the 1985 Session, shall
4 become first eligible with the convening of each Session of the General
5 Assembly, regardless of a Member's service during previous Sessions.
6 Members and their dependents enrolled when first eligible after the
7 convening of each Session of the General Assembly will not be subject to
8 any waiting periods for preexisting health conditions. Members of the 1983
9 Session of the General Assembly, not already enrolled, shall be eligible to
10 enroll themselves and their dependents on or before October 1, 1983,
11 without being subject to any waiting periods for preexisting health
12 conditions.

13 (b) Waiting Periods and Preexisting Conditions. –

- 14 (1) New employees and dependents enrolling when first eligible are subject to
15 no waiting period for preexisting conditions under the Plan.
- 16 (2) Employees not enrolling or not adding dependents when first eligible may
17 enroll later on the first of any following month, but will be subject to a
18 twelve-month waiting period for preexisting conditions except as provided
19 in subdivision (a)(3) of this section. The waiting period under this
20 subdivision is subject to applicable federal law.
- 21 (3) Retiring employees and dependents enrolled when first eligible after an
22 employee's retirement are subject to no waiting period for preexisting
23 conditions under the Plan. Retiring employees not enrolled or not adding
24 dependents when first eligible after an employee's retirement may enroll
25 later on the first of any following month, but will be subject to a 12-month
26 waiting period for preexisting conditions except as provided in subdivision
27 (a)(3) of this section.
- 28 (4) Employees and dependents enrolling or reenrolling within 12 months after a
29 termination of enrollment or employment that were not enrolled at the time
30 of this previous termination, regardless of the employing units involved,
31 shall not be considered as newly-eligible employees or dependents for the
32 purposes of waiting periods and preexisting conditions. Employees and
33 dependents transferring from optional prepaid alternative plans available
34 under the Plan; employees and dependents immediately returning to service
35 from an employing unit's approved periods of leave without pay for illness,
36 injury, educational improvement, workers' compensation, parental duties, or
37 for military reasons; employees and dependents immediately returning to
38 service from a reduction in an employing unit's work force; retiring
39 employees and dependents reenrolled in accordance with
40 ~~G.S. 135-45.4(b)(3);~~ subdivision (3) of this subsection; formerly-enrolled
41 dependents reenrolling as eligible employees; formerly-enrolled employees
42 reenrolling as eligible dependents; and employees and dependents reenrolled
43 without waiting periods and preexisting conditions under specific rules
44 adopted by the ~~Executive Administrator and Board of Trustees~~ State
45 Treasurer in the best interests of the Plan shall not be considered
46 reenrollments for the purpose of this subdivision. Furthermore, employees
47 accepting permanent, full-time appointments who had previously worked in
48 a part-time or temporary position and their qualified dependents shall not be
49 covered by waiting periods and preexisting conditions under this division
50 provided enrollment as a permanent, full-time employee is made when the
51 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.

- 1 (7) The effective date for newborns or adopted children will be date of birth,
2 date of adoption, or placement with adoptive parent provided member is
3 currently covered under employee and family or employee and child
4 coverage. If the member wishes to add a newborn or adopted child and is
5 currently enrolled in employee only coverage, the member must submit
6 application for coverage and a coverage type change within 30 days of the
7 child's birth or date of adoption or placement. Effective date for the coverage
8 category change is the first of the month in which the child is born, adopted,
9 or placed. Adopted children may also be covered the first of the month
10 following placement or adoption.
- 11 (d) Categories of Coverage Available. – There are four categories of coverage which an
12 employee or retiree may elect.
- 13 (1) Employee Only. – Covers enrolled employees only. Maternity benefits are
14 provided to employee only.
- 15 (2) Employee and Child. – Covers enrolled employee and all eligible dependent
16 children. Maternity benefits are provided to the employee only.
- 17 (3) Employee and Family. – Covers employee and spouse, and all eligible
18 dependent children. Maternity benefits are provided to employee or enrolled
19 spouse.
- 20 (4) Employee and spouse. Spouse. – Covers employee and spouse only.
21 Maternity benefits are provided to the employee or the employee's enrolled
22 spouse.
- 23 ~~(e) Notwithstanding any other provision of this section, no coverage under the Plan~~
24 ~~shall become effective prior to the payment of premiums required by the Plan.~~
- 25 ~~(f)(d)~~ Firefighters, rescue squad workers, and members of the National Guard are subject
26 to the same terms and conditions of this section as are employees. Eligible dependents of
27 firefighters, rescue squad workers, and members of the National Guard are subject to the same
28 terms and conditions of this section as are dependents of employees.
- 29 ~~(g) Different categories of coverage may be offered for optional alternative plans or~~
30 ~~programs.~~
- 31 ~~(h)(e)~~ If any provision of this section is in conflict with applicable federal law, federal law
32 shall control to the extent of the conflict.
- 33 **"§ 135-48.44. Cessation of coverage.**
- 34 (a) Coverage under this Plan of an employee and his or her surviving spouse or eligible
35 dependent children or of a retired employee and his or her surviving spouse or eligible
36 dependent children shall cease on the earliest of the following dates:
- 37 (1) The last day of the month in which an employee or retired employee dies.
38 Provided such surviving spouse or eligible dependent children were covered
39 under the Plan at the time of death of the former employee or retired
40 employee, or were covered on September 30, 1986, any such surviving
41 spouse or eligible dependent children may then elect to continue coverage
42 under the Plan by submitting written application to the Claims Processor and
43 by paying the cost for such coverage when due at the applicable fees. Such
44 coverage shall cease on the last day of the month in which such surviving
45 spouse or eligible dependent children die, except as provided by this Article.
- 46 (2) The last day of the month in which an employee's employment with the State
47 is terminated as provided in subsection (c) of this section.
- 48 (3) The last day of the month in which a divorce becomes final.
- 49 (4) The last day of the month in which an employee or retired employee
50 requests cancellation of coverage.

- 1 (5) The last day of the month in which a covered individual enters active
2 military service.
- 3 (6) The last day of the month in which a covered individual is found to have
4 knowingly and willfully made or caused to be made a false statement or
5 false representation of a material fact in a claim for reimbursement of
6 medical services under the Plan. The ~~Executive Administrator and Board of~~
7 ~~Trustees~~ State Treasurer may make an exception to the provisions of this
8 subdivision when persons subject to this subdivision have had a cessation of
9 coverage for a period of five years and have made a full and complete
10 restitution to the Plan for all fraudulent claim amounts. Nothing in this
11 subdivision shall be construed to obligate the ~~Executive Administrator and~~
12 ~~Board of Trustees~~ State Treasurer to make an exception as allowed for under
13 this subdivision.
- 14 (7) The last day of the month in which an employee who is Medicare-eligible
15 selects Medicare to be the primary payer of medical benefits. Coverage for a
16 Medicare-eligible spouse of an employee shall also cease the last day of the
17 month in which Medicare is selected to be the primary payer of medical
18 benefits for the Medicare-eligible spouse. Such members are eligible to
19 apply for conversion coverage.
- 20 (8) The last day of the month in which a covered individual is found to be
21 ineligible for coverage.
- 22 (b) Coverage under this Plan as a dependent child ceases when the child ceases to be a
23 dependent child as defined by ~~G.S. 135-45.1~~ G.S. 135-48.1 except, coverage may continue
24 under this Plan for a period of not more than 36 months after loss of dependent status on a fully
25 contributory basis provided the dependent child was covered under the Plan at the time of loss
26 of dependent status.
- 27 (c) Coverage under the Plan as a surviving dependent child whether covered as a
28 dependent of a surviving spouse, or as an individual member (no living parent), ceases when
29 the child ceases to be a dependent child as defined by ~~G.S. 135-45.1~~, G.S. 135-48.1, except
30 coverage may continue under the Plan on a fully contributory basis for a period of not more
31 than 36 months after loss of dependent status.
- 32 (d) Termination of employment shall mean termination for any reason, including layoff
33 and leave of absence, except as provided in subdivisions (a)(1) and (2) of this section, but shall
34 not, for purposes of this Plan, include retirement upon which the employee is granted an
35 immediate service or disability pension under and pursuant to a State-supported Retirement
36 System.
- 37 (1) In the event of termination for any reason other than death, coverage under
38 the Plan for an employee and his or her eligible spouse or dependent
39 children, provided the eligible spouse or dependent children were covered
40 under the Plan at termination of employment may be continued for a period
41 of not more than 18 months following termination of employment on a fully
42 contributory basis. Employees who were covered under the Plan at
43 termination of employment may be continued for a period of not more than
44 18 months or 29 months if determined to be disabled under the Social
45 Security Act, Title II, OASDI or Title XVI, SSI.
- 46 (2) In the event of approved leave of absence without pay, other than for active
47 duty in the armed forces of the United States, coverage under this Plan for an
48 employee and his or her dependents may be continued during the period of
49 such leave of absence by the employee's paying one hundred percent (100%)
50 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

1 loss of coverage under the Plan, provided that the spouse and eligible dependent children were
2 covered under the Plan at the time the employee became eligible for Medicare benefits which
3 results in a loss of coverage under the Plan.

4 **"§ 135-48.45. Conversion.**

5 (a) Upon a cessation of group coverage under the Plan and/or eligibility for group
6 coverage under the Plan, an employee or dependent shall be entitled to a conversion to
7 nongroup coverage without the necessity of a physical examination. Such conversion coverage
8 shall include hospitalization, surgical, and medical benefits as contained in the major medical
9 and alternative plan conversion provisions of Article 53 of Chapter 58 of the General Statutes.
10 The ~~Executive Administrator and Board of Trustees~~ State Treasurer in their his or her sole
11 discretion shall approve the conversion coverage, which shall be administered by the Claims
12 Processor through an insurance contract arranged by the Claims Processor, or administered as
13 otherwise directed by the ~~Executive Administrator and Board of Trustees~~ State Treasurer. An
14 eligible employee or dependent must apply for conversion coverage within 30 days after
15 termination of group eligibility.

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

21 **"Part 5. Coverage Mandates and Exclusions; Other Mandates**

22 **"§ 135-48.50. Coverage mandates.**

23 The Plan shall provide coverage subject to the following coverage mandates:

24 (1) Reserved.

25 (2) Immunizations. – The Plan shall pay one hundred percent (100%) of
26 allowable medical charges for immunizations for the prevention of
27 contagious diseases as generally accepted medical practices would dictate
28 when directed by a credentialed provider as determined by the claims
29 processor.

30 (3) Insulin. – Prescription benefits shall be provided for insulin even though a
31 prescription is not required.

32 (4) Mental health parity. – Benefits for the treatment of mental illness and
33 chemical dependency are covered by the Plan and shall be subject to the
34 same deductibles, durational limits, and coinsurance factors as are benefits
35 for physical illness generally. Nothing in this subdivision, however, shall
36 prohibit the Plan from requiring the most cost-effective treatment setting to
37 be utilized by a person undergoing necessary care and treatment for
38 chemical dependency.

39 (5) Reserved.

40 (6) Permissive coverage extension. – If a covered service becomes excluded
41 from coverage under the Plan, the Executive Administrator and Claims
42 Processor may, in the event of exceptional situations creating undue
43 hardships or adverse medical conditions, allow persons enrolled in the Plan
44 to remain covered by the Plan's previous coverage for up to three months
45 after the effective date of the change in coverage, provided the persons so
46 enrolled had been undergoing a continuous plan of specific treatment
47 initiated within three months prior to the effective date of the change in
48 coverage.

49 (7) Reconstructive surgery. – Charges for cosmetic surgery or treatment
50 required for correction of damage caused by accidental injury sustained by
51 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

1 accrued interest amount is remitted to the Plan. The remittance of premium payments under this
2 section shall be presumed to have been made if the remittance is postmarked in the United
3 States mail on a date not later than the fifteenth day of the month following the due date of the
4 remittance.

5 **"§ 135-48.56. Education of covered active and retired employees.**

6 It is the intent of the General Assembly that active employees and retired employees
7 covered under the Plan and its successor Plan shall have several opportunities in each fiscal
8 year to attend presentations conducted by Plan management staff providing detailed
9 information about benefits, limitations, premiums, co-payments, and other pertinent Plan
10 matters. To this end, the Plan's management staff shall conduct multiple presentations each year
11 to Plan members and association groups representing active and retired employees across all
12 geographic regions of the State. Regional meetings shall be held in locations that afford
13 reasonably convenient access to Plan members. The presentations shall be designed not only to
14 present information about the Plan but also to hear and respond to Plan members' questions and
15 concerns.

16 **"§ 135-48.57. Payments for county or city ambulance service.**

17 Allowable payments for services provided by a county or city ambulance service shall be
18 paid directly or shall be co-payable to the county or city ambulance service provider. As used
19 in this subsection, "county or city ambulance service" means ambulance services provided by a
20 county or county-franchised ambulance service supplemented by county funds, or a
21 municipally owned and operated ambulance service or by an ambulance service supplemented
22 by municipal funds.

23 **"§ 135-48.58. Premiums for firefighters, rescue squad workers, and members of National**
24 **Guard.**

25 In setting premiums for firefighters, rescue squad workers, and members of the National
26 Guard, and their eligible dependents, the ~~Executive Administrator and Board of Trustees~~ Plan
27 shall establish rates separate from those affecting other members of the Plan. These separate
28 premium rates shall include rate factors for incurred but unreported claim costs, for the effects
29 of adverse selection from voluntary participation in the Plan, and for any other actuarially
30 determined measures needed to protect the financial integrity of the Plan for the benefit of its
31 served employees, retired employees, and their eligible dependents.

32 **"Part 6. Long-term Care Benefits.**

33 **"§ 135-48.60. Undertaking.**

34 (a) The State of North Carolina undertakes to make available an optional program of
35 long-term care benefits for the benefit of its qualified employees, retired employees and their
36 dependents which will pay benefits in accordance with the terms hereof. Retired employees of
37 the Local Governmental Employees' Retirement System pursuant to Article 3 of Chapter 128 of
38 the General Statutes and their dependents are also eligible to be qualified for the benefits
39 provided by this Part.

40 (b) The long-term care benefits provided by this Part shall be made available through
41 the State Health Plan for Teachers and State Employees pursuant to ~~Article~~ Articles 2 and 3A
42 3B of this Chapter (hereinafter called the "Plan") and administered by the ~~Plan's Executive~~
43 ~~Administrator and Board of Trustees~~ State Treasurer. In administering the benefits provided by
44 this Part, the ~~Executive Administrator and Board of Trustees~~ State Treasurer shall have the
45 same type of powers and duties that are provided under ~~Part 3~~ the other Parts of this Article for
46 hospital and medical benefits. The benefits provided by this Part may be offered by the Plan on
47 a self-insured basis, in which case a third-party claims processor shall be chosen through
48 competitive bids, or through a contract of insurance, in which case a carrier licensed to do
49 business in North Carolina shall be selected on a competitive bid basis in accordance with State
50 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

1 physician other than a proprietor, employee, or agent of the nursing
2 home;

3 b. Confinement to a nursing home is for any overnight stay for which a
4 charge for a day's stay is due and payable; and

5 c. Prior to confinement, the admitting physician secures approval
6 certification from the Plan for confinement.

7 ~~As used in this section, a nursing home is a facility or a part of a facility which is (i) operated~~
8 ~~under State law and which is qualified as a skilled nursing or intermediate nursing facility~~
9 ~~under Medicare; or is (ii) a facility meeting the requirements for licensure under Chapter 131E~~
10 ~~of the General Statutes.~~

11 (2) Custodial Benefits. – The Plan will pay a fixed percentage of the fixed
12 amount of reasonable and customary daily charges allowed by the Plan in
13 subdivision (1) of this section for assisted living facilities, for adult day care
14 facilities, and for home care agencies up to a maximum amount per day for
15 each day after a fixed number of consecutive days that such custodial care is
16 provided. Benefits payable under this subdivision are contingent upon
17 compliance with the following conditions and will, in no instance, be paid
18 under this subdivision without compliance with each of the following
19 conditions:

20 a. Use of such custodial benefits is medically appropriate in a treatment
21 plan established and certified initially and at least once every six
22 months by an attending physician or other allied health professionals
23 other than a proprietor, employee, or agent of one or more of the
24 aforementioned facilities and agencies;

25 b. Confinement to a nursing home would be medically appropriate
26 without custodial care proposed to be rendered by one or more of the
27 aforementioned facilities or agencies; and

28 c. Prior to use of such custodial benefits, an attending physician or
29 other allied health professional secures approval from the Plan for the
30 use of the benefits.

31 ~~As used in this section, an assisted living facility is a facility which (i) is operated under State~~
32 ~~law to provide residential care for the aged or disabled whose principal need is a home which~~
33 ~~provides personal care appropriate to their age or disability; or (ii) meets the requirements for~~
34 ~~licensure under Chapter 131D of the General Statutes. As used in this section, an adult care~~
35 ~~facility is a facility which (i) is operated under State law to provide group care for the aged and~~
36 ~~disabled in a setting away from their residence on a less than 24-hour basis when such aged or~~
37 ~~disabled would otherwise be in need of full-time personal care away from their residence; or~~
38 ~~(ii) meets the requirements for certification under Chapter 131D of the General Statutes. As~~
39 ~~used in this section, a home care agency is a residential care agency which is (i) operated under~~
40 ~~State law and which is qualified as a home health care agency under Medicare; or (ii) an~~
41 ~~agency meeting the requirements for licensure as a home care agency under Chapter 131E of~~
42 ~~the General Statutes.~~

43 (3) Other Benefits. – Upon prior approval of the Plan, other care, services,
44 supplies, and equipment may be used as more cost-effective alternatives to
45 the benefits provided by this section when directed by an attending
46 physician.

47 (4) The Executive Administrator and Board of Trustees of the Plan shall
48 establish the payment percentages, maximum daily payment rates, benefit
49 periods, elimination periods, and maximum lifetime benefits payable for
50 each covered individual for the nursing home and custodial benefits
51 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.

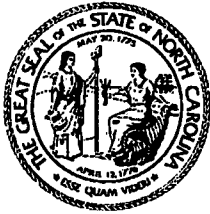
PART III. MISCELLANEOUS PROVISIONS

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: Transfer State Health Plan to State Treasurer

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Sens. Apodaca, Brunstetter, Hartsell
Analysis of: PCS to First Edition
S265-CSME-4

Date: March 16, 2011
Prepared by: Kory Goldsmith
Committee Counsel
Theresa Matula
Legislative Analyst

SUMMARY: *The PCS for 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

Senate PCS 265

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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	FY 2011-12 Proposed	FY 2012-13 Proposed	Current	FY 2011-12 Proposed	FY 2012-13 Proposed
	Basic (70/30) Plan	Basic (70/30) Plan	Basic (70/30) Plan	Standard (80/20) Plan	Standard (80/20) Plan	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-	\$55/Individual	\$64/Individual	50% Coinsurance	50% Coinsurance

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Payment ¹			after deductible	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 \$19,260 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 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

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.

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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

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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 Trustees as an ex officio member. The Treasurer would also be the chair of the Board. The remaining 9 members would still be appointed by the Governor (3 appointments) and the General Assembly (3 upon the recommendation of the President Pro Tempore of the Senate and 3 upon the recommendation of the Speaker of the House).
- 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.

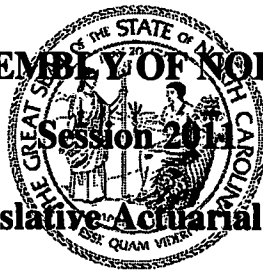
Section 2.12 provides that existing rules and policies continue to be effective unless they directly conflict with new Article 3B or until changed by the Treasurer.

Section 2.13 provides that headings are for the convenience of the reader and are for reference only.

Section 2.14 provides that Part II becomes effective January 1, 2012.

S265-SMRC-8(CSME-4) v9

GENERAL ASSEMBLY OF NORTH CAROLINA



Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: Senate Bill 265 Proposed Committee Substitute (S265-PCS35127-ME-4)

SHORT TITLE: State Health Plan/Appropriations and Transfer.

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 Proposed Committee Substitute for Senate Bill 265 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
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) 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 Additional Premium Contributions From Appropriated and Employee/Retiree Paid Funds			
Fund Source	FY 2011-12	FY 2012-13	Biennium
<u>Appropriated</u>			
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
<u>Member Contributions</u>			
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)						
Category	Aon Consulting (Plan)			Hartman & Assoc. (General Assembly)		
	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 (Proposed 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:

<u>Coverage Type</u>	Basic 70/30		Standard 80/20	
	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
<u>Actives</u>				
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%
<u>Retired</u>				
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%
<u>Former Employees with Continuation Coverage</u>				
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%
<u>Firefighters, Rescue Squad & National Guard</u>				
Employees	2	3	5	0.0%
Dependents	1	2	3	0.0%
Sub-total	3	5	8	0.0%
<u>Local Governments</u>				
Employees	486	1,429	1,915	0.3%
Dependents	303	629	932	0.1%
Sub-total	789	2,058	2,847	0.4%
<u>Total</u>				
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.

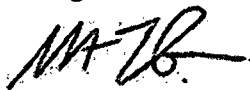
State Health Plan, various summarized claims reports for medical claims by category and purpose and time period, December 2010.

-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 Trogon



APPROVED BY: Marilyn Chism, Director
Fiscal Research Division



DATE:

SENATE INSURANCE COMMITTEE
Tuesday, March 23, 2011 at 10:00 AM
Room 1027, Legislative Building

MINUTES

The Senate Insurance Committee met at 10:00 AM on March 23, 2011, in Room 1027 of the Legislative Building. Fourteen members of the committee were present. Senator Meredith presided. Mercedes Bright of Pembroke and Mcckayla Bender of Aerdeen served as pages.

S.B. 232- Insurance Amendments- AB

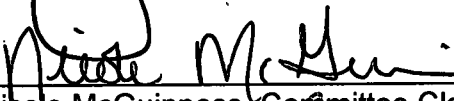
Senator Apodaca was recognized to explain the bill. Rose Williams, Legislative Liaison for the North Carolina Department of Insurance was introduced to explain the bill. Senator Apodaca moved to adopt the proposed committee substitute (PCS) for discussion. The motion carried. The PCS for Senate Bill 263 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. Senator Hise was recognized to ask a question. Senator Apodaca moved to amend the bill on page 1, line 12 by rewriting the line to read: "North Carolina Self-Insurance Security Association and the Association Aggregate Security System." Senator Apodaca moved for approval and the motion carried. Senator McKissick was recognized to ask Rose Vaughan Williams a question. Tim Hovis, NCGA Staff, was then recognized to answer the question.

Senator Vaughan moved for a favorable report as amended. A copy of the amendment, PCS and the summary are attached.

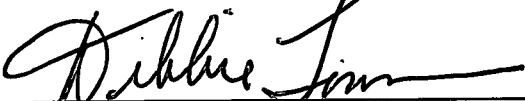
The meeting adjourned at 10:19 AM.



Senator Wesley Meredith, Presiding Chair
Senate Insurance Committee



Nicole McGuinness, Committee Clerk



Debbie Lown, Committee Clerk

Senate Insurance Committee
Wednesday, March 23, 2011, 10:00 AM
1027 LB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 323 Insurance Amendments.-AB

Senator Apodaca

Presentations

Other Business

Adjournment

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

INSURANCE COMMITTEE REPORT

**Senator Tom Apodaca, Co-Chair
Senator Wesley Meredith, Co-Chair**

Wednesday, March 23, 2011

Senator MEREDITH,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B.	323	Insurance Amendments.-AB	
		Draft Number:	15102
		Sequential Referral:	None
		Recommended Referral:	None
		Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

D

SENATE BILL 323
PROPOSED COMMITTEE SUBSTITUTE S323-PCS15102-RG-3

Short Title: Insurance Amendments.-AB

(Public)

Sponsors:

Referred to:

March 14, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO MAKE CHANGES IN THE INSURANCE LAWS TO PRIVATIZE ONLINE
3 AND ADMINISTRATIVE PROCESSES FOR LICENSE APPLICANTS, CODIFY THE
4 EXISTING SENIORS' HEALTH INSURANCE INFORMATION PROGRAM, ENSURE
5 ACCURACY IN CERTIFICATES OF INSURANCE, REQUIRE PRIOR APPROVAL OF
6 SMALL GROUP HEALTH INSURANCE RATES AND ENCOURAGE THE SALE OF
7 CHILD-ONLY HEALTH INSURANCE POLICIES, AMEND THE RISK-BASED
8 CAPITAL LAW TO MAINTAIN NAIC ACCREDITATION, PROVIDE AN
9 EXEMPTION FOR LICENSING OF CLAIMS INPUT EMPLOYEES FOR PORTABLE
10 ELECTRONIC DEVICES, PROHIBIT FEDERAL PREEMPTION OF CROP
11 ADJUSTERS' REGULATION, AND EASE THE REGULATORY BURDEN ON THE
12 NORTH CAROLINA SELF-INSURANCE SECURITY ASSOCIATION AND THE
13 ASSOCIATION AGGREGATE SECURITY SYSTEM.

14 The General Assembly of North Carolina enacts:

15 SECTION 1. G.S. 58-2-69(g) reads as rewritten:
16 "(g) The Commissioner may contract with the NAIC or other persons for the provision
17 of online services to applicants and licensees, for the provision of administrative ~~services to~~
18 ~~licensees, or services, for the provision of license processing and support services, and~~ for the
19 provision of regulatory data systems to the Commissioner. The NAIC or other person with
20 whom the Commissioner contracts may charge applicants and licensees a reasonable fee for the
21 ~~costs associated with the licensees' use the provision of online services and services, the~~
22 provision of administrative services, services, the provision of license processing and support
23 services, and the provision of regulatory data systems to the Commissioner. The fee shall be
24 agreed to by the Commissioner and the other contracting party and shall be stated in the
25 contract. The fee is in addition to any applicable license application and renewal fees. Contracts
26 for the provision of online services, contracts for the provision of administrative services, and
27 contracts for the provision of regulatory data systems shall not be subject to Article 3, 3C, or 8
28 of Chapter 143 of the General Statutes or to Article 3D of Chapter 147 of the General Statutes.
29 However, the Commissioner shall: (i) submit all proposed statewide and agency term contracts
30 for supplies, materials, printing, equipment, and contractual services that exceed one million
31 dollars (\$1,000,000) authorized by this subsection to the Attorney General or the Attorney
32 General's designee for review as provided in G.S. 114-8.3; and (ii) include in all contracts to be
33 awarded by the Commissioner under this subsection a standard clause which provides that the
34 State Auditor and internal auditors of the Commissioner may audit the records of the contractor



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1 during the term of the agreement or contract to verify accounts and data affecting fees and
2 performance. The Commissioner shall not award a cost plus percentage of cost agreement or
3 contract for any purpose."

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

6 **"§ 58-2-31. Seniors' Health Insurance Information Program.**

7 The Seniors' Health Insurance Information Program is established within the Department as
8 a statewide health benefits counseling program to provide the State's Medicare beneficiaries
9 with counseling in Medicare, Medicare supplement insurance, long-term care insurance, and
10 related health care coverage plans."

11 **SECTION 3.** G.S. 58-3-150 reads as rewritten:

12 **"§ 58-3-150. Forms to be approved by Commissioner.**

13 (a) It is unlawful for any insurance company licensed and admitted to do business in
14 this State to issue, sell, or dispose of any policy, contract, ~~or~~ certificate, or certificate of
15 insurance, or use applications in connection therewith, until the forms of the same have been
16 submitted to and approved by the Commissioner, and copies filed in the Department. If a policy
17 form filing is disapproved by the Commissioner, the Commissioner may return the filing to the
18 filer. As used in this section, "policy form" includes endorsements, riders, or amendments to
19 policies that have already been approved by the Commissioner.

20 (b) With respect to group and blanket accident and health insurance, group life
21 insurance, and group annuity policies issued and delivered to a trust or to an association outside
22 of this State and covering persons resident in this State, the group certificates to be delivered or
23 issued for delivery in this State shall be filed with and approved by the Commissioner pursuant
24 to subsection (a) of this section.

25 (c) If not submitted electronically, all contracts, literature, advertising materials, letters,
26 and other documents submitted to the Department to comply with the filing requirements of
27 this Chapter or an administrative rule adopted pursuant to this Chapter shall be submitted on
28 paper eight and one-half inches by eleven inches. Brochures and pamphlets shall not be stapled
29 or bound.

30 (d) As used in this section, "certificate of insurance" means a document prepared or
31 issued by an insurance company or producer that is used to verify or evidence the existence of
32 property or casualty insurance coverage. "Certificate of insurance" shall not include a policy of
33 insurance or insurance binder.

34 (e) A certificate of insurance is not a policy of insurance and does not amend, extend,
35 or alter the coverage afforded by the policy to which the certificate of insurance makes
36 reference. A certificate of insurance shall not confer to a certificate of insurance holder new or
37 additional rights beyond what the referenced policy of insurance expressly provides.

38 (f) It is unlawful for any person to knowingly prepare, issue, request, or require a
39 certificate of insurance that meets any of the following criteria:

40 (1) Has not been filed with and approved by the Commissioner.

41 (2) Contains any false or misleading information concerning the policy of
42 insurance to which the certificate of insurance makes reference.

43 (3) Purports to alter, amend, or extend the coverage provided by the policy of
44 insurance to which the certificate of insurance makes reference.

45 (g) A holder of a certificate of insurance shall only have a legal right to notice of
46 cancellation, nonrenewal, or any material change, or any similar notice concerning a policy of
47 insurance if the holder is named within the policy or any endorsement and the policy or
48 endorsement requires notice to be provided to the holder. The terms and conditions of the
49 notice, including the required timing of the notice, are governed by the policy of insurance and
50 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

1 the extent that such an adjustment is in compliance with the applicable product's current rate
2 filing approved by the Commissioner."

3 SECTION 6. G.S. 58-12-2 reads as rewritten:

4 "§ 58-12-2. Definitions.

5 As used in this Article, the following terms have the following meanings:

- 6 (1) Adjusted risk-based capital report. – A risk-based capital report that has been
7 adjusted by the Commissioner under G.S. 58-12-6.
- 8 (2) Corrective order. – An order issued by the Commissioner specifying
9 corrective actions that the Commissioner has determined are required.
- 10 (3) Domestic insurer. – Any insurance company or health organization
11 organized in this State under ~~Article 7~~, Article 7 of this Chapter as specified
12 in subdivisions (4b) and (5a) of this section, or under Article 15, 65, or 67
13 of this Chapter.
- 14 (4) Foreign insurer. – Any insurance company or health organization that is
15 admitted to do business in this State under Article 16 or 67 of this Chapter
16 but is not domiciled in this State.
- 17 (4a) Health organization. – Any insurer which is required by the Commissioner
18 to use the NAIC Health Annual Statement Blank when filing the annual
19 statement prescribed by G.S. 58-2-165 or any health maintenance
20 organization, limited health service organization, dental or vision plan,
21 hospital, medical, or dental indemnity or service corporation, or other
22 organization licensed under Article 65 or 67 of this Chapter. "Health
23 organization" does not include an insurer that is licensed as either a life or
24 health insurer or a property or casualty insurer under this Chapter and that is
25 otherwise subject to either the life or property and casualty risk-based capital
26 requirements.
- 27 (4b) Life or health insurer. – Any insurance company licensed to write the kinds
28 of insurance specified in G.S. 58-7-15(1), (2), or (3); or a licensed property
29 and casualty insurer writing only the kinds of insurance specified in
30 G.S. 58-7-15(3). "Life or health insurer" does not mean any insurer that is
31 required by the Commissioner to use the NAIC Health Annual Statement
32 Blank when it files the annual statement prescribed by G.S. 58-2-165.
- 33 (5) Negative trend. – A negative trend, with respect to a life or health insurer,
34 over a period of time, as determined in accordance with the "trend test
35 calculation" included in the risk-based capital instructions.
- 36 (5a) Property or casualty insurer. – Any insurance company licensed to write the
37 kinds of insurance specified in G.S. 58-7-15(4) through (22); but not
38 monoline mortgage guaranty insurers, financial guaranty insurers, or title
39 ~~insurers.~~ insurers; nor any insurer that is required by the Commissioner to use
40 the NAIC Health Annual Statement Blank when filing the annual statement
41 prescribed by G.S. 58-2-165.
- 42 (6) Risk-based capital instructions. – The risk-based capital report including
43 risk-based capital instructions adopted by the NAIC, as those risk-based
44 capital instructions may be amended by the NAIC from time to time in
45 accordance with the procedures adopted by the NAIC.
- 46 (7) Risk-based capital level. – An insurer's company action level risk-based
47 capital, regulatory action level risk-based capital, authorized control level
48 risk-based capital, or mandatory control level risk-based capital where:
49 a. "Company action level risk-based capital" means, with respect to any
50 insurer, the product of 2.0 and its authorized control level risk-based
51 capital.

- 1 b. "Regulatory action level risk-based capital" means the product of 1.5
2 and its authorized control level risk-based capital.
- 3 c. "Authorized control level risk-based capital" means the number
4 determined under the risk-based capital formula in accordance with
5 the risk-based capital instructions.
- 6 d. "Mandatory control level risk-based capital" means the product of
7 .70 and the authorized control level risk-based capital.
- 8 (8) Risk-based capital plan. – A comprehensive financial plan containing the
9 elements specified in G.S. 58-12-11(b). If the Commissioner rejects the
10 risk-based capital plan, and it is revised by the insurer, with or without the
11 Commissioner's recommendation, the plan shall be called the "revised
12 risk-based capital plan".
- 13 (9) Risk-based capital report. – The report required in G.S. 58-12-6.
- 14 (10) Total adjusted capital. – The sum of:
- 15 a. An insurer's statutory capital and surplus, as determined in
16 accordance with the statutory accounting applicable to the annual
17 financial statements required under G.S. 58-2-165; and
- 18 b. Such other items, if any, as the risk-based capital instructions may
19 provide."

20 **SECTION 7.** G.S. 58-12-11(a) reads as rewritten:

21 "(a) "Company action level event" means any of the following events:

- 22 (1) The filing of a risk-based capital report by an insurer that indicates that:
- 23 a. The insurer's total adjusted capital is greater than or equal to its
24 regulatory action level risk-based capital but less than its company
25 action level risk-based capital, ~~if the insurer is a property or casualty~~
26 ~~insurer or a health organization; capital; or~~
- 27 b. ~~The~~ In the case of a life or health insurer, the insurer has total
28 adjusted capital that is greater than or equal to its company action
29 level risk-based capital but less than the product of its authorized
30 control level risk-based capital and 2.5 and has a negative trend, ~~if~~
31 ~~the insurer is a life or health insurer; trend; or~~
- 32 c. In the case of a property or casualty insurer or a health organization,
33 the insurer has total adjusted capital that is greater than or equal to its
34 company action level risk-based capital but less than the product of
35 its authorized control level risk-based capital and 3.0 and triggers the
36 trend test determined in accordance with the trend test calculation
37 included in the property and casualty or health organization
38 risk-based capital instructions.
- 39 (2) The notification by the Commissioner to the insurer of an adjusted ~~risk-based~~
40 risk-based capital report that indicates the event in sub-subdivision ~~(1)a. or~~
41 ~~b.(1)a., (1)b., or (1)c.~~ of this subsection if the insurer does not challenge the
42 adjusted risk-based capital report under G.S. 58-12-30.
- 43 (3) If the insurer challenges an adjusted risk-based capital report that indicates
44 the event in sub-subdivision ~~(1)a. or b. (1)a., (1)b., or (1)c.~~ of this subsection
45 under G.S. 58-12-30, the notification by the Commissioner to the insurer that
46 the Commissioner has rejected the insurer's challenge."

47 **SECTION 8.** Article 33 of Chapter 58 of the General Statutes is amended by
48 adding a new section to read:

49 "§ 58-33-27. Claims handling for portable consumer electronic devices.

50 (a) As used in this section, the following definitions apply:

- 1 (1) "Automated claims adjudication system" means a preprogrammed computer
2 system designed for the collection, data entry, calculation, and system
3 generated final resolution of claims on insurance policies that provide
4 coverage only on the repair and replacement of portable consumer electronic
5 devices, which system shall meet the following criteria:
6 a. Be utilized only by a licensed adjuster or supervised individuals
7 operating pursuant to this section.
8 b. Comply with all claims payment requirements of this Chapter.
9 c. Be certified as compliant with this section by a licensed adjuster who
10 is an officer of a licensed business entity under this Chapter.
11 (2) "Portable consumer electronic devices" include the following, which must be
12 easily carried or conveyed by hand: smartphones, navigation devices,
13 cellular phones, personal digital assistants, iPads, iPhones, Androids, video
14 games, wireless reading devices, laptops, tablets, netbooks, MP3 players,
15 digital cameras, and other electronic devices that are portable in nature, their
16 accessories, and services related to the use of the device.
17 (b) No adjuster license is required for an individual who, in connection solely with
18 coverage on the repair and replacement of portable consumer electronic devices as defined in
19 subdivision (a)(2) of this section, collects claim information from or furnishes claim
20 information to insureds, who conducts data entry, including entering data into an automated
21 claims adjudication system, and who does not exercise any discretion in the disposition of the
22 claim; provided that the individual is supervised by a licensed adjuster under this Chapter and
23 there are no more than 25 individuals who may adjust claims under the supervision of the
24 licensed adjuster.
25 (c) If other property losses occur in conjunction with the loss associated with the
26 portable consumer electronic device, the individual who performs duties as described in
27 G.S. 58-33-10(2) on the total loss, including the loss associated with the portable consumer
28 electronic device, must hold an adjuster license."
29 SECTION 9. G.S. 58-33-30(e) reads as rewritten:
30 "(e) Examination.
31 (1) After completion and filing of the application with the Commissioner, the
32 Commissioner shall require each applicant for license as an agent or an
33 adjuster to take an examination as to the applicant's competence to be
34 licensed. The applicant must take and pass the examination according to
35 requirements prescribed by the Commissioner. This subsection shall not
36 apply to adjusters who adjust only federal crop insurance claims and are
37 certified in accordance with subsection (2a) of this section.
38 (2) The Commissioner may require any licensed agent, adjuster, or motor
39 vehicle damage appraiser to take and successfully pass an examination in
40 writing, testing his competence and qualifications as a condition to the
41 continuance or renewal of his license, if the licensee has been found guilty of
42 any violation of any provision of this Chapter. If an individual fails to pass
43 such an examination, the Commissioner shall revoke all licenses issued in
44 his name and no license shall be issued until such individual has passed an
45 examination as provided in this Article.
46 (2a) Adjusters who adjust federal crop insurance claims shall be certified as
47 having passed a proficiency examination approved by the federal Risk
48 Management Agency (RMA) as a condition of obtaining an adjuster's license
49 under this Chapter, or another proficiency examination approved by the
50 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, 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~~

- 1 Commissioner at least 90 days prior to the termination of the
2 Association Aggregate Security System. ~~every~~ Every self-insurer
3 shall deposit with the Commissioner, or continue to deposit, the
4 amount required by G.S. 97-185(b3) in the manner prescribed by
5 G.S. 97-185(c).
- 6 f. Group self-insurers shall not participate in the Association Aggregate
7 Security System.
- 8 (3) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.
- 9 (3a) Assess members of the Association as follows:
- 10 a. Association Aggregate Security System assessments. – The
11 Association shall assess each individual self-insurer participating in
12 the Association Aggregate Security System a security system
13 assessment. The amount of the security system assessment charged to
14 each individual self-insurer participating in the Association
15 Aggregate Security System shall be based on the Association's
16 reasonable consideration of all of the following factors:
- 17 1. The total amount of assessments necessary to provide
18 aggregate security for all participating individual
19 self-insurers.
- 20 2. The individual self-insurer's total workers' compensation
21 liabilities under the Act.
- 22 3. The financial strength and creditworthiness of the
23 participating individual self-insurer.
- 24 4. Any other relevant factors.
- 25 b. Special assessment. – In the event that there are covered claims
26 against an insolvent member or members and the assets of the Fund
27 are not sufficient to pay the obligations of the Association, then the
28 Association may collect a special assessment from the members in an
29 amount sufficient to pay the aggregate value of such covered claims.
30 Each member's special assessment shall be determined by the Board
31 and shall be based on the proportion of the member's total obligations
32 under the Act to the aggregate total of all members' obligations under
33 the Act.
- 34 c. Initial assessments. – An individual self-insurer that becomes a
35 member and does not initially participate in the Association
36 Aggregate Security System shall pay an initial assessment to the
37 Association in an amount determined by the Board. A group
38 self-insurer, upon receiving its initial license from the Commissioner,
39 shall pay an initial assessment to the Association in an amount
40 determined by the Board.
- 41 d. Each member shall be notified of assessments no later than 30 days
42 before the assessment is due.
- 43 e. Delinquent assessments, except as otherwise provided, shall bear
44 interest at a rate to be established by the Board.
- 45 f. Group assessments. – The Association may annually assess each
46 member group self-insurer in an amount not to exceed two percent
47 (2%) of the group self-insurer's annual gross premiums for the
48 preceding calendar year, as determined under G.S. 105-228.5(b),
49 (b1), and (c).
- 50 (4) Be obligated to pay covered claims.

- 1 (5) After paying any covered claim, be subrogated to the rights of the injured
2 employee and dependents and be entitled to enforce liability against the
3 self-insurer or any third party by any appropriate action brought in its own
4 name or in the name of the injured employee and dependents.
- 5 (6) Expend Fund assets in amounts necessary to pay all of the following:
6 a. The obligations of the Association under this Article subsequent to
7 an insolvency.
8 b. The expenses of handling covered claims subsequent to an
9 insolvency.
10 c. The cost of examinations under G.S. 97-137.
11 d. The costs of implementing and operating the Association Aggregate
12 Security System.
13 e. All other expenses authorized by this Article.
- 14 (7) Investigate claims brought against the Association and adjust, compromise,
15 settle, and pay covered claims to the extent of the Association's obligation;
16 and deny all other claims. The Association may review settlements to which
17 the insolvent member was a party to determine the extent to which such
18 settlements may be properly contested.
- 19 (8) Notify such persons as the Commissioner directs under G.S. 97-136.
- 20 (9) Handle claims through its directors, its employees, or through one or more
21 members or other persons designated as servicing facilities. ~~Designation of a~~
22 ~~servicing facility is subject to the approval of the Commissioner, but~~
23 ~~designation of a member as a servicing facility may be declined by such~~
24 ~~member.~~
- 25 (10) Reimburse each servicing facility for obligations of the Association paid by
26 the facility and for expenses incurred by the facility while handling claims
27 on behalf of the Association.
- 28 (11) Pay any other expenses of the Association authorized by this section.
- 29 (12) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.
- 30 (13) Require each member to determine annually its total undiscounted claims
31 liability and shall require each member to notify the Association of this
32 determination.
- 33 (b) The Association may:
34 (1) Employ or retain such persons, including, but not limited to, adjustors,
35 brokers, accountants, attorneys, financial advisors, investment bankers,
36 placement agents, and consultants, as the Board may determine are
37 necessary to handle claims, perform other duties of, provide services to, and
38 consult with the Association.
39 (2) Borrow funds necessary to effect the purposes of this Article in accord with
40 the Plan, including entering into standby lines of credit.
41 (3) Sue or be sued.
42 (4) Negotiate and become a party to such contracts as are necessary to carry out
43 the purpose of this section.
44 (5) Perform such other acts as are necessary or proper to effectuate the purpose
45 of this section.
46 (6) ~~Reimburse the Department of Insurance up to twenty thousand dollars~~
47 ~~(\$20,000) for consultants retained by the Department to review the initial~~
48 ~~plan submitted pursuant to G.S. 97-133(a)(2a).~~
- 49 (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.

...."

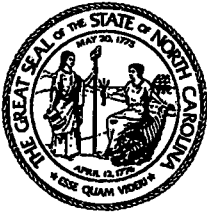
SECTION 11. G.S. 97-185(a1) reads as rewritten:

"(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.



SENATE BILL 323: Insurance Amendments.-AB

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Sen. Apodaca
Analysis of: PCS to First Edition
S323-CSR-3

Date: March 22, 2011
Prepared by: Tim Hovis
Committee Counsel

SUMMARY: *Senate Bill 323 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.*

[As introduced, this bill was identical to H298, as introduced by Rep. Dockham, which is currently in House Insurance, if favorable, Finance.]

Senate Bill 323 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 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.

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 coverage on the repair and replacement of portable consumer electronic devices; collect claims information and conduct data entry, and exercise no discretion in the disposition of the claim. For the exemption to apply, the individual must be supervised by a licensed adjuster who supervises no more than 25 individuals adjusting claims.

Senate PCS 323

Page 2

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 determine and report its 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).

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.

S323-SMRG-7(CSRG-3) v2



NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 323

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

Page 1 of 1

S323-ARG-4 [v.1]

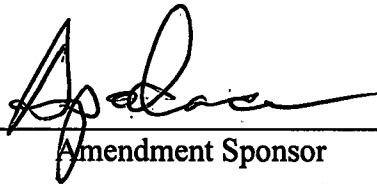
Comm. Sub. [YES]
Amends Title [YES]
First Edition

Date _____, 2011

Senator _____

- 1 moves to amend the bill on page 1, line 12,
- 2 by rewriting the line to read:
- 3 "NORTH CAROLINA SELF-INSURANCE SECURITY ASSOCIATION AND THE
- 4 ASSOCIATION AGGREGATE SECURITY SYSTEM."

SIGNED _____


Amendment Sponsor

SIGNED _____

Committee Chair if Senate Committee Amendment

ADOPTED _____

FAILED _____

TABLED _____



* S 3 2 3 - A R G - 4 - V - 1 *

VISITOR REGISTRATION SHEET

INSURANCE SENATE

Name of Committee

3/23/11

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jean Holliday	NCDOJ
Ben Popkin	NCDOJ
Barbara Condon	PRCOP
Abby Carter Emmons	NMSS-NC
DAVID BAERTS	PS
Monica E. Q.	Cory
Kevin Egan	NMPS
Robert PASHA	Young Moore
Dave / Jim	SA
Jessica Waver	
Chris Myron	NCMS

VISITOR REGISTRATION SHEET

INSURANCE SENATE

Name of Committee

3/23/11

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John McMillan	Met + S
Carly Szwed	St. Louis Firm
AM Bond	BCS
~~Justin R. Ruffolo~~	KCFB
Dana Simpson	Smith Anderson
Susan Valamini	National
Jan Andrews	Dept. of Insurance
Merrill B. W. G.	MWC
LC	PCRB
Louis BeLo	NCDOL
Carla Obuse	NCDOL

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

David Baum	Trautman Sanders
Katharine Joyce	NCAAA
Mark Fleming	B&BSNL
Mandi Wild	Norant
Christine Craig	WakeMed
Jaime King	NCEL
S. Jones	NCCU
Ed Luriston	Brooks Pierce
Bl Miller	Moses Cone
Bill Ruston	AT&P
Mike Jones	✓

VISITOR REGISTRATION SHEET

ATTACHMENT 4

Insurance
Name of Committee

3/24/11
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Emily Grimm	MWC
Jack Walker	NGSHP
Carol Durrell	"
Lacey Barnes	"
Mona Moor	SHP
Cherie Gray	City
Susan Valauri	Nationwide
John McMullen	MFS
Don Haran	NCNA, TAO
Emelyn Hawthorne	PENC, NCAP
Beverly Harris	State Health Plan

VISITOR REGISTRATION SHEET

Insurance

Name of Committee

Date

3/24/11

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Tracy Stephenson	NC SHP
Anne Rogers	SHP
Caroline Smart	SHP
LOTTA CRABTREE	NC SHP
PAGE WORSHAM	LEGISLATIVE REPORTING SERVICE
Sara Fender	IFNC
Suzanne Beasley	SEANC
Mitch Leonard	SEANC
Charles W. Lewis	SEANC
Ardis Watkins	SEANC

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

John Derrin	Governor's Office
Andrew Holton	Dept. State Treasury
David Starling	" "
A. SOLARI	DST
Andrew Lynch	DST
RON OTTAVIO	DST
David Holton	att
Robert Paschal	Young Marine
12u Kynla	Kynla Lane Farm
Forest Gilliam	Governor's Office
Rose Williams	NC DOT

VISITOR REGISTRATION SHEET

Name of Committee

Insurance

Date

3/24/11

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Andy Elle	NCR
Fred Brown	Born & Assoc
Mani Freeman	NCAE
Dana Fenton	City of Charlotte
Harold Brown	NCRMA
Toni Davis	SEARC
Donna	Tomacounts Inc Charlotte
Wen & Kelly	Poling Group
Chry Beyer	NCRS

SENATE INSURANCE COMMITTEE
Wednesday, April 13, 2011 at 10:00 AM
Room 1027, Legislative Building

MINUTES

The Senate Insurance Committee met at 10:00 AM on April 13, 2011, in Room 1027 of the Legislative Building. Fifteen members of the committee were present. Senator Meredith presided. Sydney Monsees of Greensboro and Amaranth Brunner of Murphy served as pages.

H.B. 138- Amend Health Insurance Risk Pool Statues

Senator Meredith recognized Representative Dockham to give general background of HB 138 and explanation of each section was given. House Bill 138 makes changes to the North Carolina Risk Pool. Senator Hise moved for favorable report and the motion carried. A copy of the bill summary is attached.

S.B. 195- Operation of Mopeds

Senator Meredith recognized Senator Apodaca to explain the history, describe issues, and quoted specific incidents to justify need for bill. Senate Bill 195 would require mopeds to be registered with the DMV, make it unlawful to operate a moped on a highway or public vehicular area without proper financial responsibility, and prohibit an operator of a moped from carrying passengers. Senator Clary was recognized to make a statement regarding graduated license provision in connection with moped drivers. Senator McKissick was recognized to ask a question regarding moped VIN numbers. Senator Apodaca was recognized to answer Senator McKissick questions, saying for the first year they will use the serial number until manufacturers begin using VIN numbers. Senator McKissick was recognized to ask if insurance coverage was available for mopeds. Rose Vaughan Williams, Legislative Counsel for the NC DOI, responded yes. Senator McKissick was recognized to ask if the individual traveling on a moped without insurance would be cited. Rose Vaughan Williams was recognized to answer that the offense would be a Class One misdemeanor for failure to carry insurance. Senator Jackson was recognized to ask if the limit of the policy will be the same as the vehicles. Rose Vaughan Williams was recognized to answer yes. Senator White was recognized to ask the difference between a scooters and moped. Senator Apodaca was recognized to say these details would be worked out in finance committee. Senator Vaughan was recognized to make the statement that he believed the classification of moped or motorcycle or scooter should be stated on the register. Senator Apodaca was recognized to ask if Senator Vaughan saw an increase in moped accidents. Senator Vaughan responded he did see one serious accident regarding mopeds, which changed his views on the bill. Senator Clary was recognized to amend SB 195 on page 1, lines 8-9 by rewriting the lines to read "(a) General Provisions- It shall be unlawful for any person who is under the age of 17 and has not completed the graduated drivers licenses process to operate a moped, as defined in G.S. 10-164.3. G.S. 105-164.3, upon any" and on page 2, line 3 by deleting "December 1, 2011" and substituting "July 1, 2012." Tim Hovis, NCGA Staff, was recognized to explain the amendment.

Senator Clary moved to adopt the amendment and the motion carried. Senator Clary made a motion for favorable report as amended and rolled into a proposed committee substitute and referred to Finance. A copy of the summary, PCS and amendment is attached.

S.B 321- Surplus Lines/Premium Tax. -AB

Senator Hise was recognized to make a motion to adopt the PCS for discussion and the motion carried. Tim Hovis, NCGA Staff, was recognized to explain the PCS. PCS for Senator Bill 321 makes changes to the law governing surplus lines insurers to conform to the federal Non-admitted 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. Rose Vaughan Williams, Legislative Counsel for the NC DOI expounded on the details of the bill. Bob Kaylor, National Association of Professional Surplus Lines Offices, Ltd, was recognized to comment about bill and the compact. Senator Hise was recognized to ask what is insured under surplus lines insurance. Rose Vaughan Williams responded that what is insured is a risk other insurance companies don't want to cover. Senator McKissick was recognized to ask questions about Sections 4,5 and 9. Rose Vaughan Williams responded satisfactorily to each question. Senator Apodaca was recognized to amend SB 321 on page 1, lines 5-6 by rewriting the lines to read: "PURCHASERS, TO PREVENT AN LOSS OF PREMIUM TAX REVENUE TO THE STATE, AND TO CONFORM THE DEFINITION OF RISK RETENTION GROUP TO FEDERAL LAW."

Senator Hise moved to adopt the amendment and the motion carried. Senator Clary moved for a favorable report of the PCS as amended, rolled into a new proposed committee substitute with a referral to Finance and the motion carried. A copy of the PCS, summary, and amendment is attached.

S.B. 517- Freedom to Negotiate Health Care Rules

Senator Vaughan was recognized to make a motion to adopt the PCS for discussion and the motion carried. Amy Jo Johnson, NCGA staff, was recognized to explain the bill. Senator Meredith asked for comments from the public audience. Ken Lewis, President of NC Association of Health Plans, was recognized to speak about importance of competition in health care. Senator Meredith asked for questions from the committee and there were none. Senator Apodaca was recognized to announce further discussion of the bill would take place at the next Senate Insurance Committee meeting.

A copy of the PCS and summary is attached.

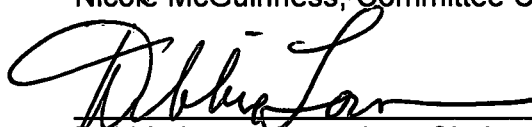
The meeting adjourned at 10:50 AM.



Senator Wesley Meredith, Presiding Chair
Senate Insurance Committee

A handwritten signature in black ink, appearing to read "Nicole McGuinness", written over a horizontal line.

Nicole McGuinness, Committee Clerk

A handwritten signature in black ink, appearing to read "Debbie Lown", written over a horizontal line.

Debbie Lown, Committee Clerk

Senate Insurance Committee
Wednesday, April 13, 2011, 10:00 AM
1027 LB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 138	Amend Health Insurance Risk Pool Statutes.	Representative Dockham
SB 195	Operation of Mopeds.	Senator Apodaca
SB 321	Surplus Lines/Premium Tax.-AB	Senator Apodaca
SB 517	Freedom to Negotiate Health Care Rates.	Senator Apodaca

Presentations

Other Business

Adjournment

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

**INSURANCE COMMITTEE REPORT
Senator Tom Apodaca, Co-Chair
Senator Wesley Meredith, Co-Chair**

Thursday, April 14, 2011

Senator MEREDITH,
submits the following with recommendations as to passage:

FAVORABLE

H.B.(CS #138) 138	Amend Health Insurance Risk Pool Statutes.
	Sequential Referral: None
	Recommended Referral: None

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B.	195	Operation of Mopeds.	
		Draft Number:	55247
		Sequential Referral:	
		Recommended Referral:	None
		Long Title Amended:	No
S.B.	321	Surplus Lines/Premium Tax.-AB	
		Draft Number:	35196
		Sequential Referral:	None
		Recommended Referral:	None
		Long Title Amended:	Yes

TOTAL REPORTED: 3

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H

2

HOUSE BILL 138
Committee Substitute Favorable 3/2/11

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:



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

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

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

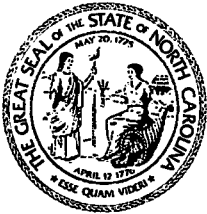
11 ...

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

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

17 "(a) Except as otherwise provided by law, Pool coverage shall exclude charges or
18 expenses incurred during the first ~~12~~six months following the effective date of coverage as to
19 any condition for which medical advice, care, or treatment was recommended or received as to
20 such conditions during the 12-month period immediately preceding the effective date of
21 coverage, except that no preexisting condition exclusion shall be applied to a federally defined
22 eligible individual or an individual who is eligible for the Pool because of his or her eligibility
23 for the credit for health insurance costs under the Trade Adjustment Assistance Reform Act of
24 2002, section 35 of the Internal Revenue Code of 1986, pursuant to G.S. 58-50-195(a)(6)."

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



HOUSE BILL 138: Amend Health Insurance Risk Pool Statutes

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Rep. Dockham
Analysis of: Second Edition

Date: April 12, 2011
Prepared by: Tim Hovis
Committee Counsel

SUMMARY: *House Bill 138 would make the following changes to the North Carolina Risk Pool:*

Section 1 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.

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-10(e2) v1

¹ <http://www.inclusivehealth.org/pages/6/About-Us/>
Research Division

PUBLIC BILL

Proposed Committee Substitute For
H.B. 138

SESSION LAW _____

A BILL TO BE ENTITLED

AN ACT TO AMEND THE HEALTH INSURANCE RISK POOL STATUTES.

Introduced by Representative(s): Duckham

For a complete list of cosponsors for this bill, please see the report inside the bill jacket.

Principal Clerk's Use Only

Committee on Insurance
being present, having considered
is, recommend that it do ☒ pass.

Rep Duckham
For the Committee

FAVORABLE TO COMM. SUB
UNFAVORABLE TO BILL

MAR 2 2011

AND PLACED ON
CALENDAR FOR

366 3-7-11

Passed 2nd & 3rd Reading

114-061 VV

MAR 07 2011

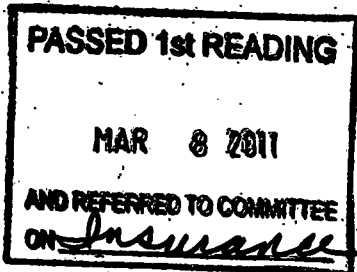
ORDERED SENT TO SENATE

Renise Weeks

RECEIVED

MAR 8 2011

From House of Representatives



GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

D

SENATE BILL 195
PROPOSED COMMITTEE SUBSTITUTE S195-PCS55247-RG-5

Short Title: Operation of Mopeds.

(Public)

Sponsors:

Referred to:

March 3, 2011

A BILL TO BE ENTITLED
AN ACT TO REQUIRE MOPEDS TO BE REGISTERED WITH THE DIVISION OF
MOTOR VEHICLES AND TO HAVE IN FULL FORCE AND EFFECT A POLICY OF
FINANCIAL RESPONSIBILITY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 20-10.1 reads as rewritten:

"§ 20-10.1. Mopeds.

(a) General Provisions. – It shall be unlawful for any person who is under the age of
~~16~~17 years and has not completed the graduated drivers license process to operate a ~~moped~~ as
moped, as defined in G.S. 105-164.3, upon any highway or public vehicular
area of this State.

(b) Passengers. – It shall be unlawful to have any passengers on a moped.

(c) Registration. – Mopeds shall be registered with the Division in the same manner as
any other motor vehicle. The owner shall pay the same fees and be issued the same type of
registration card and plate issued for a motorcycle. In order to be registered with the Division
and operated upon a highway or public vehicular area, a moped must meet the following
requirements:

(1) The moped has a vehicle identification number, as required under
G.S. 20-52(a)(2).

(2) The moped was designed and manufactured for use on public highways.

(d) Financial Responsibility. – It shall be unlawful to operate a moped on a public street
or highway or public vehicular area without having in full force and effect financial
responsibility as required by the provisions of Articles 9A and 13 of this Chapter. The Division
shall treat a moped the same as any other motor vehicle for the purposes of compliance with
Articles 9A and 13 of this Chapter."

SECTION 2. G.S. 20-51(9) is repealed.

SECTION 3. G.S. 20-140.4 reads as rewritten:

"§ 20-140.4. Special provisions for motorcycles and mopeds.

(a) No person shall operate a motorcycle or moped upon a highway or public vehicular
area:

(1) When the number of persons upon ~~such motorcycle or moped~~, a motorcycle,
including the operator, shall exceed the number of persons which it was
designed to carry.



1 (2) Unless the operator and all passengers thereon wear on their heads, with a
2 retention strap properly secured, safety helmets of a type that complies with
3 Federal Motor Vehicle Safety Standard (FMVSS) 218.

4 (b) Violation of any provision of this section shall not be considered negligence per se
5 or contributory negligence per se in any civil action.

6 (c) Any person convicted of violating this section shall have committed an infraction
7 and shall be fined according to G.S. 20-135.2A(e) and (f)."

8 **SECTION 4.** This act becomes effective July 1, 2012, and applies to offenses
9 committed on or after that date.

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____

DATE _____

S. B. No. 195

Amendment No. _____

COMMITTEE SUBSTITUTE _____

(to be filled in by
Principal Clerk)

Rep.) Apodaca
Sen.)

1 moves to amend the bill on page 1, line 8-9

2 () WHICH CHANGES THE TITLE

3 by rewriting the lines to read

4 "(a) General Provisions -

5 It shall be unlawful for any person who
6 is under the age of ~~17~~ 17 and has not completed
7 the graduated drivers license process to operate
8 a moped as moped, as defined in G.S. 105-164.3
9 G.S. 105-164.3, upon any "

10 _____

11 _____

12 and on page 2, line 3 by deleting

13 "December 1, 2011," and substituting

14 "July 1, 2012,"
~~December 1, 2011~~

15 _____

16 _____

17 _____

18 _____

19 _____

SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)



SENATE BILL 195: Operation of Mopeds

2011-2012 General Assembly

Committee:	Senate Ref to Insurance. If fav, re-ref to Finance	Date:	April 12, 2011
Introduced by:	Sen. Apodaca	Prepared by:	Amy Jo Johnson
Analysis of:	First Edition		Committee Counsel

SUMMARY: Senate Bill 195 would:

- *Require mopeds to be registered with the Division of Motor Vehicles.*
- *Make it unlawful to operate a moped on a highway or public vehicular area without proper financial responsibility.*
- *Prohibit an operator of a moped from carrying passengers.*

CURRENT LAW: Under current law, a moped is not required to be registered or carry liability insurance. A person must be at least 16 years old, but is not required to be licensed, to operate a moped on a highway or public vehicular area. The operator is subject to the same requirements as operators of motorcycles with regard to carrying passengers and wearing a helmet – the number of passengers may not exceed the number the vehicle was designed to carry, and the operator and passengers must wear helmets that comply with federal standards.

A moped is defined as a vehicle with a motor that does not exceed 50 cubic centimeters piston displacement and that cannot propel the vehicle faster than 30 miles per hour on a level surface.

BILL ANALYSIS: Senate Bill 195 would require that mopeds be registered with the Division of Motor Vehicles. Because the Division cannot register a vehicle without a vehicle identification number, which is required on the application for registration, any moped that does not have a vehicle identification number would not be able to be registered or operated on a highway or public vehicular area. A moped would also have to be designed and manufactured for use on public highways in order to be registered.

The bill would make it unlawful to operate a moped on a highway or public vehicular area without having a policy of financial responsibility in full force and effect. It would also make it unlawful to operate a moped while carrying passengers.

EFFECTIVE DATE: The act would become effective December 1, 2011, and would apply to offenses committed on or after that date.

Wendy Graf Ray, staff attorney, substantially contributed to this summary.

SI95-SMTK-14(e1) v2

S.B. 195

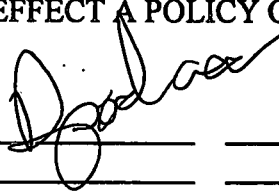
SESSION LAW _____

A BILL TO BE ENTITLED

**AN ACT TO REQUIRE MOPEDS TO BE REGISTERED WITH THE DIVISION OF MOTOR VEHICLES
AND TO HAVE IN FULL FORCE AND EFFECT A POLICY OF FINANCIAL RESPONSIBILITY.**

Introduced by Senator(s)

Apodaca



Principal Clerk's Use Only

FILED MAR 2 2011

PASSED 1st READING

MAR 3 2011

AND REFERRED TO COMMITTEE

ON Insurance

SEQUENTIAL REFERRAL:

Finance

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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D

SENATE BILL 321
PROPOSED COMMITTEE SUBSTITUTE S321-CSR-4 [v.2]

4/12/2011 12:30:18 PM

Short Title: Surplus Lines/Premium Tax.-AB.

(Public)

Sponsors:

Referred to:

March 14, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO CONFORM PROVISIONS OF NORTH CAROLINA SURPLUS LINES
3 INSURANCE LAWS TO THE FEDERAL NONADMITTED AND REINSURANCE
4 REFORM ACT OF 2010, TO STREAMLINE APPLICATIONS FOR COMMERCIAL
5 PURCHASERS, AND TO PREVENT ANY LOSS OF PREMIUM TAX REVENUE TO
6 THE STATE.

7 The General Assembly of North Carolina enacts:

8 SECTION 1. Article 21 of Chapter 58 of the General Statutes is amended by
9 adding the following new sections to read:

10 **"§ 58-21-3. Cooperative or interstate agreements.**

11 (a) The Commissioner is authorized to enter into a cooperative agreement or interstate
12 agreement or compact to do the following:

13 (1) Establish additional and alternative nationwide uniform eligibility
14 requirements that shall be applicable to nonadmitted insurers domiciled in
15 another state or territory of the United States.

16 (2) Facilitate the collection, allocation, and disbursement of premium taxes
17 attributable to the placement of nonadmitted insurance, provide for uniform
18 methods of allocation and reporting among nonadmitted insurance risk
19 classifications, and share information among states relating to nonadmitted
20 insurance premium taxes.

21 (b) The Commissioner is authorized to enter the NAIC Nonadmitted Insurance Multi-
22 State Agreement or other compact or interstate agreement for the purpose of carrying out the
23 Nonadmitted and Reinsurance Reform Act of 2010.

24 **"§ 58-21-4. Nonadmitted and Reinsurance Reform Act duties.**

25 (a) For the purposes of carrying out the provisions of the Nonadmitted and Reinsurance
26 Reform Act of 2010, the Commissioner is authorized to utilize the national insurance producer
27 database of the NAIC, or any other equivalent uniform national database, for the licensure of an
28 individual or an entity as a surplus lines producer and for renewal of such license.

29 (b) In order to assist in the performance of the Commissioner's duties, under the
30 Nonadmitted and Reinsurance Reform Act of 2010, the Commissioner may contract with
31 nongovernmental entities, including the NAIC or any affiliates or subsidiaries that the NAIC
32 oversees, to perform any ministerial functions, including the collection of fees, related to
33 producer licensing that the Commissioner and the nongovernmental entity may deem to be
34 appropriate."



* S 3 2 1 - C S R G - 4 - V - 2 *

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

1 available from the admitted market that may provide greater protection with
2 more regulatory oversight.

3 (2) The exempt commercial purchaser has subsequently requested in writing the
4 licensee to procure or place such insurance from a nonadmitted insurer.

5 (b) As used in this section, the following definitions apply:

6 (1) "Exempt commercial purchaser" means any person purchasing commercial
7 insurance that, at the time of placement, meets all of the following
8 requirements:

9 a. The person employs or retains a qualified risk manager to negotiate
10 insurance coverage.

11 b. The person has paid aggregate nationwide commercial property and
12 casualty insurance premiums in excess of one hundred thousand
13 dollars (\$100,000) in the immediately preceding 12 months.

14 c. The person meets at least one of the following criteria:

15 1. The person possesses a net worth in excess of twenty million
16 dollars (\$20,000,000), as such amount is adjusted pursuant to
17 subsection (c) of this section.

18 2. The person generates annual revenues in excess of fifty
19 million dollars (\$50,000,000), as such amount is adjusted
20 pursuant to subsection (c) of this section.

21 3. The person employs more than 500 full-time or full-time
22 equivalent employees per individual insured or is a member
23 of an affiliated group employing more than 1,000 employees
24 in the aggregate.

25 4. The person is a not-for-profit organization or public entity
26 generating annual budgeted expenditures of at least thirty
27 million dollars (\$30,000,000), as such amount is adjusted
28 pursuant to subsection (c) of this section.

29 5. The person is a municipality with a population in excess of
30 50,000 persons.

31 (2) "Qualified risk manager" means, with respect to a policyholder of
32 commercial insurance, a person who meets all of the following
33 requirements:

34 a. Is an employee of, or third party consultant retained by, the
35 commercial policyholder.

36 b. Provides skilled services in loss prevention, loss reduction, or risk
37 and insurance coverage analysis, and purchase of insurance.

38 c. Has one of the following:

39 1. A bachelor's degree or higher from an accredited college or
40 university in risk management, business administration,
41 finance, economics, or any other field determined by the
42 Commissioner to demonstrate minimum competence in risk
43 management and one of the following:

44 I. Three years of experience in risk financing, claims,
45 administration, loss prevention, risk and insurance
46 analysis, or purchasing commercial lines of insurance.

47 II. One of the following designations:

48 A. Chartered Property and Casualty Underwriter
49 (CPCU) issued by the American Institute for
50 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~~

1 (~~\$10,000,000~~) by December 31, 1991, twelve million five hundred
2 thousand dollars (~~\$12,500,000~~) by December 31, 1992, and fifteen
3 million dollars (~~\$15,000,000~~) by December 31, 1993. The
4 requirements of this sub-subdivision may be satisfied by an insurer
5 possessing less than the commitment capital and surplus upon an
6 affirmative finding of acceptability by the Commissioner. The
7 finding shall be based upon such factors as quality of management,
8 capital and surplus of any parent company, company underwriting
9 profit and investment income trends, and the insurer's record and
10 reputation within the industry. In no event shall the Commissioner
11 make an affirmative finding of acceptability when the insurer's
12 capital and surplus is less than four million five hundred thousand
13 dollars (~~\$4,500,000~~).

14 In addition, an alien insurer qualifies under this subdivision if it
15 complies with the capital and surplus requirements of this
16 subdivision and maintains in the United States an irrevocable trust
17 fund in either a national bank or a member of the Federal Reserve
18 System, in an amount not less than five million four hundred
19 thousand dollars (~~\$5,400,000~~) for the protection of all of its
20 policyholders in the United States, and the trust fund consists of cash,
21 securities, letters of credit, or of investment of substantially the same
22 character and quality as those which are eligible investments for the
23 capital and statutory reserves of admitted insurers authorized to write
24 like kinds of insurance in this State. The trust fund, which shall be
25 included in any calculation of capital and surplus or its equivalent,
26 shall have an expiration date which at no time shall be less than five
27 years; or The requirements of this sub-subdivision may be satisfied by
28 an insurer's possessing less than the minimum capital and surplus
29 upon an affirmative finding of acceptability by the Commissioner.
30 The finding shall be based upon such factors as quality of
31 management, capital and surplus of any parent company, company
32 underwriting profit and investment income trends, market
33 availability, and company record and reputation within the industry.
34 In no event shall the Commissioner make an affirmative finding of
35 acceptability when the nonadmitted insurer's capital and surplus is
36 less than four million five hundred thousand dollars (\$4,500,000).

37 b. In the case of any Lloyd's plans or other similar group of insurers,
38 which consists of unincorporated individual insurers, or a
39 combination of both unincorporated and incorporated insurers,
40 maintains a trust fund in an amount of not less than one hundred
41 million dollars (\$100,000,000) as security to the full amount thereof
42 for all policyholders and creditors in the United States of each
43 member of the group, and the trust shall likewise comply with the
44 terms and conditions established in subdivision (2)a. of this section
45 for alien insurers; ~~and insurers.~~

46 c. In the case of an "insurance exchange" created by the laws of
47 individual states, maintain capital and surplus, or the substantial
48 equivalent thereof, of not less than seventy-five million dollars
49 (\$75,000,000) in the aggregate. For insurance exchanges which
50 maintain funds in an amount of not less than fifteen million dollars
51 (\$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;

- 1 f. Whose members are engaged in businesses or activities similar or
2 related with respect to the liability of which such members are
3 exposed by virtue of any related, similar, or common business trade,
4 product, services, premises, or operations;
5 g. Whose activities do not include the provision of insurance other than:
6 (i) Liability insurance for assuming and spreading all or any
7 portion of the similar or related liability exposure of its group
8 members; and
9 (ii) Reinsurance with respect to the similar or related liability
10 exposure of any other risk retention group, or any ~~members~~
11 member of such other group, that is engaged in businesses or
12 activities so that such group or member meets the
13 requirement described in sub-subdivision f. of this
14 subdivision from membership in the risk retention group that
15 provides such reinsurance; and
16 h. The name of which includes the phrase "Risk Retention Group".
17

SECTION 10. This act becomes effective June 1, 2011.



SENATE BILL 321: Surplus Lines/Premium Tax.-AB

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Sen. Apodaca
Analysis of: PCS to First Edition
S321-CSR-4

Date: April 12, 2011
Prepared by: Tim Hovis
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, as introduced by Rep. Dockham, which is currently in House Insurance, if favorable, 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 non-admitted 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 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 the National Association of Insurance Commissioners (NAIC) Nonadmitted Insurance Multi-State Agreement or other compact for the purpose of carrying out the NRRA.

Section 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.

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

Senate PCS 321

Page 2

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 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: Senate Bill 321 becomes effective June 1, 2011.

S321-SMRG-9(CSRG-4) v5



NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 321

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

Page 1 of 1

S321-ARG-6 [v.2]

Comm. Sub. [YES]
Amends Title [YES]
First Edition

Date _____, 2011

Senator _____

- 1 moves to amend the bill on page 1, lines 5-6,
2 by rewriting the lines to read:
3
4 "PURCHASERS, TO PREVENT AN LOSS OF PREMIUM TAX REVENUE TO THE
5 STATE, AND TO CONFORM THE DEFINITION OF RISK RETENTION GROUP TO
6 FEDERAL LAW."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____



* S 3 2 1 - A R G - 6 - V - 2 *

A BILL TO BE ENTITLED

Introduced by Senator(s)

Apodaca

Principal Clerk's Use Only

FILED MAR 10 2011

PASSED 1st READING

MAR 14 2011

AND REFERRED TO COMMITTEE
ON Insurance

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 517*
PROPOSED COMMITTEE SUBSTITUTE S517-CSTK-6 [v.1]

4/12/2011 3:13:11 PM

Short Title: Freedom to Negotiate Health Care Rates.

(Public)

Sponsors:

Referred to:

April 6, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO ALLOW HEALTH PROVIDERS AND HEALTH INSURERS TO FREELY
3 NEGOTIATE REIMBURSEMENT RATES BY PROHIBITING CONTRACT
4 PROVISIONS THAT RESTRICT RATE NEGOTIATIONS.

5 The General Assembly of North Carolina enacts:

6 SECTION 1. Part 7 of Article 50 of Chapter 58 of the General Statutes is amended
7 by adding a new section to read:

8 "**§ 58-50-290. Prohibited contract provisions related to reimbursement rates.**

9 **No contract for the provision of health care services shall do any of the following:**

- 10 (1) **Prohibit, or grant a health carrier an option to prohibit, a participating**
11 **provider from contracting with another health carrier to provide health care**
12 **services at a rate that is equal to or lower than the payment specified in the**
13 **contract.**
- 14 (2) **Require a participating provider to accept a lower payment rate in the event**
15 **the participating provider agrees to provide health care services to any other**
16 **health carrier at a rate that is equal to or lower than the payment specified in**
17 **the contract.**
- 18 (3) **Require, or grant a health carrier an option to require, termination or**
19 **renegotiation of the existing health care contract in the event a participating**
20 **provider agrees to provide health care services to any other health carrier at a**
21 **rate that is equal to or lower than the payment specified in the contract.**
- 22 (4) **Require, or grant a health carrier an option to require, a participating**
23 **provider to disclose, directly or indirectly, the participating provider's**
24 **contractual rates with another health carrier.**
- 25 (5) **Require, or grant a health carrier an option to require, the nonnegotiated**
26 **adjustment by the issuer of a participating provider's contractual rate to equal**
27 **the lowest rate the provider has agreed to charge any other health carrier.**
- 28 (6) **Require, or grant a health carrier an option to require, a participating**
29 **provider to charge another health carrier a rate that is equal to or more than**
30 **the reimbursement rate specified in the contract."**

31 SECTION 2. This act becomes effective October 1, 2011.



* S 5 1 7 - C S T K - 6 - V - 1 *



SENATE BILL 517: Freedom to Negotiate Health Care Rates

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Sen. Apodaca
Analysis of: PCS to First Edition
S517-CSTK-6

Date: April 12, 2011
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *The PCS to Senate Bill 517 would prohibit contract provisions that create specified rate negotiations between health benefit plans and health care provider.*

CURRENT LAW: G.S. 58-50-270 provides the following definitions that are applicable to this bill:

- **Contract** – an agreement between an insurer and a health care provider for the provision of health care services by the provider on a preferred or in-network basis.
- **Health care Provider** – an individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes and is owned or operated by the State in which health care services are provided to patients.

BILL ANALYSIS: The only change to the PCS is technical. The placement of the new statute is now the more appropriate location of G.S. 58-50-290.

Senate Bill 517 adds a new section to Part 7 of Article 50 of Chapter 58 of the General Statutes regarding contracts between health benefit plans and health care providers. The bill states that no contract for the provision of health care services can do any of the following:

- Prohibit a participating provider from contracting with another health carrier to provide services at a rate equal to or lower than the payment specified in the contract
- Require a participating provider to accept a lower payment rate in the event that the provider agrees to provide services to any other carrier at a rate equal to or lower than that specified in the contract
- Require termination or renegotiation of the contract if the provider agrees to provide services to any other carrier at a rate equal to or lower than that specified in the contract
- Require the disclosure of a participating provider's contractual rates with another carrier
- Require the non-negotiated adjustment by the issuer of a participating provider's contractual rate to equal the lowest rate the provider has agreed to charge another carrier
- Require a participating provider to charge another carrier a rate that is equal to or greater than the rates specified in the contract.

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

S517-SMTK-16(CSTK-6) v1

PUBLIC BILL

S.B. 517

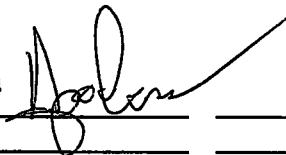
SESSION LAW _____

A BILL TO BE ENTITLED

AN ACT TO ALLOW HEALTH PROVIDERS AND HEALTH INSURERS TO FREELY NEGOTIATE REIMBURSEMENT RATES BY PROHIBITING CONTRACT PROVISIONS THAT RESTRICT RATE NEGOTIATIONS.

Introduced by Senator(s)

Apodaca



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FILED 'APR 5 2011

PASSED 1st READING

APR 06 2011

AND REFERRED TO COMMITTEE
ON Insurance

VISITOR REGISTRATION SHEET

INSURANCE SENATE

Name of Committee

4.13.11

Date

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Paul Bone	Bone + Asso
Emily Grimm	MWC
Karen Waddell	DUI
Robin Huffman	NC Psychiatric Assoc
Li-Ann C. Pagnan	Carolina State Strategies
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INSURANCE SENATE

Name of Committee

4.13.11

Date

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Amy Fowler	NCMS
Kathleen Gordon	NCMS
Kevin Gertsch	NCMS

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~~Judiciary I~~

Insurance

4.13.11

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Date

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James Wrzosek	NCMS
Angie Harris	Williams Miller
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Sara Fender	IFNC
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Kevin O'Neal, MD	Western Wake Eye Center
Terry Forrester	NCMS
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Gonteagun	NMR5
Ru/Cayla	1 Cayla Lm Firm
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Ryan	NCPBA

~~Senate Finance Committee~~

Insurance

March 29, 2011

24-13-11

Name of Committee

Date

NAME**FIRM OR AGENCY AND ADDRESS**

Breder Blackwell

Computer

Meg O'Donnell

Comp. Results.

ROBERT BARATTA.

CAPITAL RESULTS

Clay Bazzett

Nam

Andrew G. Brad

R. W. Lawrence

VISITOR REGISTRATION SHEET

~~Senate Judiciary~~

Insurance

4-13-11

Name of Committee

Date

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NAME

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NCDOJ

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NCFTB

Odette Houghton, MD

NCSEPS/NCMS

Seema Garg, MD

NCSEPS/NCMS

Kay Paksoy

NASW-NC

Sally Camera

NC Psychological Assoc

SENATE INSURANCE COMMITTEE
Wednesday, April 27, 2011 at 10:00 AM
Room 1027, Legislative Building

MINUTES

The Senate Insurance Committee met at 10:07 AM on April 27, 2011, in Room 1027 of the Legislative Building. Seventeen members of the committee were present. Senator Apodca and Senator Meredith presided. Gabe Azzato of Southport, Tommy Schutz of Southport, Erica Gurganus of Jacksonville, Spencer Goodson of Jacksonville, Mike Clemens of Slyva, Joseph Clay of Ellenboro, Kaysey Raper of Swansboro, and Drew Connery of Charlotte served as pages.

S.B. 490- Automobile Insurance Regulatory Modernization

Senator Apodaca recognized Tim Hovis, NCGA Staff, to give general background of HB 490 and an explanation of each section was given. Senate Bill 490 creates a new system called "flex-rating" for rates and rate filings for non-fleet private passenger motor vehicle insurance and eliminates the clean risk classification in the North Carolina Reinsurance Facility. Senator Apodaca recognized David Stoller of State Farm Insurance, to offer his support for the bill. Senator Apodaca then recognized Liz Reynolds of National Association of Mutual Insurance Companies to explain her support for the bill. Senator Rucho was recognized to speak about the bill. Senator East was recognized to ask a question. Tim Hovis answered the question. Senator Rucho was recognized to make a statement regarding the need for the bill. Senator Doug Berger was recognized to ask a question regarding young driver's rates. Senator Rucho was recognized to answer. A copy of the summary is attached.

S.B. 477- Reduce Overpopulation of Reinsurance Facility

Senator Apodaca explained the bill stating it was very similar to S.B. 490. Tim Hovis was recognized to explain the difference between the bills. Senate Bill 477 would amend current law applicable rates for non-fleet private passenger motor vehicle insurance to allow insurers to deviate from base rates approved by the Commissioner and promulgated by the N.C. Rate Bureau upon filing of the deviation and eliminates the clean risk subclassification in the North Carolina Reinsurance Facility and allows the Facility to charge an actuarially sound rate for all risks ceded to the Facility. Senator Meredith recognized John McMillian of the Insurance Federation of NC and American Insurance Federation. McMillian passed out a document (attached) and showed a power point. Senator Meredith recognized George Teague of the Property Casual Insurance Association to speak in support of the bill. Senator Meredith recognized John Bode of the Independent Insurance Agents to support the bill. Insurance Commissioner Wayne Goodwin was recognized by Senator Meredith to discuss the bill. Commissioner Goodwin spoke in opposition of both bills. Senator Walters was recognized to ask a question. Commissioner Goodwin spoke to answer his question. Senator Hise was recognized to ask if there was a demographic summary of individuals in the risk pool. Rose Vaughan Williams, Legislative Council to the Insurance Commissioner was recognized to answer that that data was not collected. Senator McKissick was recognized to ask a question. Commissioner Goodwin was recognized to answer.

Senator Hise was recognized to make a motion placing both Senate Bill 477 and 490 in a study committee. Senator McKissick seconded the motion and it passed. A copy of the summary and handout is attached.

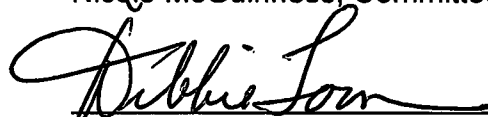
The meeting adjourned at 10:50 AM.



Senator Wesley Meredith, Presiding Chair
Senate Insurance Committee



Nicole McGuinness, Committee Clerk



Debbie Lown, Committee Clerk

Senate Insurance Committee
Wednesday, April 27, 2011, 10:00 AM
1027 LB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 477	Reduce Overpopulation of Reinsurance Facility.	Senator Apodaca
SB 490	Automobile Insurance Regulatory Modernization.	Senator Rucho

Presentations

Other Business

Adjournment

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 490

Short Title: Automobile Insurance Regulatory Modernization. (Public)

Sponsors: Senators Rucho; Brock and Rouzer.

Referred to: Insurance.

April 4, 2011

A BILL TO BE ENTITLED
AN ACT TO MODERNIZE THE NONFLEET PRIVATE PASSENGER AUTOMOBILE
AND MOTORCYCLE INSURANCE REGULATORY ENVIRONMENT.

The General Assembly of North Carolina enacts:

SECTION 1. Article 36 of Chapter 58 of the General Statutes reads as rewritten:

"Article 36.

"North Carolina Rate Bureau.

"§ 58-36-1. North Carolina Rate Bureau created.

There is hereby created a Bureau to be known as the "North Carolina Rate Bureau," with the following objects and functions:

- (1) To assume the functions formerly performed by the North Carolina Fire Insurance Rating Bureau, ~~the North Carolina Automobile Rate Administrative Office, Bureau~~ and the Compensation Rating and Inspection Bureau of North Carolina, with regard to the promulgation of rates, for insurance against loss to residential real property with not more than four housing units located in this State and any contents thereof and valuable interest therein and other insurance coverages written in connection with the sale of such property insurance; ~~except as provided in G.S. 58-36-3(a)(6), for theft of and physical damage to nonfleet private passenger motor vehicles; for liability insurance for such motor vehicles, automobile medical payments insurance, uninsured motorists coverage and other insurance coverages written in connection with the sale of such liability insurance; and for~~ workers' compensation and employers' liability insurance written in connection therewith except for insurance excluded from the Bureau's jurisdiction in G.S. 58-36-1(3)..
- (2) The Bureau shall provide reasonable means to be approved by the Commissioner whereby any person affected by a rate or loss costs made by it may be heard in person or by the person's authorized representative before the governing committee or other proper executive of the Bureau.
- (3) The Bureau shall promulgate and propose rates for insurance against loss to residential real property with not more than four housing units located in this State and any contents thereof or valuable interest therein and other insurance coverages written in connection with the sale of such property insurance; ~~for insurance against theft of or physical damage to nonfleet private passenger motor vehicles; for liability insurance for such motor vehicles, automobile medical payments insurance, uninsured and underinsured motorists coverage and other insurance coverages written in~~



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~~connection with the sale of such liability insurance; and, as provided in G.S. 58-36-100, for loss costs and residual market rate filings for workers' compensation and employers' liability insurance written in connection therewith. This subdivision does not apply to motor vehicles operated under certificates of authority from the Utilities Commission, the Interstate Commerce Commission, or their successor agencies, where insurance or other proof of financial responsibility is required by law or by regulations specifically applicable to such certificated vehicles.~~

- (4) Agreements may be made between or among members with respect to equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods. The members may agree between or among themselves on the use of reasonable rate modifications for such insurance, agreements, and rate modifications to be subject to the approval of the Commissioner.
- (5) a. It is the duty of every insurer that writes workers' compensation insurance in this State and is a member of the Bureau, as defined in this section and G.S. 58-36-5 to insure and accept any workers' compensation insurance risk that has been certified to be "difficult to place" by any fire and casualty insurance agent who is licensed in this State. When any such risk is called to the attention of the Bureau by receipt of an application with an estimated or deposit premium payment and it appears that the risk is in good faith entitled to such coverage, the Bureau will bind coverage for 30 days and will designate a member who must issue a standard workers' compensation policy of insurance that contains the usual and customary provisions found in those policies. Multiple coordinated policies, as defined by the Bureau and approved by the Commissioner, may be used for the issuance of coverage under this subdivision for risks involved in employee leasing arrangements. Coverage will be bound at 12:01 A.M. on the first day following the postmark time and date on the envelope in which the application is mailed including the estimated annual or deposit premium, or the expiration of existing coverage, whichever is later. If there should be no postmark, coverage will be effective 12:01 A.M. on the date of receipt by the Bureau unless a later date is requested. Those applications hand delivered to the Bureau will be effective as of 12:01 A.M. of the date following receipt by the Bureau unless a later date is requested. The Bureau will make and adopt such rules as are necessary to carry this section into effect, subject to final approval of the Commissioner. As a prerequisite to the transaction of workers' compensation insurance in this State, every member of the Bureau that writes such insurance must file with the Bureau written authority permitting the Bureau to act in its behalf, as provided in this section, and an agreement to accept risks that are assigned to the member by the Bureau, as provided in this section.
- b. The Bureau shall maintain a compendium of employers refused voluntary coverage, which shall be made available by the Bureau to all insurers, licensed agents, and self-insureds' administrators doing business in this State. It shall be stored and indexed to allow access to information by industry, primary classifications of employees,

geography, experience modification, and in any other manner the Bureau determines is commercially useful to facilitate voluntary coverage of listed employers. The Bureau shall be immune from civil liability for erroneous information released by the Bureau pursuant to this section, provided that the Bureau acted in good faith and without malicious or willful intent to harm in releasing the erroneous information.

- c. Failure or refusal by any assigned employer risk to make full disclosure to the Bureau, servicing carrier, or insurer writing a policy of information regarding the employer's true ownership, change of ownership, operations, or payroll, or any other failure to disclose fully any records pertaining to workers' compensation insurance shall be sufficient grounds for the termination of the policy of that employer.

(6) ~~The Bureau shall maintain and furnish to the Commissioner on an annual basis the statistics on earnings derived by member companies from the investment of unearned premium, loss, and loss expense reserves on nonfleet private passenger motor vehicle insurance policies written in this State. Whenever the Bureau proposes rates under this Article, it shall prepare a separate exhibit for the experience years in question showing the combined earnings realized from the investment of such reserves on policies written in this State. The amount of earnings may in an equitable manner be included in the ratemaking formula to arrive at a fair and equitable rate. The Commissioner may require further information as to such earnings and may require calculations of the Bureau bearing on such earnings.~~

(7) ~~Member companies shall furnish, upon request of any person carrying nonfleet private passenger motor vehicle insurance in the State upon whose risk a rate has been promulgated, information as to rating, including the method of calculation.~~

~~"§ 58-36-2. Private passenger motor vehicles; number of nonfleet policies.~~

~~Notwithstanding the definition of "nonfleet" in G.S. 58-40-10(2), the Bureau shall adopt rules, subject to the Commissioner's approval, that specify the circumstances under which more than four private passenger motor vehicles may be covered under a nonfleet private passenger motor vehicle policy that is subject to this Article.~~

~~"§ 58-36-3. Limitation of scope; motorcycle endorsements allowed; Department of Insurance report.~~

- (a) The Bureau has no jurisdiction over:

- (1) Excess workers' compensation insurance for employers qualifying as self-insurers as provided in Article 47 of this Chapter or Article 5 of Chapter 97 of the General Statutes.
- (2) Farm buildings, farm dwellings, and their appurtenant structures; farm personal property or other coverages written in connection with farm real or personal property.
- (3) Travel or camper trailers designed to be pulled by private passenger motor vehicles, ~~unless insured under policies covering nonfleet private passenger motor vehicles.~~
- (4) ~~Mechanical breakdown insurance covering nonfleet private passenger motor vehicles and other incidental coverages written in connection with this insurance, including emergency road service assistance, trip interruption reimbursement, rental car reimbursement, and tire coverage.~~

- (5) Residential real and personal property insured in multiple line insurance policies covering business activities as the primary insurable interest; and marine, general liability, burglary and theft, glass, and animal collision insurance, except when such coverages are written as an integral part of a multiple line insurance policy for which there is an indivisible premium.
- (6) ~~Insurance against theft of or physical damage to motoreycles, as defined in G.S. 20-4.01(27)d.~~
- (7) Personal excess liability or personal "umbrella" insurance.

~~(b) Member companies writing motoreycle liability insurance under this Article and writing insurance against theft of or physical damage to motoreycles under Article 40 of this Chapter may incorporate motoreycle theft and physical damage coverage as an endorsement to the liability policy issued under this Article.~~

~~(c) Beginning on February 1, 2003, and annually thereafter, the Department of Insurance shall report to the President Pro Tempore of the Senate and the Speaker of the House of Representatives on the effectiveness of S.L. 2001-389 in assuring the provision of insurance coverage to motoreyclists at fair and economical rates.~~

...

"§ 58-36-5. Membership as a prerequisite for writing insurance; governing committee; rules and regulations; expenses.

(a) Before the Commissioner shall grant permission to any stock, nonstock, or reciprocal insurance company or any other insurance organization to write in this State insurance against loss to residential real property with not more than four housing units located in this State or any contents thereof or valuable interest therein or other insurance coverages written in connection with the sale of such property insurance; ~~or insurance against theft of or physical damage to private passenger (nonfleet) motor vehicles; or liability insurance for such motor vehicles, automobile medical payments insurance, uninsured motorists coverage or other insurance coverage written in connection with the sale of such liability insurance; or workers' compensation and employers' liability insurance written in connection therewith; except for insurance excluded from the Bureau's jurisdiction in G.S. 58-36-1(3); it shall be a requisite that they shall subscribe to and become members of the Bureau.~~

...

"§ 58-36-10. Method of rate making; factors considered.

The following standards shall apply to the making and use of rates:

...

- (4) Risks may be grouped by classifications and lines of insurance for establishment of rates, loss costs, and base premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in hazards or expense provisions or both. Those standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. ~~The Bureau shall establish and implement a comprehensive classification rating plan for motor vehicle insurance under its jurisdiction. No such classification plans shall base any standard or rating plan for private passenger (nonfleet) motor vehicles, in whole or in part, directly or indirectly, upon the age or gender of the persons insured. The Bureau shall at least once every three years make a complete review of the filed classification rates to determine whether they are proper and supported by statistical evidence, and shall at least once every 10 years make a complete review of the territories for nonfleet private passenger motor vehicle insurance to determine whether they are proper and reasonable evidence.~~

(5) In the case of workers' compensation insurance and employers' liability insurance written in connection therewith, due consideration shall be given to the past and prospective effects of changes in compensation benefits and in legal and medical fees that are provided for in General Statutes Chapter 97.

(6) To ensure that policyholders in the beach and coastal areas of the North Carolina Insurance Underwriting Association whose risks are of the same class and essentially the same hazard are charged premiums that are commensurate with the risk of loss and premiums that are actuarially correct, the North Carolina Rate Bureau shall revise, monitor, and review the existing territorial boundaries used by the Bureau when appropriate to establish geographic territories in the beach and coastal areas of the Association for rating purposes. In revising these territories, the Bureau shall use statistical data sources available to define such territories to represent relative risk factors that are actuarially sound and not unfairly discriminatory. The new territories and any subsequent amendments proposed by the North Carolina Rate Bureau or Association shall be subject to the Commissioner's approval and shall appear on the Bureau's Web site, the Association's Web site, and the Department's Web site once approved.

"§ 58-36-15. Filing loss costs, rates, plans with Commissioner; public inspection of filings.

(a) The Bureau shall file with the Commissioner copies of the rates, loss costs, classification plans, rating plans and rating systems used by its members. Each rate or loss costs filing shall become effective on the date specified in the filing, but not earlier than 210 days from the date the filing is received by the Commissioner: Provided that (1) rate or loss costs filings for workers' compensation insurance and employers' liability insurance written in connection therewith shall not become effective earlier than 210 days from the date the filing is received by the Commissioner or on the date as provided in G.S. 58-36-100, whichever is earlier; and (2) any filing may become effective on a date earlier than that specified in this subsection upon agreement between the Commissioner and the Bureau.

(b) A filing shall be open to public inspection immediately upon submission to the Commissioner.

(c) The Bureau shall maintain reasonable records, of the type and kind reasonably adapted to its method of operation, of the experience of its members and of the data, statistics or information collected or used by it in connection with the rates, rating plans, rating systems, loss costs and other data as specified in G.S. 58-36-100, underwriting rules, policy or bond forms, surveys or inspections made or used by it.

~~(d) With respect to the filing of rates for nonfleet private passenger motor vehicle insurance, the Bureau shall, on or before February 1 of each year, or later with the approval of the Commissioner, file with the Commissioner the experience, data, statistics, and information referred to in subsection (c) of this section and any proposed adjustments in the rates for all member companies of the Bureau. The filing shall include, where deemed by the Commissioner to be necessary for proper review, the data specified in subsections (c), (e), (g) and (h) of this section. Any filing that does not contain the data required by this subsection may be returned to the Bureau and not be deemed a proper filing. Provided, however, that if the Commissioner concludes that a filing does not constitute a proper filing he shall promptly notify the Bureau in writing to that effect, which notification shall state in reasonable detail the basis of the Commissioner's conclusion. The Bureau shall then have a reasonable time to remedy the defects so specified. An otherwise defective filing thus remedied shall be deemed to be a proper and timely filing, except that all periods of time specified in this Article will run from the date the Commissioner receives additional or amended documents necessary to remedy all material defects in the original filing.~~

1 ...

2 **"§ 58-36-30. Deviations.**

3 (a) Except as permitted by G.S. 58-36-100 for workers' compensation loss costs filings,
4 no insurer and no officer, agent, or representative of an insurer shall knowingly issue or deliver
5 or knowingly permit the issuance or delivery of any policy of insurance in this State that does
6 not conform to the rates, rating plans, classifications, schedules, rules and standards made and
7 filed by the Bureau. An insurer may deviate from the rates promulgated by the Bureau if the
8 insurer has filed the proposed deviation with the Bureau and the Commissioner, if the proposed
9 deviation is based on sound actuarial principles, and if the proposed deviation is approved by
10 the Commissioner. Amendments to deviations are subject to the same requirements as initial
11 filings. An insurer may terminate a deviation only if the deviation has been in effect for a
12 period of six months before the effective date of the termination and the insurer notifies the
13 Commissioner of the termination no later than 15 days before the effective date of the
14 termination.

15 (b) A rate in excess of that promulgated by the Bureau may be charged by an insurer on
16 any specific risk if the higher rate is charged in accordance with rules adopted by the
17 Commissioner and with the knowledge and written consent of the insured. The insurer is not
18 required to obtain the written consent of the insured on any renewal of or endorsement to the
19 policy if the policy renewal or endorsement states that the rates are greater than those rates that
20 are applicable in the State of North Carolina. The insurer shall retain the signed consent form
21 and other policy information for each insured and make this information available to the
22 Commissioner, upon request of the Commissioner. ~~This subsection may be used to provide~~
23 ~~motor vehicle liability coverage limits above those required under Article 9A of Chapter 20 of~~
24 ~~the General Statutes and above those cedable to the Facility under Article 37 of this Chapter to~~
25 ~~persons whose personal excess liability insurance policies require that they maintain specific~~
26 ~~higher liability coverage limits. Any data obtained by the Commissioner under this subsection~~
27 ~~is proprietary and confidential and is not a public record under G.S. 132-1 or G.S. 58-2-100.~~

28 (c) Any approved rate under subsection (b) of this section with respect to workers'
29 compensation and employers' liability insurance written in connection therewith shall be
30 furnished to the Bureau.

31 ~~(d) Notwithstanding any other provision of law prohibiting insurance rate differentials~~
32 ~~based on age, with respect to nonfleet private passenger motor vehicle insurance under the~~
33 ~~jurisdiction of the Bureau, any member of the Bureau may apply for and use in this State,~~
34 ~~subject to the Commissioner's approval, a downward deviation in the rates for insureds who are~~
35 ~~55 years of age or older. A member of the Bureau may condition a deviation under this~~
36 ~~subsection or a deviation under subsection (a) of this section on the successful completion of a~~
37 ~~motor vehicle accident prevention course that has been approved by the Commissioner of~~
38 ~~Motor Vehicles, as designated in the deviation.~~

39 ...

40 **"§ 58-36-90. Prohibitions on using credit scoring to rate ~~noncommercial private~~**
41 **~~passenger motor vehicle and residential property insurance; exceptions.~~**

42 (a) Definitions. – As used in this section:

- 43 (1) "Adverse action" has the same meaning as in ~~section 1681a(k) of the federal~~
44 ~~Fair Credit Reporting Act section 603(k) of the federal Fair Credit Reporting~~
45 Act, § 15 U.S.C. § 1681a(k), and includes a denial or cancellation of, an
46 increase in any charge for, or a reduction or other adverse or unfavorable
47 change in the terms of coverage or amount of any insurance, existing or
48 applied for, in connection with the underwriting of insurance.
- 49 (2) "Credit report" means any written, oral, or other communication of any
50 information by a consumer reporting agency that bears on a consumer's
51 credit worthiness, credit standing, or credit capacity. Credit report does not

include accident or traffic violation records as maintained by the North Carolina Division of Motor Vehicles or any other law enforcement agency, a property loss report or claims history that does not include information that bears on a consumer's credit worthiness, credit standing, or credit capacity, or any report containing information solely as to transactions or experiences between the consumer and the person making the report.

(3) "Credit score" means a score that is derived by utilizing data from an individual's credit report in an algorithm, computer program, model, or other process that reduces the data to a number or rating.

(4) ~~"Noncommercial private passenger motor vehicle" means a "private passenger motor vehicle," as defined by G.S. 58-40-10, that is neither insured under a commercial policy nor used for commercial purposes.~~

(5) ~~"Private passenger motor vehicle" has the same meaning as set forth in G.S. 58-40-10.~~

(6) "Residential property" means real property with not more than four housing units located in this State, the contents thereof and valuable interest therein, and insurance coverage written in connection with the sale of that property. It also includes mobile homes, modular homes, townhomes, condominiums, and insurance on contents of apartments and rental property used for residential purposes.

(b) Prohibitions; Exceptions. – In the rating and underwriting of ~~nonecommercial private passenger motor vehicle~~ and residential property insurance coverage, insurers shall not use credit scoring as the sole basis for terminating an existing policy or any coverage in an existing policy or subjecting a policy to consent to rate as specified in G.S. 58-36-30(b) without consideration of any other risk factors, but insurers may use credit scoring as the sole basis for discounting rates. For purposes of this subsection only, "existing policy" means a policy that has been in effect for more than 60 days.

...."

SECTION 2. G.S. 58-36-41, G.S. 58-36-65 through 58-36-85, and G.S. 58-36-95 are repealed.

SECTION 3. Article 40 of Chapter 58 of the General Statutes reads as rewritten:

"Article 40.

"Regulation of Insurance Rates.

...

"§ 58-40-10. Other definitions.

As used in this Article and in Articles ~~36 and 37~~ 36, 37, 37A, and 41 of this Chapter:

(1) "Private passenger motor vehicle" means:

- a. A motor vehicle of the private passenger or station wagon type that is owned or hired under a long-term contract by the policy named insured and that is neither used as a public or livery conveyance for passengers nor rented to others without a driver; or
- b. A motor vehicle that is a pickup truck or van that is owned by an individual or by husband and wife or individuals who are residents of the same household if it:
 1. Has a gross vehicle weight as specified by the manufacturer of less than 10,000 pounds; and
 2. Is not used for the delivery or transportation of goods or materials unless such use is (i) incidental to the insured's business of installing, maintaining, or repairing furnishings or equipment, or (ii) for farming or ranching.

Such vehicles owned by a family farm copartnership or a family farm corporation shall be considered owned by an individual for the purposes of this section; or

c. ~~A motorcycle, motorized scooter or other similar motorized vehicle not used for commercial purposes as defined in G.S. 20-4.01(27)d.~~

(2) "Nonfleet" motor vehicle means a motor vehicle not eligible for classification as a fleet vehicle for the reason that the motor vehicle is one of four or fewer motor vehicles hired under a long-term contract or owned by the insured named in the policy.

"§ 58-40-15. Scope of application.

The provisions of this Article shall apply to all insurance on risks or on operations in this State, except:

- (1) Reinsurance, other than joint reinsurance to the extent stated in G.S. 58-40-60;
- (2) Any policy of insurance against loss or damage to or legal liability in connection with property located outside this State, or any motor vehicle or aircraft principally garaged and used outside of this State, or any activity wholly carried on outside this State;
- (3) Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance policies;
- (4) Accident, health, or life insurance;
- (5) Annuities;
- (6) Repealed by Session Laws 1985, c. 666, s. 43;
- (7) Mortgage guaranty insurance;
- (8) Workers' compensation and employers' liability insurance written in connection therewith;
- (9) ~~For private passenger (nonfleet) motor vehicle liability insurance, automobile medical payments insurance, uninsured motorists' coverage and other insurance coverages written in connection with the sale of such liability insurance;~~
- (10) ~~Theft of or physical damage to nonfleet private passenger motor vehicles; except this Article applies to insurance against theft of or physical damage to motorcycles, as defined in G.S. 20-4.01(27)d.; and~~
- (11) Insurance against loss to residential real property with not more than four housing units located in this State or any contents thereof or valuable interest therein and other insurance coverages written in connection with the sale of such property insurance. Provided, however, that this Article shall apply to insurance against loss to farm dwellings, farm buildings and their appurtenant structures, farm personal property and other coverages written in connection with farm real or personal property; travel or camper trailers designed to be pulled by private passenger motor vehicles ~~unless insured under policies covering nonfleet private passenger motor vehicles; vehicles;~~ residential real and personal property insured in multiple line insurance policies covering business activities as the primary insurable interest; and marine, general liability, burglary and theft, glass, and animal collision insurance except when such coverages are written as an integral part of a multiple line insurance policy for which there is an indivisible premium.

The provisions of this Article shall not apply to hospital service or medical service corporations, investment companies, mutual benefit associations, or fraternal beneficiary associations.

"§ 58-40-17. Private passenger motor vehicles; number of nonfleet policies.

Notwithstanding the definition of "nonfleet" in G.S. 58-40-10(2), an insurer may adopt rules, subject to the Commissioner's approval, that specify the circumstances under which more than four private passenger motor vehicles may be covered under a nonfleet private passenger motor vehicle policy that is subject to this Article.

...

"§ 58-40-30. Filing of rates and supporting data.

(a) With the exception of inland marine insurance that is not written according to manual rates and rating plans, plans and rate filings subject to Article 37A of this Chapter, every admitted insurer and every licensed statistical organization, which has been designated by any insurer for the filing of rates under G.S. 58-40-40, shall file with the Commissioner all rates and all changes and amendments ~~thereto~~ to rates made by it for use in this State prior to the time they become effective.

(b) The Commissioner may require the filing of supporting data including:

- (1) The experience and judgment of the filer, and to the extent the filer wishes or the Commissioner requires, of other insurers or rating organizations;
- (2) The filer's interpretation of any statistical data relied upon; and
- (3) Descriptions of the methods employed in setting the rates.

(c) Upon written consent of the insured stating the insured's reasons, a rate or deductible or both in excess of that provided by an otherwise applicable filing may be used on a specific risk, in accordance with rules adopted by the Commissioner. The insurer is not required to obtain the written consent of the insured on any renewal of or endorsement to the policy if the policy renewal or endorsement states that the rates or deductible, or both, are greater than those rates or deductibles, or both, that are applicable in the State of North Carolina. The insurer shall retain the signed consent form and other policy information for each insured and make this information available to the Commissioner, upon request of the Commissioner.

(d) This section and G.S. 58-41-50 shall be construed in pari materia.

...

"§ 58-40-145. Prohibitions on using credit scoring to rate nonfleet private passenger motor vehicle insurance; exceptions.

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

- (1) Adverse action. – As defined in section 603(k) of the federal Fair Credit Reporting Act, 15 U.S.C. § 1681a(k), a denial or cancellation of, an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of any insurance, existing or applied for, in connection with the underwriting of insurance.
- (2) Credit report. – Any written, oral, or other communication of any information by a consumer reporting agency that bears on a consumer's creditworthiness, credit standing, or credit capacity. Credit report does not include accident or traffic violation records as maintained by the North Carolina Division of Motor Vehicles or any other law enforcement agency, a property loss report or claims history that does not include information that bears on a consumer's creditworthiness, credit standing, or credit capacity, or any report containing information solely as to transactions or experiences between the consumer and the person making the report.
- (3) Credit score. – A score that is derived by utilizing data from an individual's credit report in an algorithm, computer program, model, or other process that reduces the data to a number or rating.

(b) Prohibitions; Exceptions. – In the rating and underwriting of noncommercial private passenger motor vehicle coverage, insurers shall not use credit scoring as the sole basis for

1 terminating an existing policy or any coverage in an existing policy or subjecting a policy to
2 consent to rate as specified in G.S. 58-40-30(c) without consideration of any other risk factors,
3 but insurers may use credit scoring as the sole basis for discounting rates. For purposes of this
4 subsection only, "existing policy" means a policy that has been in effect for more than 60 days.

5 (c) Notification. – If a credit report is used in conjunction with other criteria to take an
6 adverse action, the insurer shall provide the applicant or policyholder with written notice of the
7 action taken, in a form approved by the Commissioner. The notification shall include, in easily
8 understandable language:

9 (1) The specific reason for the adverse action and, if the adverse action was
10 based upon a credit score, a description of the factors that were the primary
11 influence on the score.

12 (2) The name, address, and toll-free telephone number of the credit bureau that
13 provided the insurer with the credit-based information.

14 (3) The fact that the consumer has the right to obtain a free copy of the
15 consumer's credit report from the appropriate credit bureau.

16 (4) The fact that the consumer has the right to challenge information contained
17 in the consumer's credit report.

18 (d) Disputed Credit Report Information. – If it is determined through the dispute
19 resolution process set forth in section 611(a) of the federal Fair Credit Reporting Act, 15 U.S.C.
20 § 1681i(a), that the credit information of a current insured was incorrect or incomplete and if
21 the insurer receives notice of such determination from either the consumer reporting agency or
22 from the insured, the insurer shall re-underwrite or re-rate the consumer within 30 days of
23 receiving the notice. After re-underwriting or re-rating the insured, the insurer shall make any
24 adjustments necessary, consistent with its underwriting guidelines. If an insurer determines the
25 insured has overpaid premium, the insurer shall refund to the insured the amount of
26 overpayment calculated back to the shorter of either the last 12 months of coverage or the
27 actual policy period.

28 (e) Indemnification. – An insurer shall indemnify, defend, and hold agents harmless
29 from and against all liability, fees, and costs arising out of or relating to the actions, errors, or
30 omissions of an agent who obtains or uses credit information or credit scores for an insurer,
31 provided the agent follows the instructions or procedures established by the insurer and
32 complies with any applicable law or regulation. Nothing in this subsection shall be construed to
33 provide a consumer or other insured with a cause of action that does not exist in the absence of
34 this subsection.

35 (f) Filing. – Insurers that use credit scores to underwrite and rate risks shall file their
36 scoring models, or other scoring processes, with the Department. A filing that includes credit
37 scoring may include loss experience justifying the applicable surcharge or credit. A filer may
38 request that its credit score data be considered a trade secret and may designate parts of its
39 filings accordingly.

40 **"§ 58-40-150. Use of nonoriginal crash repair parts.**

41 (a) The following definitions apply in this section:

42 (1) Crash repair part. – Sheet metal or plastic parts that are intended for use as
43 replacements for components of the exterior of a motor vehicle.

44 (2) Insurer. – Any insurance company licensed by the Commissioner to write
45 nonfleet private passenger motor vehicle insurance policies, as well as any
46 person authorized to represent an insurer with respect to a claim.

47 (3) Nonoriginal. – When used to describe a crash repair part, windshield, auto
48 glass, or other component of a motor vehicle, "nonoriginal" means the
49 component was not manufactured by or for the original equipment
50 manufacturer of the vehicle.

(b) An insurer shall disclose to a claimant in writing, either on the estimate or on a separate document attached to the estimate, the following in no smaller than 10 point type: "THIS ESTIMATE HAS BEEN PREPARED BASED ON THE USE OF AUTOMOBILE PARTS NOT MADE BY THE ORIGINAL MANUFACTURER. PARTS USED IN THE REPAIR OF YOUR VEHICLE MADE BY OTHER THAN THE ORIGINAL MANUFACTURER ARE REQUIRED TO BE AT LEAST EQUIVALENT IN TERMS OF FIT, QUALITY, PERFORMANCE, AND WARRANTY TO THE ORIGINAL MANUFACTURER PARTS THEY ARE REPLACING."

(c) It is a violation of G.S. 58-3-180 for an automobile repair facility or parts person to place a nonoriginal crash repair part, nonoriginal windshield, or nonoriginal auto glass on a motor vehicle and to submit an invoice for an original repair part.

(d) Any insurer or other person who has reason to believe that fraud has occurred under this section shall report that fraud to the Commissioner for further action pursuant to G.S. 58-2-160.

"§ 58-40-155. Material misrepresentation on application for motor vehicle insurance policy.

If an applicant for the issuance or renewal of a nonfleet private passenger motor vehicle insurance policy knowingly makes a material misrepresentation of the years of driving experience or the driving record of any named insured or of any other operator who resides in the same household and who customarily operates a motor vehicle to be insured under the policy, the insurer may take any of the following actions:

(1) Cancel or refuse to renew the policy.

(2) Surcharge the policy.

(3) Recover from the applicant the appropriate amount of premium or surcharge that would have been collected by the insurer had the applicant furnished the correct information."

SECTION 4. G.S. 58-41-50 reads as rewritten:

"§ 58-41-50. Policy form and rate filings; punitive damages; data required to support filings.

(a) With the exception of inland marine insurance that is not written according to manual rates and rating plans, all policy forms must be filed with and either approved by the Commissioner or 90 days have elapsed and he has not disapproved the form before they may be used in this State. With respect to liability insurance policy forms, an insurer may exclude or limit coverage for punitive damages awarded against its insured.

(b) With the exception of inland marine insurance that is not written according to manual rates and rating plans, plans and rate filings subject to Article 37A of this Chapter, all rates or prospective loss cost multipliers by licensed fire and casualty companies or their designated statistical organizations must be filed with the Commissioner at least 60 days before they may be used in this State. Any fire and casualty filing may become effective on a date earlier than that specified in this subsection upon agreement between the Commissioner and the filer.

(c) A- With the exception of nonfleet private passenger motor vehicle insurance filings, a filing that does not include the statistical and rating information required by subsections (d) and (e) of this section is not a proper filing, and will be returned to the filing insurer or organization. The filer may then remedy the defects in the filing. An otherwise defective filing thus remedied shall be deemed to be a proper filing, except that all periods of time specified in this Article will run from the date the Commissioner receives additional or amended documents necessary to remedy all material defects in the filing.

(d) The following information must be included in each policy form, rule, and rate filing:

- 1 (1) A detailed list of the rates, rules, and policy forms filed, accompanied by a
2 list of those superseded; and
3 (2) A detailed description, properly referenced, of all changes in policy forms,
4 rules, and rates, including the effect of each change.
5 (e) Each policy form, rule, and rate filing that is based on statistical data must be
6 accompanied by the following properly identified information:
7 (1) North Carolina earned premiums at the actual and current rate level; losses
8 and loss adjustment expenses, each on paid and incurred bases without
9 trending or other modification for the experience period, including the loss
10 ratio anticipated at the time the rates were promulgated for the experience
11 period;
12 (2) Credibility factor development and application;
13 (3) Loss development factor derivation and application on both paid and
14 incurred bases and in both numbers and dollars of claims;
15 (4) Trending factor development and application;
16 (5) Changes in premium base resulting from rating exposure trends;
17 (6) Limiting factor development and application;
18 (7) Overhead expense development and application of commission and
19 brokerage, other acquisition expenses, general expenses, taxes, licenses, and
20 fees;
21 (8) Percent rate change;
22 (9) Final proposed rates;
23 (10) Investment earnings, consisting of investment income and realized plus
24 unrealized capital gains, from loss, loss expense, and unearned premium
25 reserves;
26 (11) Identification of applicable statistical plans and programs and a certification
27 of compliance with them;
28 (12) Investment earnings on capital and surplus;
29 (13) Level of capital and surplus needed to support premium writings without
30 endangering the solvency of the company or companies involved; and
31 (14) Such other information that may be required by any rule adopted by the
32 Commissioner.

33 Provided, however, that no filing may be returned or disapproved on the grounds that such
34 information has not been furnished if the filer has not been required to collect such information
35 pursuant to statistical plans or programs or to report such information to statistical agents,
36 except where the Commissioner has given reasonable prior notice to the filer to begin
37 collecting and reporting such information or except when the information is readily available to
38 the filer.

39 (f) It is unlawful for an insurer to charge or collect, or attempt to charge or collect, any
40 premium for insurance except in accordance with filings made with the Commissioner under
41 this section and Article 40 of this Chapter.

42 (g) An insurer subject to this Article may develop and use an individual form or rate as
43 a result of the uniqueness of a particular risk. The form or rate shall be developed, filed, and
44 used in accordance with rules adopted by the Commissioner.

45 (h) For purposes of this Article, "nonfleet" and "private passenger motor vehicle" shall
46 be defined as set forth in G.S. 58-40-10. "

47 **SECTION 5.** Chapter 58 of the General Statutes is amended by adding a new
48 Article to read:

49 "Article 37A.

50 "Motor Vehicle Insurance Flex-Rating.

51 "§ 58-37A-1. Scope.

The provisions of this Article shall apply only to nonfleet private passenger motor vehicle insurance written in this State by any insurer licensed by the Commissioner to write nonfleet private passenger motor vehicle insurance.

"§ 58-37A-5. Definitions.

The following definitions apply in this Article:

- (1) Inadequate. – With respect to a rate filed under this Article, unreasonably low for the insurance coverage provided and, with continued use, likely to result in any of the following:
 - a. Endanger the solvency of insurers using the rate.
 - b. Substantially lessen competition among insurers.
 - c. Creation of a monopoly in the market for nonfleet private passenger motor vehicle insurance in the State.
- (2) Nonfleet. – Defined in G.S. 58-40-10.
- (3) Nonfleet private passenger motor vehicle insurance. – Coverage for theft of and physical damage to nonfleet private passenger motor vehicles, for liability insurance for such motor vehicles, and for automobile medical payments insurance, uninsured motorists coverage, and other insurance coverages written in connection with the sale of such liability insurance.
- (4) Private passenger motor vehicle. – Defined in G.S. 58-40-10.
- (5) Unfairly discriminatory. – With respect to a rate filed under this Article, congruent with the standard in G.S. 58-40-20.

"§ 58-37A-10. Flex-Rating.

(a) Notwithstanding any other provision of this Chapter, a nonfleet private passenger motor vehicle insurance rate filing made by an insurer that provides for an overall statewide rate increase or decrease of no more than fifteen percent (15%), when aggregated for all policyholders and all coverages subject to the filing, may take effect on or after the date it is filed. The filing and effective dates of the rate increase or decrease shall be decided by the insurer and set forth in the rate filing. No more than one rate filing may be made by an insurer pursuant to the expedited process provided by this section during any 12-month period, unless a rate filing, when combined with any other rate filings made by that insurer within the 12-month period, does not result in an overall statewide rate increase or decrease of no more than fifteen percent (15%) when aggregated for all policyholders and all coverages subject to the filing.

(b) Rate filings that provide for an overall statewide rate increase or decrease greater than fifteen percent (15%), when aggregated for all policyholders and all coverages subject to the filing, shall be subject to Articles 40 and 41 of this Chapter.

(c) Notwithstanding any other provision of this Chapter, a filing subject to subsection (a) of this section submitted to the Commissioner shall be deemed to comply with G.S. 58-40-20 and approved by the Commissioner upon filing. If the Commissioner subsequently determines that the filing is inadequate or unfairly discriminatory, the Commissioner shall issue a written order specifying in detail the basis for the determination that the filing is inadequate or unfairly discriminatory, and setting forth a reasonable future date on which the filing shall be considered no longer effective. An order by the Commissioner pursuant to this subsection shall apply prospectively only, and shall not affect any contract of insurance issued or made before the effective date of the order."

SECTION 6.(a) G.S. 58-37-35 reads as rewritten:

"§ 58-37-35. The Facility; functions; administration.

...

(l) The classifications, rules, rates, rating plans and policy forms used on motor vehicle insurance policies reinsured by the Facility may be made by the Facility or by any licensed or statutory statistical organization or bureau on its behalf and shall be filed with the Commissioner. The Board of Governors shall establish a separate subclassification within the

Facility for "clean risks". For the purpose of this Article, a "clean risk" is any owner of a nonfleet private passenger motor vehicle as defined in G.S. 58-40-10, if the owner, principal operator, and each licensed operator in the owner's household have two years' driving experience as licensed drivers and if none of the persons has been assigned any Safe Driver Incentive Plan points under ~~Article 36 of this Chapter~~ G.S. 58-37-80 during the three-year period immediately preceding either (i) the date of application for a motor vehicle insurance policy or (ii) the date of preparation of a renewal of a motor vehicle insurance policy. The filings may incorporate by reference any other material on file with the Commissioner. Rates shall be neither excessive, inadequate nor unfairly discriminatory. If the Commissioner finds, after a hearing, that a rate is either excessive, inadequate or unfairly discriminatory, the Commissioner shall issue an order specifying in what respect it is deficient and stating when, within a reasonable period thereafter, the rate is no longer effective. The order is subject to judicial review as set out in Article 2 of this Chapter. Pending judicial review of said order, the filed classification plan and the filed rates may be used, charged and collected in the same manner as set out in G.S. 58-40-45 of this Chapter. The order shall not affect any contract or policy made or issued before the expiration of the period set forth in the order. All rates shall be on an actuarially sound basis and shall be calculated, insofar as is possible, to produce neither a profit nor a loss. ~~However, the rates made by or on behalf of the Facility with respect to "clean risks" shall not exceed the rates charged "clean risks" who are not reinsured in the Facility.~~ However, the rates for "clean risks" reinsured in the Facility on policies becoming effective on or after October 1, 2012, shall provide for an incremental elimination over the four year period from October 1, 2012, to October 1, 2016, of the difference between the rate in effect on September 30, 2012, for "clean risks" reinsured in the Facility and actuarially sound rates for all risks reinsured in the Facility. The difference between the actual rate charged and the actuarially sound and self-supporting rates for "clean risks" reinsured in the Facility may be recouped in similar manner as assessments under G.S. 58-37-40(f). Rates shall not include any factor for underwriting profit on Facility business, but shall provide an allowance for contingencies. There shall be a strong presumption that the rates and premiums for the business of the Facility are neither unreasonable nor excessive.

(m) In addition to annual premiums, the rules of the Facility shall allow semiannual and quarterly premium terms."

SECTION 6.(b) G.S. 58-37-40 reads as rewritten:

"§ 58-37-40. Plan of operation.

...

(f) The plan of operation shall provide that every member shall, following payment of any pro rata assessment, begin recoupment of that assessment by way of a surcharge on motor vehicle insurance policies issued by the member or through the Facility until the assessment has been recouped. Any surcharge under this subsection or under subsection (e) of this section shall be a percentage of premium adopted by the Board of Governors of the Facility; and the charges determined on the basis of the surcharge shall be ~~combined with and displayed as a part of the applicable premium charges set out as a separate charge on any statement of applicable premium charges provided to the policyholder.~~ Recoupment of losses sustained by the Facility since September 1, 1977, with respect to nonfleet private passenger motor vehicles may be made only by surcharging nonfleet private passenger motor vehicle insurance policies. If the amount collected during the period of surcharge exceeds assessments paid by the member to the Facility, the member shall pay over the excess to the Facility on a date specified by the Board of Governors. If the amount collected during the period of surcharge is less than the assessments paid by the member to the Facility, the Facility shall pay the difference to the member. Except as otherwise provided in this Article, the amount of recoupment shall not be considered or treated as a rate or premium for any purpose. The Board of Governors shall adopt and implement a plan for compensation of agents of Facility members when recoupment

1 surcharges are imposed; that compensation shall not exceed the compensation or commission
2 rate normally paid to the agent for the issuance or renewal of the automobile liability policy
3 issued through the North Carolina Reinsurance Facility affected by the surcharge. However, the
4 surcharge shall include an amount necessary to recover the amount of the assessment to
5 member companies and the compensation paid by each member, under this section, to agents.

6 (g) The plan of operation shall provide that all investment income from the premium on
7 business reinsured by the Facility shall be retained by or paid over to the Facility. In
8 determining the cost of operation of the Facility, all investment income shall be taken into
9 consideration.

10 (h) The plan of operation shall provide for audit of the annual statement of the Facility
11 by independent auditor approved by the Legislative Services Commission.

12 (i) The Facility shall file with the Commissioner revisions in the Facility plan of
13 operation for his approval or modification. Such revisions shall be made for the purpose of
14 revising the classification and rating plans for other than nonfleet private passenger motor
15 vehicle insurance ceded to the Facility."

16 **SECTION 6.(c)** Article 37 of Chapter 58 of the General Statutes is amended by
17 adding two new sections to read:

18 **"§ 58-37-80. Classifications and Safe Driver Incentive Plan.**

19 (a) The Facility shall file, subject to review, modification, and promulgation by the
20 Commissioner, such rate classifications, schedules, or rules that the Commissioner deems to be
21 desirable and equitable to classify drivers of nonfleet private passenger motor vehicles for
22 purposes of reinsurance under this Article. Subsequently, the Commissioner may require the
23 Facility to file modifications of the classifications, schedules, or rules. If the Facility does not
24 file the modifications within a reasonable time, the Commissioner may promulgate the
25 modifications. In promulgating or modifying these classifications, schedules, or rules, the
26 Commissioner may give consideration to the following:

- 27 (1) Uses of vehicles, including without limitation to farm use, pleasure use,
28 driving to and from work, and business use;
29 (2) Principal and occasional operation of vehicles;
30 (3) Years of driving experience of insureds as licensed drivers;
31 (4) The characteristics of vehicles; or
32 (5) Any other factors, not in conflict with any law, deemed by the
33 Commissioner to be appropriate.

34 (b) The Facility shall file, subject to review, modification, and promulgation by the
35 Commissioner, a Safe Driver Incentive Plan ("Plan") that adequately and factually
36 distinguishes among various classes of drivers assigned to the Facility that have safe driving
37 records and various classes of drivers that have a record of at-fault accidents; a record of
38 convictions of major moving traffic violations; a record of convictions of minor moving traffic
39 violations; or a combination thereof; and that provides for premium differentials among those
40 classes of drivers. Subsequently, the Commissioner may require the Facility to file
41 modifications of the Plan. If the Facility does not file the modifications within a reasonable
42 time, the Commissioner may promulgate the modifications. The Commissioner is authorized to
43 structure the Plan to provide for surcharges above and discounts below the rate otherwise
44 charged.

45 (c) The classifications and Plan filed by the Facility shall be subject to the filing,
46 hearing, modification, approval, disapproval, review, and appeal procedures provided by law.

47 (d) Whenever any policy ceded to the Facility is surcharged due to an accumulation of
48 points under the Plan, the insurer shall, pursuant to rules adopted by the Commissioner, prior to
49 or simultaneously with the billing for additional premium, inform the named insured of the
50 surcharge or loss of discount by mailing to such insured a notice that states the basis for the
51 surcharge or loss of discount, and that advises that upon receipt of a written request from the

1 named insured it will promptly mail to the named insured a statement of the amount of
2 increased premium attributable to the surcharge or loss of discount. The statement of the basis
3 of the surcharge or loss of discount is privileged, and does not constitute grounds for any cause
4 of action for defamation or invasion of privacy against the insurer or its representatives, or
5 against any person who furnishes to the insurer the information upon which the insurer's
6 reasons are based, unless the statement or furnishing of information is made with malice or in
7 bad faith.

8 (e) Records of convictions for moving traffic violations to be considered under this
9 section shall be obtained at least annually from the Division of Motor Vehicles and applied by
10 the Facility's member companies in accordance with rules to be established by the Facility.

11 (f) The Facility is authorized to establish reasonable rules providing for the exchange of
12 information among its member companies as to chargeable accidents and similar information
13 involving persons to be insured under policies. Neither the Facility, any employee of the
14 Facility, nor any company or individual serving on any committee of the Facility has any
15 liability for defamation or invasion of privacy to any person arising out of the adoption,
16 implementation, or enforcement of any such rule. No insurer or individual requesting,
17 furnishing, or otherwise using any information that such insurer or person reasonably believes
18 to be for purposes authorized by this section has any liability for defamation or invasion of
19 privacy to any person on account of any such requesting, furnishing, or use. The immunity
20 provided by this subsection does not apply to any acts made with malice or in bad faith.

21 (g) As used in this section, "conviction" means a conviction as defined in G.S. 20-279.1
22 and means an infraction as defined in G.S. 14-3.1.

23 (h) If an insured disputes his insurer's determination that the operator of an insured
24 vehicle was at fault in an accident, such dispute shall be resolved following a procedure
25 developed by the Facility, unless there has been an adjudication or admission of negligence of
26 such operator.

27 (i) Subclassification plan surcharges shall be applied to a policy for a period of not less
28 nor more than three policy years.

29 (j) The subclassification plan may provide for premium surcharges for insureds having
30 less than three years' driving experience as licensed drivers.

31 **"§ 58-37-85. At-fault accidents and certain moving traffic violations under the Safe**
32 **Driver Incentive Plan.**

33 (a) The subclassification plan promulgated pursuant to G.S. 58-37-80(b) may provide
34 for separate surcharges for major, intermediate, and minor accidents. A "major accident" is an
35 at-fault accident that results in either (i) bodily injury or death or (ii) only property damage of
36 three thousand dollars (\$3,000) or more. An "intermediate accident" is an at-fault accident that
37 results in only property damage of more than one thousand eight hundred dollars (\$1,800) but
38 less than three thousand dollars (\$3,000). A "minor accident" is an at-fault accident that results
39 in only property damage of one thousand eight hundred dollars (\$1,800) or less. The
40 subclassification plan may also exempt certain minor accidents from the Facility recoupment
41 surcharge. The Facility shall assign varying Safe Driver Incentive Plan point values and
42 surcharges for bodily injury in at-fault accidents that are commensurate with the severity of the
43 injury, provided that the point value and surcharge assigned for the most severe bodily injury
44 shall not exceed the point value and surcharge assigned to a major accident involving only
45 property damage.

46 (b) The subclassification plan shall provide that there shall be no premium surcharge or
47 assessment of points against an insured where (i) the insured is involved and is at fault in a
48 "minor accident," as defined in subsection (a) of this section; (ii) the insured is not convicted of
49 a moving traffic violation in connection with the accident; (iii) neither the vehicle owner,
50 principal operator, nor any licensed operator in the owner's household has a driving record
51 consisting of one or more convictions for a moving traffic violation or one or more at-fault

1 accidents during the three-year period immediately preceding the date of the application for a
2 policy or the date of the preparation of the renewal of a policy; and (iv) the insured has been
3 covered by liability insurance with the same company or company group continuously for at
4 least the six months immediately preceding the accident. Notwithstanding (iv) of this
5 subsection, if the insured has been covered by liability insurance with the same company or
6 company group for at least six continuous months, some or all of which were after the accident,
7 the insurance company shall remove any premium surcharge or assessment of points against
8 the insured if requirements (i), (ii), and (iii) of this subsection are met. Also notwithstanding
9 (iv) of this subsection, an insurance company may choose not to assess a premium surcharge or
10 points against an insured who has been covered by liability insurance with that company or
11 with the company's group for less than six months immediately preceding the accident, if
12 requirements (i), (ii), and (iii) are met.

13 (c) The subclassification plan shall provide that there shall be no premium surcharge or
14 assessment of points against an insured where (i) the insured's drivers license has been revoked
15 under G.S. 20-16.5; and (ii) the insured is subsequently acquitted of the offense involving
16 impaired driving, as defined in G.S. 20-4.01(24a), that is related to the revocation, or the charge
17 for that offense is dismissed. In addition, no insurer shall use, for rating, underwriting, or
18 classification purposes, including ceding any risk to the Facility or writing any kind of
19 coverage subject to this Article, any license revocation under G.S. 20-16.5 if the insured is
20 acquitted or the charge is dismissed as described in this subsection.

21 (d) There shall be no Safe Driver Incentive Plan surcharges under G.S. 58-37-80 for
22 accidents occurring when only operating a firefighting, rescue squad, or law enforcement
23 vehicle in accordance with G.S. 20-125(b) and in response to an emergency if the operator of
24 the vehicle at the time of the accident was a paid or volunteer member of any fire department,
25 rescue squad, or any law enforcement agency. This exception does not include an accident
26 occurring after the vehicle ceases to be used in response to the emergency and the emergency
27 ceases to exist.

28 (e) The subclassification plan shall provide that with respect to a conviction for a
29 "violation of speeding 10 miles per hour or less over the speed limit" there shall be no premium
30 surcharge nor any assessment of points unless there is a driving record consisting of a
31 conviction or convictions for a moving traffic violation or violations, except for a prayer for
32 judgment continued for any moving traffic violation, during the three years immediately
33 preceding the date of application or the preparation of the renewal. The subclassification plan
34 shall also provide that with respect to a prayer for judgment continued for any moving traffic
35 violation, there shall be no premium surcharge nor any assessment of points unless the vehicle
36 owner, principal operator, or any licensed operator in the owner's household has a driving
37 record consisting of a prayer or prayers for judgment continued for any moving traffic violation
38 or violations during the three years immediately preceding the date of application or the
39 preparation of the renewal. For the purpose of this subsection, a "prayer for judgment
40 continued" means a determination of guilt by a jury or a court though no sentence has been
41 imposed. For the purpose of this subsection, a "violation of speeding 10 miles per hour or less
42 over the speed limit" does not include the offense of speeding in a school zone in excess of the
43 posted school zone speed limit.

44 (f) The subclassification plan shall provide that in the event an insured is at fault in an
45 accident and is convicted of a moving traffic violation in connection with the accident, only the
46 higher plan premium surcharge between the accident and the conviction shall be assessed on
47 the policy.

48 (g) As used in this section, "conviction" means a conviction as defined in G.S. 20-279.1
49 and means an infraction as defined in G.S. 14-3.1.

50 (h) The Facility shall assign one insurance point under the Safe Driver Incentive Plan
51 for persons who fail to yield to a pedestrian under G.S. 20-158(b)(2)b."

1 **SECTION 7.** On or before October 1, 2016, and again on or before October 1,
2 2018, the Executive Director and the Chair of the Board of Governors of the North Carolina
3 Reinsurance Facility shall report to the Joint Legislative Commission on Governmental
4 Operations on the size and market share of the Reinsurance Facility, and the analysis of the
5 Reinsurance Facility of the effect of the flex-rating authorized by Article 37A of the General
6 Statutes in reducing the size of the Reinsurance Facility. The reports shall include the
7 recommendations, if any, of the Reinsurance Facility of transitioning the North Carolina
8 involuntary automobile insurance mechanism from a reinsurance facility to an assigned risk
9 plan, joint underwriting association, or other mechanism for an involuntary automobile
10 insurance market.

11 **SECTION 8.** Sections 6(a) and 7 of this act become effective October 1, 2012. The
12 remainder of this act becomes effective October 1, 2014.



SENATE BILL 490: Automobile Insurance Regulatory Modernization

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Sen. Rucho
Analysis of: First Edition

Date: April 25, 2011
Prepared by: Tim Hovis
Committee Counsel

SUMMARY: *Senate Bill 490 does the following: (1) creates a new system called "flex-rating" for rates and rate filings for nonfleet private passenger motor vehicle insurance; and (2) eliminates the clean risk classification in the North Carolina Reinsurance Facility.*

Flex-Rating

The bill repeals various provisions of Article 36 of Chapter 58 requiring the filing of motor vehicle insurance rates and rating plans by the North Carolina Rate Bureau for approval by the Commissioner. In its place, the bill creates a new "flex-rating" system. Under flex-rating, rate increases or decreases of no more than 15% in a 12 month period may be filed with the Commissioner directly by an insurer and may take effect upon filing.

N.C. Reinsurance Facility

The bill also eliminates the clean risk subclassification in the North Carolina Reinsurance Facility and allows the facility to charge an actuarially sound rate for all risks ceded to the Facility. This would reduce the "Facility surcharge" assessed against drivers to cover losses incurred by the Facility resulting from insuring clean risks.

FLEX RATING

CURRENT LAW: Article 36 of Chapter 58 requires the N.C. Rate Bureau to file rates and rating plans for nonfleet private passenger motor vehicle insurance with the Commissioner for approval. Rates become effective as specified in the filing, but not earlier than 210 days from the date of the filing. Rates may not be excessive, inadequate, or unfairly discriminatory. At any time within 50 days from the date of the filing, the Commissioner may disapprove the filing and, if disapproved, fix a date for hearing not less than 30 days from the notice of disapproval. If a notice of hearing is not issued within 50 days FO the filing, the filing is deemed approved.

BILL ANALYSIS: Sections 1 and 2 of Senate Bill 490 delete language throughout Article 36 of Chapter 58 of the General Statutes applicable to nonfleet private passenger motor vehicles to remove coverage for these vehicles from the jurisdiction of the North Carolina Rate Bureau, and to make technical and conforming changes.

Provisions deleted are repealed. However, certain provisions are moved to Article 40 in Section 3 of the bill. These include prohibitions on credit scoring, use of nonoriginal crash repair parts, and material misrepresentation on application for motor vehicle insurance.

Section 3 makes conforming changes to Article 40, *Regulation of Insurance Rates*. As noted above, certain provisions deleted from Article 36 are set forth in similar language in Article 40. These provisions include:

- New G.S. 58-40-17 authorizing insurers to adopt rules, subject to approval by the Commissioner of Insurance, under which an insurer may insure more than four private passenger motor vehicles

Senate Bill 490

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under a private passenger policy. Existing law authorized the Rate Bureau, with the Commissioner's approval, to do so.

- New G.S. 58-40-145 prohibiting credit scoring as the sole basis for terminating a policy or subjecting a policy to consent to rate. Except for technical changes, this language is largely identical to existing law.
- New G.S. 58-40-150 governing the use of nonoriginal crash repair parts.
- New G.S. 58-40-155 addressing material misrepresentations by applicants for motor vehicle insurance. New language authorizes surcharges to be determined by the insurer. Existing law provides for surcharges in accordance with rules adopted by the rate Bureau and approved by the Commissioner.

In addition, rate filings greater than 15% under the new flex-rating system are subject to the requirements of Article 40, as discussed in Section 5 below.

Section 4 makes conforming changes.

Section 5 sets forth a new Article 37A, *Motor Vehicle Insurance Flex-Rating*, governing rates for nonfleet private passenger motor vehicle coverage.

Under flex-rating, rates for private passenger motor vehicle insurance that provide for an overall statewide rate increase or decrease of no more than 15%, aggregated for all policyholders and coverages, may take effect on or after the date of filing. The effective date of the increase or decrease is determined by the insurer as provided in the filing. Only one rate filing is allowed under this section during any 12-month period, unless all rate filings combined for the 12-month period do not result in an increase or decrease of more than 15%.

Rate filings under the flex-rating system are deemed to not be excessive, inadequate, or unfairly discriminatory and are deemed approved by the Commissioner upon filing. If the Commissioner subsequently determines the rate to be inadequate or unfairly discriminatory, he may enter an order specifying the basis for his determination and setting forth a reasonable future date on which the filing is no longer effective. The order shall apply prospectively only and shall not affect any contract of insurance issued or made before the effective date of the order.

Rate filings greater than 15% are subject to the requirements of Article 40 and 41. Under Article 40, rates must be filed with the Commissioner prior to use and may take effect upon filing. If the Commissioner disapproves the rate, he may order a refund or adjustment for policyholders. The insurer may continue to use the rate pending judicial review of the order, but must place the funds in an escrow account.

REINSURANCE FACILITY

CURRENT LAW: Under current law, insurers may cede to the Facility any eligible risk it chooses for liability and other required coverages. The Facility is required to establish a separate subclassification for owners and operators who are "clean risks." A "clean risk" is defined as "any owner of a nonfleet private passenger motor vehicle...if the owner, principal operator, and each licensed operator in the owner's household have two years' driving experience...and none of the persons has been assigned any Safe Driver Incentive Plan Points" in the preceding three years. All rates in the Facility must be actuarially sound and calculated to not produce a profit or loss. However, the rates for clean risks may not exceed rates for clean risks outside of the Facility, even if the rate is not actuarially sound. This rate is the base rate approved by the Commissioner for all drivers. The difference in the actuarially sound

Senate Bill 490

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rate for clean risks and the rate charged to clean risks in the Facility is recouped by a surcharge on all policies in the State, known as the "Facility surcharge."

Section 6(a) requires the gradual elimination from October 1, 2012 to October 1, 2016 of the difference between the rate in effect for clean risks on September 30, 2012 to an actuarially sound rate.

Section 6(b) requires the Facility surcharge to be set out as a separate charge on any statement of premium charges provided to a policyholder. Existing law provides that these charges are combined with and displayed as a part of the applicable premium charges.

Section 6(c) moves the Safe Driver Incentive Plan (SDIP) and the corresponding insurance point system to the Facility. Under current law, the SDIP and the point system are under the jurisdiction of the Rate Bureau and are applicable to all drivers. It is anticipated that with the enactment of Flex-Rating and the elimination of the clean risk classification in the Facility, insurers will be able to charge all drivers an actuarially sound rate and the need for the SDIP and a point system applicable to all drivers will be reduced. The population of the facility will also be greatly reduced and will be needed only as an "assigned risk pool."

Section 7 directs the Executive Director and the Chair of the Board of Governors of the Reinsurance Facility to report to the Joint Legislative Commission on Governmental Operations on the size and market share of the Facility, the effect of flex-rating in reducing the size of the Facility, and any recommendations on transitioning the Facility to an assigned risk pool, joint underwriting association, or other mechanism.

EFFECTIVE DATE: Sections 6(a) and 7 of Senate Bill 490 become effective October 1, 2012. The remainder of the act becomes effective October 1, 2014.

S490-SMRG-15(e1) v6

PUBLIC BILL

S.B. 490

SESSION LAW _____

A BILL TO BE ENTITLED

AN ACT TO MODERNIZE THE NONFLEET PRIVATE PASSENGER AUTOMOBILE AND MOTORCYCLE
INSURANCE REGULATORY ENVIRONMENT.

Introduced by Senator(s)

Rucho

RA Rucho

Bush

Principal Clerk's Use Only

FILED MAR 31 2011

PASSED 1st READING

APR 04 2011

AND REFERRED TO COMMITTEE

ON: Insurance

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 477

Short Title: Reduce Overpopulation of Reinsurance Facility.

(Public)

Sponsors: Senators Apodaca; and Jackson.

Referred to: Insurance.

March 31, 2011

A BILL TO BE ENTITLED

AN ACT TO REDUCE THE EXCESSIVE NUMBER OF NORTH CAROLINA DRIVERS
INSURED BY THE NORTH CAROLINA REINSURANCE FACILITY BY PROVIDING
FOR FILE AND USE RATE DEVIATIONS FOR AUTOMOBILE LIABILITY
INSURANCE AND BY PROVIDING A FIVE-YEAR PHASEOUT OF THE "CLEAN
RISK" SUBCLASSIFICATION WITHIN THE REINSURANCE FACILITY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-36-30 reads as rewritten:

"§ 58-36-30. Deviations.

(a) Except as permitted by G.S. 58-36-100 for workers' compensation loss costs filings, or subsection (e) of this section for nonfleet private passenger motor vehicle liability insurance, no insurer and no officer, agent, or representative of an insurer shall knowingly issue or deliver or knowingly permit the issuance or delivery of any policy of insurance in this State that does not conform to the rates, rating plans, classifications, schedules, rules and standards made and filed by the Bureau. An insurer may deviate from the rates promulgated by the Bureau if the insurer has filed the proposed deviation with the Bureau and the Commissioner, if the proposed deviation is based on sound actuarial principles, and if the proposed deviation is approved by the Commissioner. Amendments to deviations are subject to the same requirements as initial filings. An insurer may terminate a deviation only if the deviation has been in effect for a period of six months before the effective date of the termination and the insurer notifies the Commissioner of the termination no later than 15 days before the effective date of the termination.

...

(e) The provisions of this subsection apply only to the setting of rates for nonfleet private passenger motor vehicle liability insurance. An insurer may deviate from the rates promulgated by the Bureau if the insurer has filed the proposed deviation with the Bureau and the Commissioner and if the proposed deviation is based on sound actuarial principles. Rate deviations shall take effect upon filing. The Commissioner may disapprove a deviation filing submitted under this section only if the Commissioner determines that the filing is excessive, inadequate, or unfairly discriminatory. Deviations above the Bureau rate up to the applicable rates established for risks ceded to the Reinsurance Facility shall be presumed not to be excessive, inadequate, or unfairly discriminatory. If, after a hearing, the Commissioner disapproves a deviation filing, the Commissioner shall issue a written order specifying in detail the reasons the filing is excessive, inadequate, or unfairly discriminatory and stating a reasonable future date on which the filing is to be considered no longer effective. An order by the Commissioner pursuant to this subsection is prospective only and does not affect any policy that takes effect or is delivered before the effective date of the order, even if the effective date



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1 of the policy is subsequent to the effective date of the order. Amendments to deviations are
2 subject to the same requirements as initial filings. An insurer may terminate a deviation only if
3 the deviation has been in effect for a period of six months before the effective date of the
4 termination and the insurer notifies the Commissioner of the termination no later than 15 days
5 before the effective date of the termination."

6 **SECTION 2.(a)** G.S. 58-37-35 reads as rewritten:

7 **"§ 58-37-35. The Facility; functions; administration.**

8 ...

9 (l) The classifications, rules, rates, rating plans and policy forms used on motor vehicle
10 insurance policies reinsured by the Facility may be made by the Facility or by any licensed or
11 statutory statistical organization or bureau on its behalf and shall be filed with the
12 Commissioner. The Board of Governors shall establish a separate subclassification within the
13 Facility for "clean risks". For the purpose of this Article, a "clean risk" is any owner of a
14 nonfleet private passenger motor vehicle as defined in G.S. 58-40-10, if the owner, principal
15 operator, and each licensed operator in the owner's household have two years' driving
16 experience as licensed drivers and if none of the persons has been assigned any Safe Driver
17 Incentive Plan points under Article 36 of this Chapter during the three-year period immediately
18 preceding either (i) the date of application for a motor vehicle insurance policy or (ii) the date
19 of preparation of a renewal of a motor vehicle insurance policy. The filings may incorporate by
20 reference any other material on file with the Commissioner. Rates shall be neither excessive,
21 inadequate nor unfairly discriminatory. If the Commissioner finds, after a hearing, that a rate is
22 either excessive, inadequate or unfairly discriminatory, the Commissioner shall issue an order
23 specifying in what respect it is deficient and stating when, within a reasonable period thereafter,
24 the rate is no longer effective. The order is subject to judicial review as set out in Article 2 of
25 this Chapter. Pending judicial review of said order, the filed classification plan and the filed
26 rates may be used, charged and collected in the same manner as set out in G.S. 58-40-45 of this
27 Chapter. The order shall not affect any contract or policy made or issued before the expiration
28 of the period set forth in the order. All rates shall be on an actuarially sound basis and shall be
29 calculated, insofar as is possible, to produce neither a profit nor a loss. However, the rates made
30 by or on behalf of the Facility with respect to "clean risks" shall not exceed the rates charged
31 "clean risks" who are not reinsured in the Facility. The Facility, except that rates for "clean
32 risks" on policies reinsured by the Facility that become effective on or after January 1, 2013,
33 shall be established on a schedule that provides that any difference between rates charged for
34 "clean risks" reinsured in the Facility on policies becoming effective immediately prior to
35 January 1, 2013, and the actuarially sound rate for all risks reinsured by the Facility shall be
36 eliminated over a five-year period ending on December 31, 2017. Any difference between the
37 actual rate charged and the actuarially sound and self-supporting rates for "clean risks"
38 reinsured in the Facility may be recouped in similar manner as assessments under
39 G.S. 58-37-40(f). Rates shall not include any factor for underwriting profit on Facility business,
40 but shall provide an allowance for contingencies. There shall be a strong presumption that the
41 rates and premiums for the business of the Facility are neither unreasonable nor excessive.

42"

43 **SECTION 2.(b)** G.S. 58-37-35, as rewritten by Section 2(a) of this act, reads as
44 rewritten:

45 **"§ 58-37-35. The Facility; functions; administration.**

46 ...

47 (l) The classifications, rules, rates, rating plans and policy forms used on motor vehicle
48 insurance policies reinsured by the Facility may be made by the Facility or by any licensed or
49 statutory statistical organization or bureau on its behalf and shall be filed with the
50 Commissioner. ~~The Board of Governors shall establish a separate subclassification within the~~
51 ~~Facility for "clean risks". For the purpose of this Article, a "clean risk" is any owner of a~~

1 ~~nonfleet private passenger motor vehicle as defined in G.S. 58-40-10, if the owner, principal~~
2 ~~operator, and each licensed operator in the owner's household have two years' driving~~
3 ~~experience as licensed drivers and if none of the persons has been assigned any Safe Driver~~
4 ~~Incentive Plan points under Article 36 of this Chapter during the three-year period immediately~~
5 ~~preceding either (i) the date of application for a motor vehicle insurance policy or (ii) the date~~
6 ~~of preparation of a renewal of a motor vehicle insurance policy. The filings may incorporate by~~
7 ~~reference any other material on file with the Commissioner. Rates shall be neither excessive,~~
8 ~~inadequate nor unfairly discriminatory. If the Commissioner finds, after a hearing, that a rate is~~
9 ~~either excessive, inadequate or unfairly discriminatory, the Commissioner shall issue an order~~
10 ~~specifying in what respect it is deficient and stating when, within a reasonable period thereafter,~~
11 ~~the rate is no longer effective. The order is subject to judicial review as set out in Article 2 of~~
12 ~~this Chapter. Pending judicial review of said order, the filed classification plan and the filed~~
13 ~~rates may be used, charged and collected in the same manner as set out in G.S. 58-40-45 of this~~
14 ~~Chapter. The order shall not affect any contract or policy made or issued before the expiration~~
15 ~~of the period set forth in the order. All rates shall be on an actuarially sound basis and shall be~~
16 ~~calculated, insofar as is possible, to produce neither a profit nor a loss. However, rates for~~
17 ~~"clean risks" on policies reinsured by the Facility that become effective on or after January 1,~~
18 ~~2013 shall be established on a schedule that provides that any difference between rates charged~~
19 ~~for "clean risks" reinsured in the Facility on policies becoming effective immediately prior to~~
20 ~~January 1, 2013 and the actuarially sound rate for all risks reinsured by the Facility shall be~~
21 ~~eliminated over a five-year period ending on December 31, 2017. Any difference between the~~
22 ~~actual rate charged and the actuarially sound and self-supporting rates for "clean risks"~~
23 ~~reinsured in the Facility may be recouped in similar manner as assessments under~~
24 ~~G.S. 58-37-40(f). Rates shall not include any factor for underwriting profit on Facility business,~~
25 ~~but shall provide an allowance for contingencies. There shall be a strong presumption that the~~
26 ~~rates and premiums for the business of the Facility are neither unreasonable nor excessive.~~

27"

28 **SECTION 3.** Section 2(b) of this act becomes effective January 1, 2018. The
29 remainder of this act becomes effective January 1, 2012.



SENATE BILL 477: Reduce Overpopulation of Reinsurance Facility

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Sen. Apodaca
Analysis of: First Edition

Date: April 26, 2011
Prepared by: Tim Hovis
Committee Counsel

SUMMARY: *Senate Bill 477 would make the following changes: (1) amends current law applicable to rates for nonfleet private passenger motor vehicle insurance to allow insurers to deviate from base rates approved by the Commissioner and promulgated by the N.C. Rate Bureau upon filing of the deviation; and (2) eliminates the clean risk subclassification in the North Carolina Reinsurance Facility and allows the Facility to charge an actuarially sound rate for all risks ceded to the Facility.*

[As introduced, this bill was identical to H834, as introduced by Rep. Rhyne, which is currently in House Insurance.]

DEVIATIONS

CURRENT LAW: G.S. 58-36-30 governing deviations allows an insurer to deviate from rates promulgated by the North Carolina Rate Bureau if all of the following are met: (1) the insurer files the proposed deviation with the Bureau and the Commissioner; (2) the proposed deviation is based on sound actuarial principles; and (3) the proposed deviation is approved by the Commissioner.

BILL ANALYSIS: Section 1 of Senate Bill 477 adds a new subsection to G.S. 58-36-30, applicable only to deviations for nonfleet private passenger motor vehicle liability insurance, to provide that an insurer may deviate from approved rates promulgated by the Bureau if the insurer has: (1) filed the proposed deviation with the Bureau and the Commissioner and (2) if the proposed deviation is based on sound actuarial principles. Deviations under the new subsection take effect upon filing.

A deviation filing may be disapproved by the Commissioner if it is excessive, inadequate or unfairly discriminatory. Deviations above the approved Bureau rate up to the applicable Facility rate are presumed not to be excessive, inadequate, or unfairly discriminatory. (Please note that under existing law, the Facility is authorized to file a rate for approval by the Commissioner for risks ceded to the Facility. This is separate from the base rate promulgated by the Rate Bureau.)

If, after a hearing, the filing is disapproved, the Commissioner must issue a written order specifying why the deviation is disapproved and specifying a reasonable future date on which the filing is no longer effective. The order may be prospective only and does not affect any policy delivered before the order's effective date.

REINSURANCE FACILITY

CURRENT LAW: Under current law, insurers may cede to the Facility any eligible risk it chooses for liability and other required coverages. The Facility is required to establish a separate subclassification for owners and operators who are "clean risks." A "clean risk" is defined as "any owner of a nonfleet private passenger motor vehicle...if the owner, principal operator, and each licensed operator in the owner's household have two years' driving experience...and none of the persons has been assigned any Safe Driver Incentive Plan Points" in the preceding three years. All rates in the Facility must be actuarially sound and calculated to not produce a profit or loss. However, the rates for clean risks may

Senate Bill 477

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not exceed rates for clean risks outside of the Facility, even if the rate is not actuarially sound. This rate is the base rate approved by the Commissioner for all drivers. The difference in the actuarially sound rate for clean risks and the rate charged to clean risks in the Facility is recouped by a surcharge on all policies in the State, known as the "Facility surcharge."

Section 2(a) provides that rates for clean risks in the Facility that become effective on or after January 1, 2013 shall be established on a schedule that eliminates, over a five-year period ending on December 31, 2017, any difference between rates charged for clean risks and the actuarially sound rate for all risks in the Facility.

Section 2(b) eliminates statutory language pertaining to clean risks in the Facility including the language enacted in Section 2(a) of the bill, effective January 1, 2018. This section also strikes language authorizing insurers to assess the Facility surcharge against all policyholders in the State.

EFFECTIVE DATE: Section 2(b) becomes effective January 1, 2018. The remainder of the act becomes effective January 1, 2012.

S477-SMRG-16(e1) v3

PUBLIC BILL

S.B. 477
ID = H 834

SESSION LAW _____

A BILL TO BE ENTITLED

AN ACT TO REDUCE THE EXCESSIVE NUMBER OF NORTH CAROLINA DRIVERS INSURED BY THE NORTH CAROLINA REINSURANCE FACILITY BY PROVIDING FOR FILE AND USE RATE DEVIATIONS FOR AUTOMOBILE LIABILITY INSURANCE AND BY PROVIDING A FIVE-YEAR PHASEOUT OF THE "CLEAN RISK" SUBCLASSIFICATION WITHIN THE REINSURANCE FACILITY.

Introduced by Senator(s)

^{1A}
Apodaca



Principal Clerk's Use Only

FILED MAR 30 2011

PASSED 1st READING

MAR 31 2011

AND REFERRED TO COMMITTEE

ON

Insurance

INSURANCE FEDERATION *of North Carolina*



Member Companies

Allstate

Amica Mutual Insurance Company

Auto-Owners Insurance Company

Erie Insurance Group

GEICO

GMAC Insurance

Nationwide Insurance and Financial
Services

NC Farm Bureau Mutual Insurance Company

Penn National Insurance

Progressive

State Auto Insurance Company

USAA

Travelers

Associates

American Insurance Association

National Association of Mutual Insurance
Companies

Property & Casualty Insurance Association of
America

Reinsurance Association of America



- “And I believe we need to depopulate the Facility.” –Commissioner Goodwin, May 2008
- “I agree that the percentage of drivers in the Facility must be reduced.”
–Commissioner Goodwin, January 2009
- “There’s always room for change, and we must consider targeted reforms and targeted modernization. For example, we need to depopulate the Reinsurance Facility.”
–Commissioner Goodwin, January 2009



How big is the problem with the
Reinsurance Facility?

**PRIVATE PASSENGER CARS INSURED
IN THE SHARED AND VOLUNTARY MARKETS, 2008**

State	Voluntary market	Shared market	Total	Shared market as a percent of total
Alabama	3,384,021	6	3,384,027	1
Alaska	437,274	122	437,396	0.028%
Arizona	4,130,900	20	4,130,920	1
Arkansas	2,069,310	0	2,069,310	1
California	24,127,758	5,941	24,133,699	0.025
Colorado	3,667,061	0	3,667,061	1
Connecticut	2,442,996	487	2,443,483	0.020
Delaware	608,459	25	608,484	0.004
D.C.	221,678	457	222,135	0.206
Florida	11,288,408	6	11,288,414	1
Georgia	6,789,526	37	6,789,529	1
Hawaii	796,742	5,188	801,930	0.647
Idaho	1,068,562	38	1,068,600	0.004
Illinois	7,936,919	1,153	7,938,072	0.015
Indiana	4,578,960	6	4,578,966	1
Iowa	2,398,138	9	2,398,147	1
Kansas	2,349,365	1,327	2,350,692	0.056
Kentucky	3,013,470	64	3,013,534	0.002
Louisiana	2,834,988	7	2,834,995	1
Maine	1,022,278	28	1,022,306	0.003
Maryland	3,792,401	73,328	3,865,729	1.897
Massachusetts	3,955,971	112,891	4,068,862	2.775
Michigan	6,164,846	1,297	6,166,143	0.021
Minnesota	3,746,861	5	3,746,866	1
Mississippi	2,076,581	76	2,076,657	0.004
Missouri	4,195,783	41	4,195,824	0.001
Montana	775,934	230	776,164	0.030
Nebraska	1,501,473	4	1,501,477	1
Nevada	1,793,132	23	1,793,155	0.001
New Hampshire	904,727	710	905,437	0.078
New Jersey	5,290,260	15,048	5,305,308	0.284

**PRIVATE PASSENGER CARS INSURED
IN THE SHARED AND VOLUNTARY MARKETS, 2008 (Cont'd)**

State	Voluntary market	Shared market	Total	Shared market as a percent of total
New Mexico	1,455,016	24	1,455,040	0.002%
New York	9,233,103	92,283	9,325,386	0.990
North Carolina	5,607,617	1,442,470	7,050,087	20.460
North Dakota	592,814	4	592,818	0.001
Ohio	8,029,756	0	8,029,756	1
Oklahoma	2,719,636	52	2,719,688	0.002
Oregon	2,724,683	9	2,724,692	1
Pennsylvania	8,483,438	19,151	8,502,589	0.225
Rhode Island	663,890	9,335	673,225	1.387
South Carolina	3,294,512	17	3,294,513	1
South Dakota	681,839	0	681,839	1
Tennessee	4,187,461	24	4,187,485	0.001
Texas	NA	NA	NA	NA
Utah	1,808,234	2	1,808,236	1
Vermont	474,881	450	475,331	0.095
Virginia	6,023,910	1,460	6,025,370	0.024
Washington	4,513,296	0	4,513,296	1
West Virginia	1,305,657	39	1,305,696	0.003
Wisconsin	3,674,130	0	3,674,130	1
Wyoming	503,741	1	503,742	1
United States	185,342,396	1,783,845	187,126,241	0.953%

¹Less than 0.001 percent. NA=Data not available.

Source: Automobile Insurance Plans Service Office.



South Carolina	3,294,512	1	3,294,513	1

Georgia	6,789,526	3	6,789,529	1

Tennessee	4,187,461	24	4,187,485	0.001

Virginia	6,023,910	1,460	6,025,370	0.024

North Carolina	5,607,617	1,442,470	7,050,087	20.460



North Carolina has 80% of the total residual market for the whole country.

North Carolina	5,607,617	1,442,470	7,050,087	20.460

United States	185,342,396	1,783,845	187,126,241	0.953%



Why?

N.C is the only state with a Rate Bureau that proposes a base rate for all the drivers in the state. The Commissioner has to approve that rate. That rate is not the correct rate for all drivers. Some drivers should have lower rates and some should have higher rates.



Most companies file downward deviations with the Commissioner to allow them to provide lower rates to the drivers the underwriters determine should have lower rates.

Nationwide Property & Casualty Insurance Company
– 25 downward deviations

State Farm Mutual Automobile Insurance
– 12 downward deviations

North Carolina Farm Bureau Mutual Insurance Company
– 9 downward deviations



Companies are not allowed to deviate upward and provide adequate rates. The only alternative companies have is to cede those drivers to the Reinsurance Facility.

Facility base rates are on average 20% higher than the Bureau approved rates.

Rates for the Reinsurance Facility are also approved by the Commissioner.



SB 477 would allow companies to file deviations up to the Facility approved rates.

Companies could then write policies in that gap between the Bureau and Facility rates.



Current law directs the Facility Board to have a sub-classification for risks that have been ceded to the Facility but have no Safe Driver Incentive Plan points. These are called “clean risks” but underwriters have determined that they pose a higher risk.



These “clean risks” pay the lower Bureau rates and are currently being **subsidized** by all other drivers in the state to the tune of over \$132 million a year. Every driver in the state pays a “clean risk” surcharge of 4.8% of the liability coverage to subsidize these drivers. This surcharge has been as high as 10%.



SB 477 gradually eliminates this subsidy over time by doing away with the “clean risk” sub-classification in the Facility and the “clean-risk” surcharge over a period of 5 years.

When fully implemented, SB 477 will result in 85.6% of North Carolina drivers paying lower premiums than they would have otherwise have to pay.



SB 477 will have no effect on:

- The North Carolina Rate Bureau
- The ability of the Rate Bureau to propose rates to the Commissioner
- The Commissioner's ability to set rates for both the Rate Bureau and the Reinsurance Facility



Comparing North Carolina's auto rates with other states is misleading:

- 12 states have no fault insurance- policy holders recover financial losses from their own carriers without regard to fault.
- 13 states have pure comparative fault- everyone who is injured recovers, no matter how much at fault they may be. (3 of these are no fault states)
- 21 states have modified comparative fault- injured party recovers even if 50% at fault. (5 of these are also no fault states)

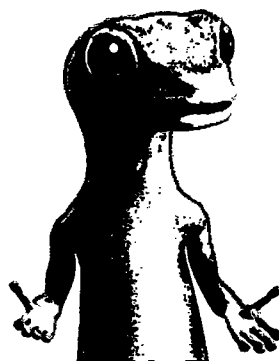
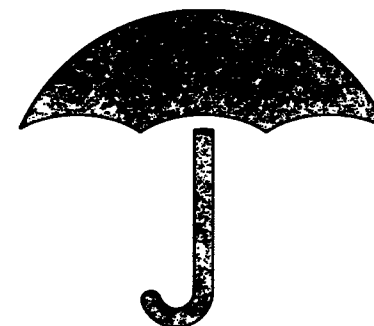


Auto Insurance Companies actively compete for business

- The largest growth in advertising this year was in automotive (+27%) and auto insurance (+23%).
- Auto insurance companies maintain web sites that compare prices.



Do you recognize any of these?





The Commissioner has called for:

- Incremental change
- Depopulation of the Facility

SB 477 does exactly those two things

VISITOR REGISTRATION SHEET

NAME OF COMMITTEE

Insurance

DATE

4-27

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DeANNE MANGUM

NAME	FIRM OR AGENCY AND ADDRESS
Don STEPHENS	TRAVELERS Ins. Co.
George Marcoccia	Travelers Ins Co.
Ben Popken	NCDOI
Mark [Signature]	NCDOI
Kerry Hall	NCDOI
Louis Belo	NCDOI
[Signature]	inc
David Sollen	STATE FARM
Matthew Eising	Smith Anderson
Katy Feinberg	McGuire Woods Consulting
Ken BURKO	MWC

VISITOR REGISTRATION SHEET

INSURANCE SENATE

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME

FIRM OR AGENCY AND ADDRESS

JOE TERMINI

GEICO

HARRY PAYNE

NC Justice

Joan Ann
Gibbs & Hurd

SA

IIANC

Mildred Smith

Freedom works

Ramona D Timm

freedom Works

E. A. Timm

Freedom works

Lafelle Alsip

Freedom Works

DANIEL BAUM

TROOTMAN SANDERS

Rodney TARRANTS

ALLSTATE - Sanford

Dani Tarrant

Allstate - Sanford

VISITOR REGISTRATION SHEET

INSURANCE SENATE

Name of Committee

4.27.11

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sally Estraneic	Westfield Insurance Westfield Center, OH.
James Andrews	NC State AFL-CIO
Stewart Johnson	NC DOT
Steve Woodson	NCFB
Dean Phunkett	PS
Ken Melton	K. M. A.
DAVID RICE	MANNING FULTON
M. K. Strickland	Young Moore & Henderson
BILL SCOBOW	TS S
MARTY BOGGS	HP
JOE THOMAS	GEICO

VISITOR REGISTRATION SHEET

NAME OF COMMITTEE

Insurance

DATE

4-27-77

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DeANNE MANGUM

NAME	FIRM OR AGENCY AND ADDRESS
Bo Heath	McGuire Wood
Tracey Harney	USAA
Cady Thomas	NCAR
Sherri Hubbard	N.C. DOI
Rose Williams	NC DOI
Bob Mack	NC DOI
ERNEST L. Nickerson	NC DOI
Bryan Heckle	NC DOI
Tom Fiquette	Allstate
Jennifer Cohen	IFNC
Sara Fender	IFNC

VISITOR REGISTRATION SHEET

name of committee

~~Rates Insurance~~ 4-27-11

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DeANNE MANGUM

[illegible]

VISITOR REGISTRATION SHEET

INSURANCE SENATE

Name of Committee

4-27-11

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
James McCall	Mooreville, NC 28115 McCall Insurance Agency, 961 N. Main St.
Micaela Isler	PCI
Skip Brazier	METLIFE
Nancy Crespo	State Auto Insurance Companies
DAMIEN JOSEFIAK	ERIE INSURANCE
STEVEN H. BLINSKY	INDEPENDENT AGENT / ERIE GRAD
Ray Farmer	American Insurance Association
DENNIS BURKE	REINSURANCE ASSN. OF AMERICA
Jeff Butler	Auto Agents of N.C.
Tim Lucas	NC Rate Bureau
Ant Lyon	Commerce Insurance

VISITOR REGISTRATION SHEET

Name of Committee INSURANCE

DATE 4-27-11--

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DeANNE MANGUM

[illegible]

VISITOR REGISTRATION SHEET

NAME OF COMMITTEE INSURANCE

DATE 4-27

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DEANNE MANGUM

NAME	FIRM OR AGENCY AND ADDRESS
Kurt Riehl	State Farm
Ryan Morgan	State Farm
Bill Tibbens	Farmers Group, Inc.
Doug Smith	State Farm
Erin Engle	State Farm
Liz Reynolds	NAMIC
Kim Conyers	State Farm
Janet Leath	State Farm
Matt Mitchell	GEICO
John Polinski	NCNA
Pat Lovelle	Penn National

VISITOR REGISTRATION SHEET

NAME OF COMMITTEE **INSURANCE**

DATE **4-27**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DeANNE MANGUM

NAME	FIRM OR AGENCY AND ADDRESS
	
Bill Wilson	AARP
Kerim McGee	Progressive
Doug Heaton	NM
Kathy Hartkopf	Freedom Works
Allen Page	Freedom Works
Fred Fuller	NCDOT
John Milette	Travelers Companies Inc.
Sherman McCoy	Nationwide
Kelley Estine	IIA/C
J Bode	IIA/C

SENATE INSURANCE COMMITTEE
Wednesday, May 4, 2011 at 10:00 AM
Room 1027, Legislative Building

MINUTES

The Senate Insurance Committee met at 10:09 AM on April 13, 2011, in Room 1027 of the Legislative Building. Fourteen members of the committee were present. Senator Apodaca and Meredith presided. Katie Brown of Fayetteville, Grant Murphy Herndan of Durham, and Elisabeth Stroman of Raleigh served as pages.

S.B. 6- State Health Plan/Refunds for No Coverage

Senator Apodaca recognized Senator Berger to explain the bill. Senate Bill 6 requires the State Health Plan to refund premiums paid by a Plan subscriber when the subscriber, or the subscriber's dependents, was not actually covered under the Plan due to ineligibility. Senator Atwater was recognized to ask a question. Senator Berger was recognized to answer. Senator Hise was recognized to ask a question. Senator Berger was again recognized to answer. Senator Meredith was recognized to ask a question and Senator Berger was recognized to answer. Senator Hise was recognized to ask a question. Mark Trogden of Fiscal Research was recognized to answer the question. Senator Davis was recognized to ask a question. Mark Trogden was recognized to answer. Lacy Barnes from the State Health Plan was recognized to speak regarding their opposition to the bill. Senator Berger was recognized to make a statement regarding his openness on the retroactivity. Senator McKissick was recognized to ask Senator Berger if he would be okay with an amendment stating the retroactivity was limited to 90 days. Senator Berger was recognized to give his approval. Senator McKissick moved to amend the bill on page 1, line 19 by rewriting the line to read: "Section 2. This act becomes effective April 1, 2011." Senator Meredith made a motion for favorable report as amended and rolled into a proposed committee substitute and referred to Appropriations. A copy of the summary, PCS, actuarial note and amendment is attached.

S.B. 517- Freedom to Negotiate Health Care Rates

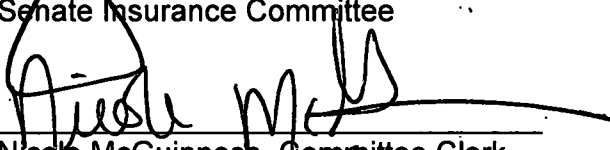
Senator Davis made a motion to consider the Post Committee Substitute and the motion passed. S.B. 517 would prohibit contract provisions that create specific rate negotiations between health benefit plans and health care provider. Chris Evans of Regulatory Affairs for BCBS was recognized to give testimony and explain why BCBS is opposed to S.B. 517. Senator McKissick was recognized to ask a question. Chris Evans was recognized to answer. Senator Doug Berger was recognized to ask a question. Jim Burns of Williams and Mullins representing BCBS was recognized to speak in opposition of the bill and answer the question. Chris Evans was recognized to continue to answer Senator Berger's question. Senator Atwater was recognized to ask a question. Jim Burns was recognized to answer. A copy of the summary and PCS is attached.

Senator Hise was recognized to make a motion that Senate Bills 477 and 490 from last week's meeting be moved to a subcommittee rather than a study committee. The motion passed.

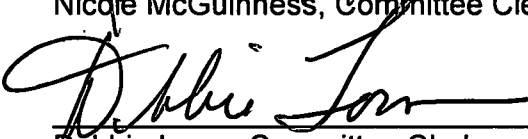
The meeting adjourned at 10:50 AM.



Senator Wesley Meredith, Presiding Chair
Senate Insurance Committee



Nicole McGuinness, Committee Clerk



Debbie Lown, Committee Clerk

Senate Insurance Committee
Wednesday, May 4, 2011, 10:00 AM
1027 LB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 6 State Health Plan/Refunds for No Coverage.

Senator Berger

SB 517 Freedom to Negotiate Health Care Rates.

Senator Apodaca

Presentations

Other Business

Adjournment

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

INSURANCE COMMITTEE REPORT

**Senator Tom Apodaca, Co-Chair
Senator Wesley Meredith, Co-Chair**

Thursday, May 05, 2011

Senator APODACA,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B.	6	State Health Plan/Refunds for No Coverage.
		Draft Number: 55297
		Sequential Referral: None
		Recommended Referral: None
		Long Title Amended: No

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 6
PROPOSED COMMITTEE SUBSTITUTE S6-PCS55297-RG-11

Short Title: State Health Plan/Refunds for No Coverage.

(Public)

Sponsors:

Referred to:

January 31, 2011

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE STATE HEALTH PLAN FOR TEACHERS AND STATE
EMPLOYEES TO REFUND PREMIUMS PAID WHEN THE PLAN DID NOT
ACTUALLY PROVIDE COVERAGE.

The General Assembly of North Carolina enacts:

SECTION 1. Part 3 of Article 3A of Chapter 135 of the General Statutes is
amended by adding a new section to read:

"§ 135-45.12A. Refund of premiums.

The Plan shall refund premiums to a subscriber who paid premiums during months in which
the subscriber or a dependent was not actually covered under the Plan due to ineligibility.
When refunding premiums, the Plan may deduct (i) the amount of ineligible claims paid by the
Plan during the period in which the subscriber or dependent was not actually covered under the
Plan and (ii) reasonable administrative costs directly related to a subscriber's failure to notify
the Plan of a coverage category change in a timely manner.

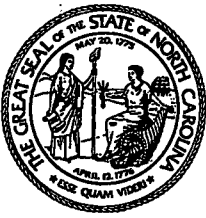
Regardless of the amount of a refund, a subscriber may still owe the Plan reimbursement
for claims paid during the period in which the subscriber or dependent was not covered under
the Plan.

The Plan is not required to refund premiums under this section in cases of fraud."

SECTION 2. This act becomes effective April 1, 2011.



* S 6 - P C S 5 5 2 9 7 - R G - 1 1 *



SENATE BILL 6: State Health Plan/Refunds for No Coverage

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Sen. D. Berger
Analysis of: First Edition

Date: May 3, 2011
Prepared by: Tim Hovis
Committee Counsel

SUMMARY: Senate Bill 6 requires the State Health Plan to refund premiums paid by a Plan subscriber when the subscriber, or the subscriber's dependents, was not actually covered under the Plan due to ineligibility.

When refunding the premiums, the Plan may deduct the following:

- The amount of ineligible claims paid by the Plan during the period of ineligibility
- Reasonable administrative costs directly related to the subscriber's failure to timely notify the Plan of a coverage category change rendering the subscriber or dependent ineligible.

A subscriber may still be required to reimburse the Plan for claims paid during the period of ineligibility.

In cases of fraud, the Plan is not required to refund premiums under this section.

EFFECTIVE DATE: Senate Bill 6 would be effective retroactively, July 1, 2008.

S6-SMRG-17(e1) v3

PUBLIC BILL

S.B. 6

SESSION LAW

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES TO REFUND PREMIUMS PAID WHEN THE PLAN DID NOT ACTUALLY PROVIDE COVERAGE.

Introduced by Senator(s)

~~Berger of Frankfurt~~

Principal Clerk's Use Only

FILED JAN 27 2011

PASSED 1st READING

JAN 31 2011

AND REFERRED TO COMMITTEE
ON Insurance

Actuarial Note Attached **MAR 21 2011**

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. 1st

H. B. No. _____

DATE 5/4/11

S. B. No. 6

Amendment No. _____

COMMITTEE SUBSTITUTE _____

(to be filled in by
Principal Clerk)

Rep.) McKissick
Sen.) _____

1 moves to amend the bill on page 1, line 19

2 () WHICH CHANGES THE TITLE

3 by rewriting the line to read:

4 "Section 2. This act becomes effective
5 April 1, 2011."

6 _____

7 _____

8 _____

9 _____

10 _____

11 _____

12 _____

13 _____

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15 _____

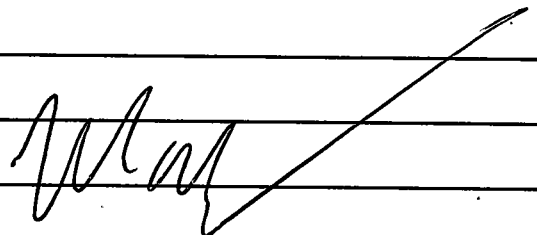
16 _____

17 _____

18 _____

19 _____

SIGNED



ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

1

SENATE BILL 517*

Short Title: Freedom to Negotiate Health Care Rates.

(Public)

Sponsors: Senators Apodaca; and Pate.

Referred to: Insurance.

April 6, 2011

A BILL TO BE ENTITLED
AN ACT TO ALLOW HEALTH PROVIDERS AND HEALTH INSURERS TO FREELY
NEGOTIATE REIMBURSEMENT RATES BY PROHIBITING CONTRACT
PROVISIONS THAT RESTRICT RATE NEGOTIATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. Part 7 of Article 50 of Chapter 58 of the General Statutes is amended
by adding a new section to read:

"§ 50-58-270. Prohibited contract provisions related to reimbursement rates.

No contract for the provision of health care services shall do any of the following:

- (1) Prohibit, or grant a health carrier an option to prohibit, a participating provider from contracting with another health carrier to provide health care services at a rate that is equal to or lower than the payment specified in the contract.
- (2) Require a participating provider to accept a lower payment rate in the event the participating provider agrees to provide health care services to any other health carrier at a rate that is equal to or lower than the payment specified in the contract.
- (3) Require, or grant a health carrier an option to require, termination or renegotiation of the existing health care contract in the event a participating provider agrees to provide health care services to any other health carrier at a rate that is equal to or lower than the payment specified in the contract.
- (4) Require, or grant a health carrier an option to require, a participating provider to disclose, directly or indirectly, the participating provider's contractual rates with another health carrier.
- (5) Require, or grant a health carrier an option to require, the nonnegotiated adjustment by the issuer of a participating provider's contractual rate to equal the lowest rate the provider has agreed to charge any other health carrier.
- (6) Require, or grant a health carrier an option to require, a participating provider to charge another health carrier a rate that is equal to or more than the reimbursement rate specified in the contract."

SECTION 2. This act becomes effective October 1, 2011.



* S 5 1 7 - V - 1 *

VISITOR REGISTRATION SHEET

INSURANCE

MAY 4, 2011

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bl Miller	MCHS
Joyce Peters	JP Assoc
Ken Lewis	First Carolina Care
Lacey Barnes	SHP
Caroline Smart	SHP
Mona Moon	SHP
James Burns	Williams Mullen
King Archer	BCBSNC
A Sherrill	NCMC
Margo Foreman	NCHAE
Amy White	NCMB
Marty Bocock	AHIP

VISITOR REGISTRATION SHEET

INSURANCE

MAY 4, 2011

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Harry Leph	MHC
Heather Barnett	Williams Muller
Jim Bone	Bone & Assoc.
Mark Fleming	BCSS NC
Chris Evers	BCSS NC
M. Foster	Phzer
Ted Hamby	NC DOT
Rose Williams	NC DOT
Joanne Stevens	NCNA / Stevens & Assoc.
Robert Paschal	Young Moore

VISITOR REGISTRATION SHEET

INSURANCE

MAY 4, 2011

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Christine Craig

Wakefield

Tom Fetzer
Quarica

Fetzer Strategic Partners
" "

Kristen Laster

FSP

David Barnes

PS

Andrew S. Lee

A. Lee & Associates

Maria Wilkey

Norant

Lisa N. Nutter

NC Home Builders

John McAlist

NC Chamber

Juni Haynes

NCHBA

Angie Zilk

30 PR

VISITOR REGISTRATION SHEET

INSURANCE

MAY 4, 2011

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
J Goodman	N/C CHAMBER
P Howard	MCIC
MIKE WATSON	NCRPA
Katherine Ross	PPAB
Dr. C. Carlton	alter
Toy Nichols	CT
Kathryn Hall	BLBSNC
John Polanski	NCAA
Gutierrez	NMRS

SENATE INSURANCE COMMITTEE
Wednesday, May 18th, 2011 at 10:00 AM
Room 1027, Legislative Building

MINUTES

The Senate Insurance Committee met at 10:01 AM on May 18th, 2011, in Room 1027 of the Legislative Building. Seventeen members of the committee were present. Senators Apodaca and Meredith presided. Walters Odom from Salemburg, Tyler Hinnant from Whiteville, and Amber Pritchard from Belmont served as pages.

H.B. 578 State Health Plan/Additional Changes

Senator Hise recognized Senator Apodaca to make a motion to consider the Proposed Committee Substitute and the motion passed. The PCS of HB 578 allows the State Health Plan to do the following related to the State Health plan: provides the Basic Rate premium-free fiscal year 2011-2012 using available cash balance reserves and offer a premium-free plan option in 2012-2013 using operational savings; delays implementation of certain Plan changes from July 1 to September 1; Makes statutory changes to comply with the Federal Affordable Care Act; Clarifies the State Health Plan's subrogation rights; Grants the State Treasurer immediate access to confidential State Health Plan documents to plan for upcoming transfer; Clarifies the Board of Trustees composition and staffers initial appointments. Senator Apodaca is recognized to announce all involved parties are in agreement on this PCS. Ryan Blackledge, NCGA Staff, is recognized to explain PCS and give the high points. Senator D. Berger was recognized to ask a question. Ryan Blackledge was recognized to answer his question. Senator McKissick was recognized to ask a question. Senator Garrou was recognized to ask a question. Discussion was suspended to discuss SB 517 while clarifying some questions raised by members. When discussion on 578 resumed, Senator Rucho was recognized to move unfavorable as to original bill but favorable as to the Proposed Committee Substitute.

A copy of the summary, PCS, actuarial note, and letter from Dr. Jack Walker is attached.

S.B. 517- Freedom to Negotiate Health Care Rates

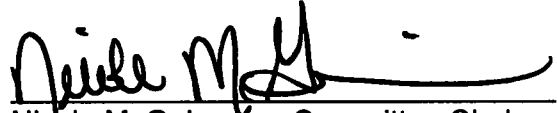
Senator Apodaca recognized that the motion to consider the PCS has already adopted and explained that members would hear more information about the bill. Ken Lewis, First Carolina Care, was recognized to address questions from committee members. Jeff James, CEO of Wilmington Health, was recognized to discuss the MFN Clause. Senator Atwater was recognized to ask a question. Senator D. Berger was recognized to ask a question. Senator Newton was recognized to ask a question. Chris Evans, BCBS, was recognized to speak on BCBS opposition. Discussion was suspended for 517 until the next meeting. A summary, PCS, and letter from Insurance Commissioner Wayne Goodman is attached.

The meeting adjourned at 10:50 AM.

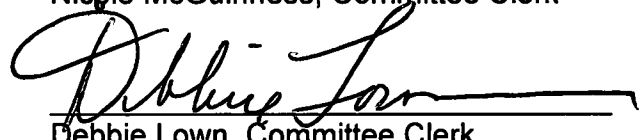


Senator Wesley Meredith, Presiding Chair

Senate Insurance Committee

A handwritten signature in black ink, appearing to read "Nicole McGuinness", written over a horizontal line.

Nicole McGuinness, Committee Clerk

A handwritten signature in black ink, appearing to read "Debbie Lown", written over a horizontal line.

Debbie Lown, Committee Clerk

Senate Insurance Committee
Wednesday, May 18, 2011, 10:00 AM
1027 LB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 517	Freedom to Negotiate Health Care Rates.
HB 578	Health Care Sharing Organizations.

Senator Apodaca
Representative Barnhart
Representative Dockham
Representative Murry

Presentations

Other Business

Adjournment

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

**INSURANCE COMMITTEE REPORT
Senator Tom Apodaca, Co-Chair
Senator Wesley Meredith, Co-Chair**

Wednesday, May 18, 2011

Senator APODACA,
submits the following with recommendations as to passage:

**UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO
SENATE COMMITTEE SUBSTITUTE BILL**

H.B.(CS #1) 578	Health Care Sharing Organizations.	
	Draft Number:	50340
	Sequential Referral:	None
	Recommended Referral:	None
	Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

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SENATE BILL 517*
PROPOSED COMMITTEE SUBSTITUTE S517-CSTK-6 [v.1]

4/12/2011 3:13:11 PM

Short Title: Freedom to Negotiate Health Care Rates.

(Public)

Sponsors:

Referred to:

April 6, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO ALLOW HEALTH PROVIDERS AND HEALTH INSURERS TO FREELY
3 NEGOTIATE REIMBURSEMENT RATES BY PROHIBITING CONTRACT
4 PROVISIONS THAT RESTRICT RATE NEGOTIATIONS.

5 The General Assembly of North Carolina enacts:

6 SECTION 1. Part 7 of Article 50 of Chapter 58 of the General Statutes is amended
7 by adding a new section to read:

8 "**§ 58-50-290. Prohibited contract provisions related to reimbursement rates.**

9 **No contract for the provision of health care services shall do any of the following:**

- 10 (1) Prohibit, or grant a health carrier an option to prohibit, a participating
11 provider from contracting with another health carrier to provide health care
12 services at a rate that is equal to or lower than the payment specified in the
13 contract.
- 14 (2) Require a participating provider to accept a lower payment rate in the event
15 the participating provider agrees to provide health care services to any other
16 health carrier at a rate that is equal to or lower than the payment specified in
17 the contract.
- 18 (3) Require, or grant a health carrier an option to require, termination or
19 renegotiation of the existing health care contract in the event a participating
20 provider agrees to provide health care services to any other health carrier at a
21 rate that is equal to or lower than the payment specified in the contract.
- 22 (4) Require, or grant a health carrier an option to require, a participating
23 provider to disclose, directly or indirectly, the participating provider's -
24 contractual rates with another health carrier.
- 25 (5) Require, or grant a health carrier an option to require, the nonnegotiated
26 adjustment by the issuer of a participating provider's contractual rate to equal
27 the lowest rate the provider has agreed to charge any other health carrier.
- 28 (6) Require, or grant a health carrier an option to require, a participating
29 provider to charge another health carrier a rate that is equal to or more than
30 the reimbursement rate specified in the contract."

31 SECTION 2. This act becomes effective October 1, 2011.



* S 5 1 7 - C S T K - 6 - V - 1 *



SENATE BILL 517: Freedom to Negotiate Health Care Rates

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Sen. Apodaca
Analysis of: PCS to First Edition
S517-CSTK-6

Date: April 12, 2011
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *The PCS to Senate Bill 517 would prohibit contract provisions that create specified rate negotiations between health benefit plans and health care provider.*

CURRENT LAW: G.S. 58-50-270 provides the following definitions that are applicable to this bill:

- Contract – an agreement between an insurer and a health care provider for the provision of health care services by the provider on a preferred or in-network basis.
- Health care Provider – an individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes and is owned or operated by the State in which health care services are provided to patients.

BILL ANALYSIS: The only change to the PCS is technical. The placement of the new statute is now the more appropriate location of G.S. 58-50-290.

Senate Bill 517 adds a new section to Part 7 of Article 50 of Chapter 58 of the General Statutes regarding contracts between health benefit plans and health care providers. The bill states that no contract for the provision of health care services can do any of the following:

- Prohibit a participating provider from contracting with another health carrier to provide services at a rate equal to or lower than the payment specified in the contract.
- Require a participating provider to accept a lower payment rate in the event that the provider agrees to provide services to any other carrier at a rate equal to or lower than that specified in the contract.
- Require termination or renegotiation of the contract if the provider agrees to provide services to any other carrier at a rate equal to or lower than that specified in the contract.
- Require the disclosure of a participating provider's contractual rates with another carrier.
- Require the non-negotiated adjustment by the issuer of a participating provider's contractual rate to equal the lowest rate the provider has agreed to charge another carrier.
- Require a participating provider to charge another carrier a rate that is equal to or greater than the rates specified in the contract.

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

S517-SMTK-16(CSTK-6) v3

May 4, 2011

The Honorable Tom Apodaca
North Carolina Senator
16 W. Jones Street
2010 State Legislative Building
Raleigh, NC 27601-1096

Re: SB 517 Freedom to Negotiate Health Care Rates

Dear Senator Apodaca,

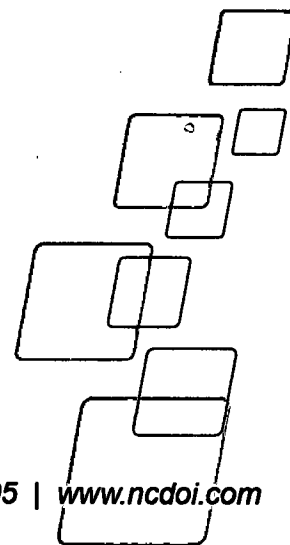
I applaud your efforts in bringing Senate Bill 517. Over a period of years predating the current administration, the Department has had concerns about the activity referenced in the bill. "Most Favored Nation" clauses can be a benefit to the consumer and help lower rates, but when one insurance company has such a large market share, it appears that such clauses can negatively impact network expansion by inhibiting providers from contracting with other carriers with a smaller market share.

Because of the Department's concerns shared on this subject in the past, I support Senate Bill 517. I cannot be at the committee hearing this morning, but my Legislative Counsel and the Deputy Commissioner of the Life and Health Division of the Department will attend. Low rates and a competitive health insurance market comprised of solvent carriers are twin goals of mine, and no doubt of yours, too.

Yours very truly,



Wayne Goodwin
NC Commissioner of Insurance



GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H

2

HOUSE BILL 578*
Committee Substitute Favorable 4/27/11

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."



1

SECTION 2. This act becomes effective October 1, 2011.



HOUSE BILL 578: State Health Plan/ Additional Changes

2011-2012 General Assembly

Committee:	Senate Insurance	Date:	May 16, 2011
Introduced by:	Reps. Murry, Dockham, Barnhart	Prepared by:	Ryan Blackledge
Analysis of:	H578-PCS50340-ME-16		Staff Attorney

SUMMARY: *The proposed committee substitute for H587 does the following related to the State Health Plan for Teachers and State Employees:*

- (1) Allows the State Health Plan to provide the Basic Plan premium-free in fiscal year 2011-2012, using available cash balance reserves and offer a premium-free plan option in 2012-2013 using operational savings.*
- (2) Delays implementation of certain Plan changes from July 1 to September 1.*
- (3) Makes statutory changes to comply with the Federal Affordable Care Act.*
- (4) Clarifies the State Health Plan's subrogation rights.*
- (5) Grants the State Treasurer immediate access to confidential State Health Plan documents to plan for the upcoming transfer.*
- (6) Clarifies the Board of Trustees composition and staggers initial appointments.*

[As introduced, this bill was identical to S608, as introduced by Sen. Hunt, which is currently in House Insurance.]

BILL ANALYSIS:

Section 1(a) of the bill states that the State Health Plan may offer the Basic Plan to employees for no premium if the State Health Plan has enough available cash balance reserves to do so. This would be for the period starting September 1, 2011, through June 30, 2012. This differs from Senate Bill 323 of the 2011 Regular Session, as ratified (SB 323), which would require a non-Medicare eligible employee to pay \$10.81 per month for the Basic Plan. **Section 1(b)** directs the State Health Plan to find savings in the Plan's operation and states that the Plan may use those savings to offer a free option to employees during fiscal year 2011-2013.

Section 2 provides for the delayed implementation of the benefit changes required by SB 323, making the changes effective September 1 instead of July 1. Because of the delay in enacting SB 323, the State Health Plan does not have adequate time to enroll members for July 1 based on the changes in SB 323. **Section 2(a)**, then, would change the default effective date for Part I of SB 323 from July 1 to September 1. The following sections of SB 323, however, remain effective July 1, 2011:

Section 1.1	Appropriations from General Fund and Highway Fund
Section 1.7	Allow coverage for children up to 26 years old, in compliance with Federal Patient Protection and Affordable Care Act
Section 1.8	Salary-related contributions by the State to the Plan
Section 1.10(c)	Definition clarification of term "Health Benefits Representative"

Sections 2(b) and 2(c) change the statutory date after which the Executive Administrator and Board of Trustees shall not change the Plan from July 1, 2009, to September 1, 2011. Section 1.4 of SB 323 changed this date to July 1, 2011, so Section 1.4 is repealed in this bill. **Section 2(d)** makes a change to

House Bill 578

Page 2

the effective date of a small statutory change in Section 1.7(c) of SB 323 and fixes a few typos in SB 323. **Section 2(e)** provides how deductible and coinsurance maximums will be handled during the periods of July and August of 2011 and the rest of the year.

Section 3 makes changes, effective July 1, 2011, to comply with the Federal Patient Protection and Affordable Care Act (PPACA) and the rules related to the coverage of those under 19 and under 26. PPACA forbids the discrimination among types of children (e.g., foster, natural, adopted, step) based on age, so **Section 3(a)** clarifies that all children are eligible up to the first month following their 26th birthday. **Section 3(b)** makes a change to comply with PPACA's requirement that, for grandfathered plans, children under 26 may be excluded from coverage only if the child has a *non-parental* coverage option. Thus, a child under 26 could be eligible for a plan under both parents, but could choose to enroll the State Health Plan. **Sections 3(c) and 3(d)** deal with the issue of enrolling of State employees younger than 19, who cannot be subject to enrollment timing restrictions and pre-existing condition waiting periods under PPACA. **Section 3(e)** provides an effective date of July 1, 2011, consistent with the date of the changes made in SB 323 related to coverage of dependents up to 26.

Section 4 clarifies that the State Health Plan, and not just its Claims Processor, may exercise subrogation rights to recover overpayments.

Section 5 grants the Department of State Treasurer immediate access to confidential records of the State Health Plan in order to plan for the impending transfer of the State Health Plan to the Department of State Treasurer. SB 323 provides for this as part of the statutory rewrite of the State Health Plan statutes, but that means that the Treasurer would not have access to confidential information until January 1, 2012, when the transfer takes place. The Department of the State Treasurer would assume the same level of responsibility for maintaining the information imposed on the Executive Administrator and Board of Trustees of the State Health Plan.

Section 6 makes changes related to the Board of Trustees. **Section 6(a)** clarifies that each appointing authority must consult with the other appointing authorities prior to making its own appointments. This is designed to ensure a good mix of employees, teachers, and retirees, as well as of experts. **Section 6(b)** repeals the carryover of the current Board of Trustees until the end of June 2012 in favor of appointments effective January 1, 2012. **Section 6(c)** provides for staggered terms by providing for first terms of 2.5 and 3.5 years, with the employees, teachers, and retirees group serving first terms of 2.5 years.

EFFECTIVE DATE: As provided in **Section 7**, this act is effective when it becomes law, except as otherwise provided. Also, no section of this act becomes law unless SB 323 becomes law.

BACKGROUND: The State Health Plan for Teachers and State Employees 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.

PUBLIC BILL

Proposed Committee Substitute For
H.B. 578

SESSION LAW _____

ID = SB608

A BILL TO BE ENTITLED

AN ACT TO EXEMPT HEALTH CARE SHARING ORGANIZATIONS FROM THE HEALTH INSURANCE
REGULATORY LAWS.

Introduced by Representative(s): Murry, Duckham, and Barnhart (Primary Sponsors)

For a complete list of cosponsors for this bill, please see the report inside the bill jacket.

Principal Clerk's Use Only

The Comm. Hec on Insurance,
a majority being present, having considered
this bill, recommend that it do pass.

Rep. Duckham
For the Committee.

FAVORABLE TO COMM. SUB
UNFAVORABLE TO BILL

APR 27 2011

AND PLACED ON
CALENDAR FOR

366

4-28-11

Passed 2nd & 3rd Reading
113-00 VU
APR 28 2011
ORDERED SENT TO SENATE

Linn Weeks

RECEIVED

APR 29 2011

From House of Representatives
By Clerk, SP9.42 AM/PM

PASSED 1st READING

MAY 02 2011

AND REFERRED TO COMMITTEE
ON: Insurance

Recall Note Attached MAY 6 2011

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

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D

**HOUSE BILL 578*
Committee Substitute Favorable 4/28/11
PROPOSED SENATE COMMITTEE SUBSTITUTE H578-PCS50340-ME-16**

Short Title: State Health Plan/Additional Changes. (Public)

Sponsors:

Referred to:

April 4, 2011

A BILL TO BE ENTITLED

AN ACT (1) TO ALLOW THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES TO PROVIDE THE BASIC PLAN PREMIUM-FREE USING AVAILABLE CASH BALANCE RESERVES, (2) TO DELAY IMPLEMENTATION OF CERTAIN CHANGES TO THE STATE HEALTH PLAN UNTIL SEPTEMBER 2011, (3) TO COMPLY WITH THE FEDERAL AFFORDABLE CARE ACT, (4) TO CLARIFY THE STATE HEALTH PLAN'S SUBROGATION RIGHTS, (5) TO GRANT THE STATE TREASURER IMMEDIATE ACCESS TO CONFIDENTIAL STATE HEALTH PLAN DOCUMENTS TO PLAN FOR THE TRANSFER, AND (6) TO CLARIFY THE BOARD COMPOSITION AND STAGGER INITIAL APPOINTMENTS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Notwithstanding Section 1.2(a) of Senate Bill 323 of the 2011 Regular Session, if the State Health Plan for Teachers and State Employees has sufficient available cash balance reserves to do so, the State Health Plan may offer the Basic Plan premium-free to employees during fiscal year 2011-2012.

SECTION 1.(b) Notwithstanding Section 1.2(a) of Senate Bill 323 of the 2011 Regular Session, the State Health Plan for Teachers and State Employees is directed to find savings through wellness programs, Medicare Advantage plans, alternative plan designs, or other resources and, if those found savings and any available cash balance reserves allow the State Health Plan to do so, the State Health Plan may offer a premium-free plan option to employees during fiscal year 2012-2013.

SECTION 2. Delayed implementation of certain changes. – (a) Section 1.11 of Senate Bill 323 of the 2011 Regular Session reads as rewritten:

"**SECTION 1.11.** Except as otherwise provided, Part I of this act becomes effective ~~July 1, 2011~~, September 1, 2011. Sections 1.1, 1.7, 1.8, and 1.10(c) become effective July 1, 2011."

SECTION 2.(b) Section 1.4 of Senate Bill 323 is repealed.

SECTION 2.(c) Effective September 1, 2011, 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~~, September 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."



1 **SECTION 2.(d)** When revising the General Statutes as directed by Senate Bill 323
2 of the 2011 Regular Session, the Revisor of Statutes shall make the following changes to what
3 appears in Senate Bill 323:

- 4 (1) In Section 1.7(c), notwithstanding Section 1.11, as amended by this act, the
5 deletion of the word "noncontributory" and replacement with the words
6 "partially contributory" in G.S. 135-45.3(a) shall be made effective
7 September 1, 2011, rather than July 1, 2011. The remainder of the changes
8 in Section 1.7(c) shall remain effective July 1, 2011, as provided in Section
9 1.11 of Senate Bill 323 of the 2011 Regular Session, as amended by Section
10 2(a) of this act.
- 11 (2) In Section 2.10, within the changes to G.S. 135-48.43 the designation of a
12 second subsection "(d)" shall instead be "(e)" and the following subsection's
13 designation as "(e)" shall instead be "(f)".
- 14 (3) In Section 2.10, the reservation of "§ 135.48.36" shall instead be a
15 reservation of "§ 135-48.36".

16 **SECTION 2.(e)** Credits toward deductibles and coinsurance maximums that Plan
17 members earn for services incurred during the months of July and August of 2011 shall be
18 carried forward and applied toward meeting the new deductibles and coinsurance maximums
19 for the period beginning September 1, 2011. If a Plan member fully meets his or her deductible
20 or coinsurance maximum during the months of July and August of 2011, then that Plan member
21 shall receive credit for the amount of the deductible or coinsurance maximum that the Plan
22 member met during that time, but shall then be subject to meeting any additional amounts
23 required by the new deductible and coinsurance maximums effective September 1, 2011.

24 **SECTION 3.** Affordable Care Act compliance. – (a) G.S. 135-45.1(10), as
25 amended by Section 1.7(a) of Senate Bill 323 of the 2011 Regular Session, reads as rewritten:

26 "(10) Dependent child. – Subject to the eligibility requirements of
27 G.S. 135-45.2(d), any of the ~~following~~ following up to the first month
28 following the dependent child's 26th birthday:

- 29 a. A natural or legally adopted child or children of the ~~employee up to~~
30 ~~the first of the month following the child's 26th birthday~~, employee,
31 whether or not the child is living with the employee.
- 32 b. A foster child or children of the ~~employee up to the first month~~
33 ~~following the child's 19th birthday~~, employee, whether or not the
34 child is living with the employee, as long as the employee is legally
35 responsible for the child's maintenance and support.
- 36 c. A child for which an employee is a court-appointed guardian, as long
37 as the employee is legally responsible for the child's maintenance and
38 support.
- 39 d. A stepchild ~~who primarily resides with~~ of a member who is married
40 to the stepchild's natural parent.
- 41 e. ~~Any child under age 19 who has reached his or her 18th birthday,~~
42 ~~provided the employee was legally responsible for the child's~~
43 ~~maintenance and support on his or her 18th birthday.~~

44 Dependent children of firefighters, rescue squad workers, and members of
45 the National Guard are subject to the same terms and conditions as are other
46 dependent children covered by this subdivision."

47 **SECTION 3.(b)** G.S. 135-45.2(d), as amended by Section 1.7(b) of Senate Bill 323
48 of the 2011 Regular Session, reads as rewritten:

49 "(d) A foster child is covered as a dependent child (i) if living in a regular parent-child
50 relationship with the expectation that the employee will continue to rear the child into
51 adulthood, (ii) if at the time of enrollment, or at the time a foster child relationship is

1 established, whichever occurs first, the employee applies for coverage for such child and
2 submits evidence of a bona fide foster child relationship, identifying the foster child by name
3 and setting forth all relevant aspects of the relationship, (iii) if the claims processor accepts the
4 foster child as a participant through a separate written document identifying the foster child by
5 name and specifically recognizing the foster child relationship, and (iv) if at the time a claim is
6 incurred, the foster child relationship, as identified by the employee, continues to exist.
7 Children placed in a home by a welfare agency which obtains control of, and provides for
8 maintenance of the child, are not eligible participants.

9 A dependent child shall not be eligible for coverage under the Plan if the dependent child is
10 eligible for employer based health care outside of the State Health Plan for Teachers and State
11 ~~Employees. Employees, other than a parent's plan.~~ Coverage of a dependent child may be
12 extended beyond the 26th birthday if the dependent is physically or mentally incapacitated to
13 the extent that he or she is incapable of earning a living and (i) such handicap developed or
14 began to develop before the dependent's 19th birthday, or (ii) such handicap developed or
15 began to develop before the dependent's 26th birthday if the dependent was covered by the Plan
16 in accordance with G.S. 135-45.2(c)(7)."

17 **SECTION 3.(c)** G.S. 135-45.3, as amended by Section 1.7(c) of Senate Bill 323 of
18 the 2011 Regular Session, as modified by Section 2(d)(1) of this act, reads as rewritten:

19 **"§ 135-45.3. Enrollment.**

20 (a) Except as otherwise required by applicable federal law, new employees must be
21 given the opportunity to enroll or decline enrollment for themselves and their dependents
22 within 30 days from the date of employment or from first becoming eligible on a
23 noncontributory basis. Coverage may become effective on the first day of the month following
24 date of entry on payroll or on the first day of the following month. New employees age 19 and
25 older not enrolling themselves and their dependents age 19 and older within 30 days, or not
26 adding dependents when first eligible as provided herein may enroll on the first day of any
27 month but will be subject to a 12-month waiting period for preexisting health conditions,
28 except for employees who elect to change their coverage in accordance with rules established
29 by the Executive Administrator and Board of Trustees for optional or alternative plans
30 available under the Plan. Children born to covered employees having coverage type (2) or (3),
31 as outlined in G.S. 135-45.4(d) shall be automatically covered at the time of birth without any
32 waiting period for preexisting health conditions. Children born to covered employees having
33 coverage type (1) shall be automatically covered at birth without any waiting period for
34 preexisting health conditions so long as the claims processor receives notification within 30
35 days of the date of birth that the employee desires to change from coverage (1) to coverage type
36 (2) or (3), provided that the employee pays any additional premium required by the coverage
37 type selected retroactive to the first day of the month in which the child was born.

38 ...
39 (c) Eligible employees younger than age 19 and dependents younger than age 19 may
40 be enrolled at any time and shall not be subject to any waiting period for a preexisting
41 condition.

42"

43 **SECTION 3.(d)** G.S. 135-45.4, as amended by Section 1.7(d) of Senate Bill 323 of
44 the 2011 Regular Session, reads as rewritten:

45 **"§ 135-45.4. Effective dates of coverage.**

46 (a) Employees and Retired Employees. –

47 ...

48 (3) Employees age 19 and older not enrolling or adding dependents age 19 and
49 older when first eligible in accordance with G.S. 135-45.3 may enroll later
50 on the first of any following month but will be subject to a 12-month waiting
51 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. –

(2) Employees age 19 and older 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.

(5) To administer the 12-month waiting period for preexisting conditions for employees age 19 and older 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.

...."

SECTION 3.(e) This section becomes effective July 1, 2011.

SECTION 4. Subrogation by Plan. – G.S. 135-45.14(g) reads as rewritten:

"(g) Right of Recovery. – Whenever payments have been made by the Plan or its Claims Processor with respect to covered services in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, the Plan or its Claims Processor shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Plan or its Claims Processor shall determine: any persons to or for or with respect to whom such payments were made, any insurance companies, or any other organizations."

SECTION 5. Treasurer's access to records. – Notwithstanding G.S. 135-43, the Department of the State Treasurer shall have immediate access to all records, including confidential records, of the State Health Plan for Teachers and State Employees in order to plan for the January 1, 2012, transfer of the State Health Plan to the Department of State Treasurer. The Department of the State Treasurer shall assume the same level of responsibility for maintaining the confidentiality of the records as the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees.

SECTION 6. Governance adjustments. – (a) Effective January 1, 2012, G.S. 135-48.20, as enacted by and amended by Senate Bill 323 of the 2011 Regular Session, reads as rewritten:

"§ 135-48.20. Board of Trustees established.

(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 (1) An employee of a State department, agency, or institution;
- 2 (2) A teacher employed by a North Carolina public school system;
- 3 (3) A retired employee of a State department, agency, or institution; or
- 4 (4) A retired teacher from a North Carolina public school system.

5 ~~Each~~ In making appointments to the Board under this section, each appointing authority
6 shall consult with all other appointing authorities prior to making its own appointments to
7 ensure that the ~~Board's composition reflects a diversity of employees, teachers, retired~~
8 ~~employees, and retired teachers.~~ Board includes members of each of the groups listed in
9 subdivisions (1) through (4) of this subsection.

10 (j) In making appointments, ~~except for the appointees under subsection (i) of this~~
11 ~~section,~~ the appointing authorities shall appoint individuals from the following areas of
12 expertise:

- 13 (1) Actuarial science.
- 14 (2) Health economics.
- 15 (3) Health benefits and administration.
- 16 (4) Health law and policy.

17 In making appointments to the Board under this section, each appointing authority shall
18 consult with all other appointing authorities prior to making its own appointments to ensure that
19 each of the areas of expertise ~~required by~~ listed in subdivisions (1) through (4) of this
20 subsection is represented by at least one member of the Board. ~~Each appointing authority shall~~
21 ~~consider the expertise of the other members of the Board and make appointments so that the~~
22 ~~Board's composition reflects a diversity of expertise.~~

23"

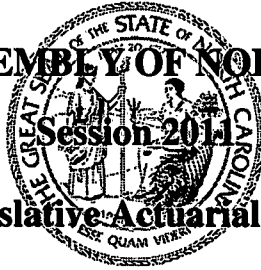
24 **SECTION 6.(b)** Section 2.13(b) of Senate Bill 323 of the 2011 Regular Session is
25 repealed.

26 **SECTION 6.(c)** Notwithstanding the two-year term limitation in
27 G.S. 135-48.20(m), as enacted by Senate Bill 323 of the 2011 Regular Session, the terms of
28 appointees under G.S. 135-48.20 shall be as follows and shall begin January 1, 2012:

- 29 (1) Two and one-half years. – Appointees under G.S. 135-48.20(i).
- 30 (2) Three and one-half years. – Appointees not under G.S. 135-48.20(i).

31 **SECTION 7.** Except as otherwise provided, this act is effective when it becomes
32 law. No section of this act, however, becomes effective unless Senate Bill 323 of the 2011
33 Regular Session becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA



Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: Proposed Committee Substitute to House Bill 578 [H578-CSME-16]

SHORT TITLE: State Health Plan/Additional Changes

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 Proposed Committee Substitute to House Bill 578, entitled "State Health Plan/Additional Changes," amends Senate Bill 323 (Ratified), entitled "State Health Plan/Appropriations & Transfer II," to make various technical, clarifying and substantive changes to the Plan. The sections described below relate to those provisions that are expected to have a financial impact on the Plan:

Section 1(a): Allows the Plan to offer a non-contributory option to employees in the Basic 70/30 plan during FY 2011-12 provided the Plan has sufficient cash balance reserves to do so;

Section 1(b): Allows the Plan to offer a non-contributory option to employees during FY 2012-13 if it can be funded through savings accrued through wellness programs, Medicare Advantage plans, alternative plan designs, cash balances or other resources; and

Section 2: Changes the effective date to September 1, 2011 for the application of higher out-of-pocket amounts, the repeal of the Comprehensive Wellness Initiative, the authorization to charge employees or retirees a premium for their own coverage, and authorization to charge increased premium contribution rates for dependent coverage.

The sections from the Proposed Committee Substitute described above provide for realistic implementation dates for the changes enacted in SB 323 (Ratified). Due to prevailing federal law requirements and operational time periods required for enrollment of plan members under new premium contribution and out-of-pocket requirements schedules, implementation of certain changes in SB 323 were not possible by the original July 1, 2011 effective date.

EFFECTIVE DATE: When it becomes law provided Senate Bill 323 (Ratified) becomes law; otherwise the bill does not become law.

ESTIMATED IMPACT ON STATE:

2011-13 Biennium

Increased Premium Contributions

Appropriated Funds

Sections 1.1(a), (b), and (c) of SB 323 (Ratified) 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 5.3 % premium increase in total premium rates for the fiscal year beginning July 1, 2011, and an additional annual premium increase of 5.3% for the fiscal year beginning July 1, 2012. The Proposed Committee Substitute for HB 578 did not change the effective date for increased employer contributions. 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	\$7,119,541	\$102,151,104	\$109,270,645
Highway Fund	\$332,245	\$4,767,052	\$5,099,297
Other Funds	\$1,468,770	\$21,073,896	\$22,542,666
Total	\$8,920,556	\$127,992,052	\$136,912,608

Employee Funds

Section 1.2(a) of SB 323 (Ratified) 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	
	<u>Basic 70/30</u>	<u>Standard 80/20</u>	<u>Basic 70/30</u>	<u>Standard 80/20</u>
Employee Contribution				
Non-Medicare Eligible				
Medicare Secondary	\$10.81	\$21.63	\$11.38	\$22.77
Medicare Primary	\$5.00	\$10.00	\$5.27	\$10.53
Retiree Contribution				
Non-Medicare Eligible	\$0.00	\$21.63	\$0.00	\$22.77
Medicare Eligible	\$0.00	\$10.00	\$0.00	\$10.53

However, Section 1(a) and 1(b) of the Proposed Committee Substitute for HB 578 provides the Plan with authorization to reduce to zero the monthly premium contribution rates for employee coverage in FY 2011-12 and FY 2012-13 provided certain conditions are met. The amounts below assume that the Plan will offer the Basic 70/30 plan with no premium contribution in either year.

Section 1.2(b) of SB 323 (Ratified) authorizes an annual 5.3% premium increase in contributory premium rates for dependent coverage for the fiscal year beginning July 1, 2011, and an additional annual premium increase of 5.3% for the fiscal year beginning July 1, 2012. Section 2 of the Proposed Committee Substitute for HB 578 delays the effective date of the premium contribution rate increase to September 1, 2011 for FY 2011-12. For purposes of estimating additional premium contributions collected by the Plan in FY 2011-12, the estimated amounts below are assumed to be collected over a delayed 10-month period rather than a full 12-month plan year:

Additional Member Contributions			
Coverage Category	FY 2011-12	FY 2012-13	Biennium
Contributions for Employee Coverage	\$57,405,761	\$71,818,378	\$129,224,139
Contributions for Retiree Coverage	\$17,858,739	\$22,788,680	\$40,647,419
Contributions for Dependent Coverage	\$13,066,442	\$41,685,531	\$54,751,973
Total	\$88,330,942	\$136,292,589	\$224,623,531

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 Additional Premium Contributions From Appropriated and Employee/Retiree Paid Funds			
Fund Source	FY 2011-12	FY 2012-13	Biennium
<u>Appropriated</u>			
General Fund	\$7,119,541	\$102,151,104	\$109,270,645
Highway Fund	\$332,245	\$4,767,052	\$5,099,297
Other Funds	\$1,468,770	\$21,073,896	\$22,542,666
Sub-total	\$8,920,556	\$127,992,052	\$136,912,608
<u>Member Contributions</u>			
Contributions for Employee Coverage	\$57,405,761	\$71,818,378	\$129,224,139
Contributions for Retiree Coverage	\$17,858,739	\$22,788,680	\$40,647,419
Contributions for Dependent Coverage	\$13,066,442	\$41,685,531	\$54,751,973
Sub-total	\$88,330,942	\$136,292,589	\$224,623,531
Total	\$97,251,498	\$264,284,641	\$361,536,139

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 Senate Bill 323 (Ratified) 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. Section 2 of the Proposed Committee Substitute for HB 578 delays the effective date of the increased out-of-pocket amounts to September 1, 2011. Therefore, the financial savings to be generated by increasing current out-of-pocket limits are assumed over a delayed 10-month period for FY 2011-12 instead of a full 12-month plan year.

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	\$12	\$10	\$12
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	\$36,381,527	\$48,670,257	\$85,051,784
Pharmacy Benefits	\$19,923,309	\$27,574,933	\$47,498,242
Total	\$56,304,836	\$76,245,190	\$132,550,026

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	\$38,782,051	\$52,400,552	\$91,182,603
Pharmacy Benefits	\$18,144,189	\$22,277,574	\$40,421,763
Total	\$56,926,240	\$74,678,126	\$131,604,366

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)						
Category	Aon Consulting (Plan)			Hartman & Assoc. (General Assembly)		
	FY 2011-12	FY 2012-13	Biennium	FY 2011-12	FY 2012-13	Biennium
Medical Benefits						
Primary Care Co-pay (Increase)	\$5,541,767	\$7,454,181	\$12,995,948	\$5,687,460	\$8,009,992	\$13,697,452
Mid-tier Specialty Co-pay (Increase)	\$2,391,270	\$3,216,476	\$5,607,746	\$2,378,186	\$3,349,342	\$5,727,528
Specialist Co-pay (Increase)	\$6,586,243	\$8,859,097	\$15,445,340	\$6,514,216	\$9,375,444	\$15,889,660
Urgent Care Co-pay (Increase)	\$377,288	\$507,488	\$884,776	\$396,881	\$563,851	\$960,732
Inpatient Co-pay (Increase)	\$1,101,651	\$1,481,822	\$2,583,473	\$1,174,733	\$1,654,448	\$2,829,181
Emergency Room Co-pay (Increase)	\$1,835,861	\$2,469,400	\$4,305,261	\$1,878,231	\$2,645,226	\$2,726,939
Deductible and Coinsurance Max (Increase)	\$18,547,447	\$24,681,793	\$43,229,240	\$20,752,344	\$26,802,249	\$47,554,593
Sub-total	\$36,381,527	\$48,670,257	\$85,051,784	\$38,782,051	\$52,400,552	\$91,182,603
Outpatient Prescription Drugs (acute drugs)						
Generic Drug Co-pay (Increase)	\$5,504,247	\$7,576,117	\$13,080,364	\$5,885,447	\$7,626,400	\$13,511,847
Brand Drug Co-pay (Increase)	\$9,100,922	\$12,523,397	\$21,624,319	\$6,910,060	\$8,258,637	\$15,168,697
Non-Preferred Brand Drug Co-pay (Increase)	\$5,318,140	\$7,475,419	\$12,793,559	\$5,348,682	\$6,392,537	\$11,741,219
Sub-total	\$19,923,309	\$27,574,933	\$47,498,242	\$18,144,189	\$22,277,574	\$40,421,763
Grand Total	\$56,304,836	\$76,245,190	\$132,550,026	\$56,926,240	\$74,678,126	\$131,604,366

Other Changes Affecting the Plan

Section 1.5 of Senate Bill 323 (Ratified) 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.

Section 2 of the Proposed Committee Substitute for HB 578 delays the repeal of the Comprehensive Wellness Initiative to September 1, 2011. For purposes of projecting the additional financial cost to the Plan from repealing the Comprehensive Wellness Initiative, it was assumed that the program would remain in effect until August 31, 2011. Thereafter the program is assumed to be repealed for purposes of estimating financial impact. 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	\$14.4M	\$26.0M	\$40.4M

Section 1.6 of Senate Bill 323 (Ratified) 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 2 of the Proposed Committee Substitute for HB 578 delays the implementation of monthly contribution rates to be paid by employees and certain retired employees for their own coverage to September 1, 2011.

Section 1.7 of SB 323 (Ratified) 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. Sections 2(d) and 3 of the Proposed Committee Substitute to HB 578 amended Section 1.7 of SB 323 (Ratified) generally to make various technical and clarifying changes.

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. The Proposed Committee Substitute to HB 578 did not amend or change the effective date of Section 1.8 of SB 323 (Ratified).

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	\$4,931	\$5,192	\$4,931	\$5,192
Non-Medicare Retiree	\$4,931	\$5,192	\$4,931	\$5,192
Medicare Retiree	\$3,832	\$4,035	\$3,832	\$4,035
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. The Proposed Committee Substitute to HB 578 did not amend Section 1.7 of SB 323 (Ratified).

Section 1.10(a) of Senate Bill 323 (Ratified) 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. The Proposed Committee Substitute to HB 578 did not amend Section 1.10(a) of SB 323 (Ratified).

Section 1.10(b) of Senate Bill 323 (Ratified) makes the amended change effective July 1, 2010. The Proposed Committee Substitute to HB 578 did not amend Section 1.10(b) of SB 323 (Ratified).

Section 1.10(c) of Senate Bill 323 (Ratified) 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. The Proposed Committee Substitute to HB 578 did not amend Section 1.10(c) of SB 323 (Ratified).

Section 2 of SB 323 (Ratified) (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. The Proposed Committee Substitute to HB 578 makes various clarifying and technical changes to Part II of SB 323 (Ratified), however, none of these changes are expected to have a financial impact on the Plan for the 2011-13 biennium.

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 5.3% annual premium increase on July 1 of each fiscal year of the biennium for total premium contribution rates; the employer contributions will be effective July 1, 2011, and all other premium contribution rates paid by employees and retirees will increase or become effective September 1, 2011;
2. Increasing plan member out-of-pocket requirements for certain medical and prescription drug benefits; the changes to out-of-pocket limits will be effective September 1, 2011; 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.
4. Using available cash balances from the Plan's operating reserves.

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 (Ratified) as Amended by HB 578 PCS
(\$ 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)	(\$5.5)	(\$7.5)	(\$13.0)
Mid-tier Specialist Co-pay (Increase)	(\$2.4)	(\$3.2)	(\$5.6)
Specialist Co-pay (Increase)	(\$6.6)	(\$8.9)	(\$15.4)
Urgent Care Co-pay (Increase)	(\$0.4)	(\$0.5)	(\$0.9)
Inpatient Co-pay (Increase)	(\$1.1)	(\$1.5)	(\$2.6)
Emergency Room Co-pay (Increase)	(\$1.8)	(\$2.5)	(\$4.3)
Deductible and Coinsurance Maximum (Increase)	(\$18.5)	(\$24.7)	(\$43.2)
Sub-total	(\$36.4)	(\$48.7)	(\$85.1)
Outpatient Acute and Specialty Prescription Drugs			
Generic Drug Co-pay (Increase)	(\$6.6)	(\$7.6)	(\$14.2)
Brand Drug Co-pay (Increase)	(\$9.1)	(\$12.5)	(\$21.6)
Non-Preferred Brand Drug Co-pay (Increase)	(\$5.3)	(\$7.5)	(\$12.8)
Sub-total	(\$21.0)	(\$27.6)	(\$48.6)
Total -- Benefit Reductions	(\$57.4)	(\$76.3)	(\$133.7)
3) Appropriations by the General Assembly			
Premium increase for Employing Agencies			
General Fund	(\$7.1)	(\$102.2)	(\$109.3)
Highway Fund	(\$0.3)	(\$4.8)	(\$5.1)
Other Employer Funds	(\$1.5)	(\$21.1)	(\$22.5)
Total Additional Employer Funds	(\$8.9)	(\$128.0)	(\$136.9)
4) Premium increases paid by Employees and Retirees			
Paid for Employee's Own Coverage	(\$57.4)	(\$71.8)	(\$129.2)
Paid for Retiree's Own Coverage	(\$17.9)	(\$22.8)	(\$40.6)
Paid for Spouses and Dependent Children	(\$13.1)	(\$41.7)	(\$54.8)
Total Employee Additional Funds	(\$88.3)	(\$136.3)	(\$224.6)
5) Net Financial Effect of Member Migration Between Plan Options	\$6.2	\$19.6	\$25.8
6) Balance	\$20.3	\$25.7	\$46.1

Notes:

¹ The \$46.1 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. An estimated \$28.3 million of this remaining balance is attributable to the delayed effective date (September 1, 2011) of applying higher out-of-pocket limits on plan members and beginning to charge of premium contributions to employees and certain retired employees in FY 2011-12. An additional \$13.0 million of the total is based on an assumption that the Plan will offer

non-contributory coverage to employees in the Basic 70/30 plan in FY 2011-12 and FY 2012-13. Year-to date operating results for the Plan through March 30, 2011, adjusting for one-time gains of certain financial transaction that increase Plan receipts in the current plan year, indicate the Plan's cash balance is \$102 million greater than expected as noted in the Plan's August 31, 2010 Authorized Budget. According to the Plan's Executive Administrator on May 17, 2011, by the end of the plan year on June 30, 2011, the Plan's ending cash balance is expected to be \$50 million higher than originally estimated.

²The \$25.8 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 Non-Medicare retiree only contracts and 20% of Medicare-eligible 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 25% of employee only contracts and 5% of 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:

<u>Coverage Type</u>	Basic 70/30		Standard 80/20	
	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
<u>Actives</u>				
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%
<u>Retired</u>				
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%
<u>Former Employees with Continuation Coverage</u>				
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%
<u>Firefighters, Rescue Squad & National Guard</u>				
Employees	2	3	5	0.0%
Dependents	1	2	3	0.0%
Sub-total	3	5	8	0.0%
<u>Local Governments</u>				
Employees	486	1,429	1,915	0.3%
Dependents	303	629	932	0.1%
Sub-total	789	2,058	2,847	0.4%
<u>Total</u>				
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 (\$12 Generic), 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, 2.5% Basic; NMC Retiree 5% Std, 0% Basic; MC Retiree \$10 Std, \$0 Basic No CWI, Non-Smoker Movement: Active 5% single, 5% dep; NMC Retiree: 25% single, 5% dep; MC Retiree: 20% Single, 5% dep, April 26, 2011. [For Employer Contributions].

Aon Consulting, 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, 2.5% Basic; NMC Retiree 5% Std, 0% Basic; MC Retiree \$10 Std, \$0 Basic No CWI, Non-Smoker Movement: Active 5% single, 5% dep; NMC Retiree: 25% single, 5% dep; MC Retiree: 20% Single, 5% dep, May 6, 2011.

Aon Consulting, 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.

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.

Various communications with the Plan's staff regarding year-to-date operating results and cash balances and operation issues regarding implementation of required benefit changes.

-Actuarial Note, Hartman & Associates, House Bill 578 PCS, "House Bill 578 Proposed Committee Substitute H578-PCS50340-ME-16: An Act to Make Additional Changes and Clarifications to the State Health Plan", May 17, 2011, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Hartman & Associates, Senate Bill 323 PCS, "Senate Bill 323 Proposed Committee Substitute S323-PCCS55289-ME-1: 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", May 6, 2011, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, House Bill 578 PCS, "House Bill 578 Proposed Senate Committee Substitute H578-PCS50340-ME-16 State Health Plan/Additional Changes", May 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.

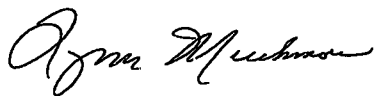
-Actuarial Note, Aon Consulting, Senate Bill 323 PCS, "Senate Bill 323 Proposed Committee Substitute S323-PCCS55289-ME-1 State Health Plan/Appropriations and Transfer", May 10, 2011, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogon

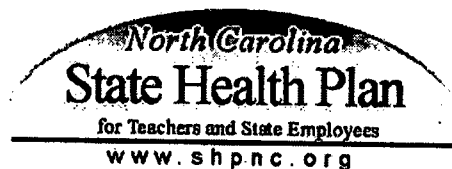


APPROVED BY:



Lynn Muchmore, Director
Fiscal Research Division

DATE: May 18, 2011



4901 Glenwood Avenue, Suite 300, Raleigh, NC 27612-3854 Phone: 919-881-2300 Fax: 919-881-2308

May 18, 2011

The Honorable Beverly Perdue
20301 Mail Service Center
Raleigh, NC 27699-0301

The Honorable Phil Berger
Legislative Building 2008
Raleigh, NC 27601

The Honorable Thom Tillis
Legislative Building 2304
Raleigh, NC 27601

The Plan has been asked to address certain premium recommendations in the Proposed Senate Committee Substitute (PCS) to House Bill 578. Specifically, Section 1 authorizes the Plan to offer the Basic 70/30 plan premium free to state employees and teachers in the upcoming biennium if there are sufficient cash reserves to do so.

Based on the latest actuarial forecasts, the Plan anticipates that it will end the current fiscal year with cash reserves which exceed our target reserve balance by approximately \$40-\$50 million dollars. These reserves should be sufficient to cover the delayed implementation of the benefit changes in Senate Bill 323, as well as provide the employee only tier of the Basic 70/30 plan to teachers and state employees on a premium free basis for fiscal year 2011-12.

Therefore, if Senate Bill 323, Ratified and the PCS to House Bill 578 become law, I, as the Executive Administrator of the Plan, will offer the employee only tier of the Basic 70/30 plan to active state employees and teachers premium free for fiscal year 2011-12. Provided that this legislation becomes law no later than May 31, 2011, I will implement all of the proposed changes, including the premium-free Basic 70/30 option effective September 1, 2011.

Since Senate Bill 323 transfers the administration and oversight of the Plan to the Department of State Treasurer and a newly appointed and empowered Board of Trustees effective January 1, 2012, it is most appropriate to defer decisions about premium rates for the second year of the biennium until after the transfer takes effect. By that time the Plan and its Board of Trustees will have additional financial experience on which to base its decision about continuing a premium free option.

Sincerely,

A handwritten signature in cursive script that reads "Jack W. Walker".

Jack W. Walker, PhD
Executive Administrator

Cc: The Honorable Janet Cowell, State Treasurer

VISITOR REGISTRATION SHEET

May 18

INSURANCE

~~MAY 4, 2011~~

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Nicole Fisher	John Locke Foundation
Du-An O'Ryan	CSS
L. A. Harris	LAHM
PRIGE WORTHAM	LEGISLATIVE REPORTING SERVICE
Lacey Barnes	STP
JD Rego	NCRGEA
Albin	Enclavo.
greg flynn	gregflynn.org

VISITOR REGISTRATION SHEET

INSURANCE

Name of Committee

May 18
MAY 4, 2011

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Forrest Gilman	Commerce Office
Virginia Litchner	HARVEY & ASSOC.
Jake Cashion	NC Chamber
Amy Zalk	30 PR
W. Gordon Lupton	DLC + Assoc
Steve Kitchell	Asst. Dir.
Ante Cigan	NMRS
Allison Waller	Nelson Mullins
Andrew Meehan	Capstrat
Andrew Holton	DST
Rose Williams	NC DOI

VISITOR REGISTRATION SHEET

May 18

INSURANCE

~~MAY 4~~, 2011

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
TED HAMBY	NC Dept of Ins.
DAVID KELLAM	
Jack Walker	SHP
Monn Moa	SHP
Ed Gulefsen	Brooks Pierce
Quaritch	FSP
Katherine Ross	FRAB
Brylyn Hawthorne	ETGR
MICHELLE HEALY	SMITHANDERSON
Manick	Smith Anderson
Bo Healy	NLWC

VISITOR REGISTRATION SHEET

INSURANCE SENATE

Name of Committee

May 18, 2011
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amy Whited	North caroline medical society
Robert Paschal	Young Moore
Tom Fether	Fether Strategic Partners
Margaret Little	NCACET Southern Pines, NC
Joyce Redden	JPASSA
Sara Fender	IFNC
Mark Fleming	RCBSNC
Jack Cozart	NC RGEA
Pam Deardorff	NCRSP
Marge Freeman	NCAE
Chuck Stone	SEANL
Ardis Watkins	SEAXIO

VISITOR REGISTRATION SHEET

INSURANCE

Name of Committee

May 18

MAY 4, 2011

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Gretchen Kelly	FHC
Jeff James	Wilmington
Ken Lewis	FIRST CAROLINA CARE
Jami Fitzgerald	Alliance of Health Care Sharing
Gene Causby	Nr SC A
Larry Presnell, Jr.	NCRSP
Emilyn Hawthorne	EHGR
Burkley Crowder	Governor's Office
Doug Heron	WM
Cedra Kochanek	NCCEP
DAVID BARNES	PS

SENATE INSURANCE COMMITTEE
Tuesday, June 7th at 8:00 AM
Room 1027, Legislative Building

MINUTES

The Senate Insurance Committee met at 8:01 AM on June 7th, 2011, in Room 1027 of the Legislative Building. Eighteen members of the committee were present. Senator's Apodaca and Meredith presided. Ryder Smith from Burlington, Lee Payne from Lexington, Nathan Ravenel from Cary, Nicole Day from Raleigh, and Mariah Bishop from Apex served as pages.

SB 702- Director and Officer Insurance for Treasurer

Senator Apodaca recognized Senator Meredith to explain the bill. The bill 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; employees and agents of the State Treasurer, including coverage for potential liability related investments managed by the State Treasurer. Senator Meredith moved to amend the bill on page 1, line 10 by inserting between the word "Treasurer" and the word "and" the words "members of board of the State Treasurer,"; and on page 1, line 19 by deleting "G.S. 143-300.6 (c)" and substituting "G.S. 143-300.6 (a)." The motion passed. Senator Vaughan moved to give the bill an unfavorable report, but a favorable report to the amended bill rolled into a new PCS. The motion passed. The PCS, summary, and amendment is attached.

S.B. 517- Freedom to Negotiate Health Care Rates

Senator Meredith recognized Senator Newton's motion to consider the PCS and the motion passed. Senator Rouzer was recognized to give his reservations on the bill. Senator Atwater was recognized to speak on bill. Senator Garrou was recognized to give suggestions about the health care crisis. Senator Rucho moved unfavorable as to the original bill, but favorable as to the PCS. The motion passed. The PCS and summary is attached.

S.B. 609- Facilitate Locum Tenens Physicians

Senator Apodaca recognized Senator Newton who moved to consider the PCS of SB 609. The PCS directs an insurer that provides a health benefit plan to establish a process to allow a patient's regular physician to submit a claim and receive payment for covered visits that are provided by a locum tenens physician under certain conditions. Senator East was recognized to ask a question. Senator McKissick was recognized to move for a unfavorable report as to the original bill, but a favorable report as to the PCS. A copy of the PCS and summary is attached.

S.B. 647- Mutual Insurance Holding Companies

Senator Rouzer was recognized to make a motion to consider the PCS. Tom Hovis, NCGA Staff, was recognized to explain the PCS. The PCS authorizes 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 policy holders. Also, the holding company must at all times own a majority of the voting shares of the mutual insurance company. Senator Newton was recognized to ask a question. Senator Garrou was recognized to ask a question. Senator McKissick was recognized to ask a question. Steven Sawyer, Medical Mutual of NC, was recognized to speak in favor of the bill. Senator's Jackson, Davis, and Garrou asked questions of Mr. Sawyer. Kimberly Moore, NC Mutual Life Insurance Company, was recognized to talk in favor of the bill. Rose Vaughan Williams, NC DOI, spoke regarding the DOI's position on this bill. Senator McKissick moved for a unfavorable report to the original bill, but favorable report as to the Post Committee Substitute. The PCS, letter from the Department of Insurance, and summary are attached.

S.B. 656- Right to Choose Physical Therapist

Senator Davis was introduced to explain the bill. Dr. Matt Hornsby, a retired urologist, spoke in favor of the bill. Senator Newton was recognized to ask a question. Because no actuarial note is available for the bill, the committee will hear the bill at the next meeting. The summary is attached.

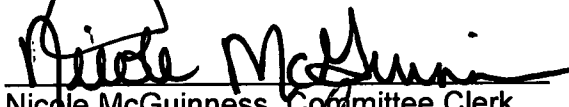
S.B. 738- Liability Insurance Required for ABC Permits

Senator Newton was recognized to make a motion to consider the PCS for 738. Senator Goolsby was recognized to speak on the bill. The PCS increases the total amount of damages that may be award 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 \$1,000,00 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. Senator Newton moved for an unfavorable report to the original bill, but a favorable report to the PCS. The PCS and summary is attached.

The meeting adjourned at 9:00 AM.



Senator Wesley Meredith, Presiding Chair
Senate Insurance Committee



Nicole McGuinness, Committee Clerk



Debbie Lown, Committee Clerk

Senate Insurance Committee
Tuesday, June 7, 2011, 8:00 AM
1027 LB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 517	Freedom to Negotiate Health Care Rates.	Senator Apodaca
SB 609	Facilitate Locum Tenens Physicians.	Senator Rouzer
		Senator Rabon
SB 647	Mutual Insurance Holding Companies.	Senator Rucho
SB 656	Right to Choose Physical Therapist.	Senator Davis
SB 702	Director and Officer Insurance for Treasurer.	Senator Meredith
SB 738	Liability Insurance Required for ABC Permits.	Senator Goolsby
SB 744	Transparency in the Cost of Health Care.	Senator Goolsby

Presentations

Other Business

Adjournment

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

INSURANCE COMMITTEE REPORT

**Senator Tom Apodaca, Co-Chair
Senator Wesley Meredith, Co-Chair**

Tuesday, June 07, 2011

Senator APODACA,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B.	517	Freedom to Negotiate Health Care Rates.	
		Draft Number:	75172
		Sequential Referral:	None
		Recommended Referral:	None
		Long Title Amended:	No
S.B.	609	Facilitate Locum Tenens Physicians.	
		Draft Number:	15172
		Sequential Referral:	None
		Recommended Referral:	None
		Long Title Amended:	No
S.B.	647	Mutual Insurance Holding Companies.	
		Draft Number:	35268
		Sequential Referral:	Finance
		Recommended Referral:	None
		Long Title Amended:	No
S.B.	702	Director and Officer Insurance for Treasurer.	
		Draft Number:	85213
		Sequential Referral:	None
		Recommended Referral:	None
		Long Title Amended:	No
S.B.	738	Liability Insurance Required for ABC Permits.	
		Draft Number:	85212
		Sequential Referral:	None
		Recommended Referral:	None
		Long Title Amended:	Yes

TOTAL REPORTED: 5

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

1

SENATE BILL 702

Short Title: Director and Officer Insurance for Treasurer.

(Public)

Sponsors: Senator Meredith.

Referred to: Insurance.

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.

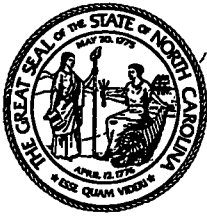
(a) The State Treasurer may purchase commercial insurance of any kind to cover all risks or potential liability of the State Treasurer, boards in the Department of the State Treasurer, and employees and agents of the State Treasurer, including the risks and potential liability related to investments 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(c) 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 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: Senate Insurance
Introduced by: Sen. Meredith
Analysis of: First Edition

Date: June 6, 2011
Prepared by: Tim Hovis
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, 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 ANALYSIS: 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 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(c) 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.

PUBLIC BILL

S.B. 702

SESSION LAW _____

A BILL TO BE ENTITLED

AN ACT TO ALLOW THE STATE TREASURER TO PURCHASE LIABILITY INSURANCE.

Introduced by Senator(s)

W. A. Marshall
Meredith

Principal Clerk's Use Only

FILED APR 19 2011

PASSED 1st READING

APR 20 2011

REFERRED TO COMMITTEE

ON

Insurance

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. 1st

H. B. No. _____

DATE 6/7/11

S. B. No. 702

Amendment No. _____

COMMITTEE SUBSTITUTE _____

(to be filled in by
Principal Clerk)

Rep.)

Sen.)

1 moves to amend the bill on page 1, line 10

2 () WHICH CHANGES THE TITLE

3 by inserting between the words "Treasurer,"
4 and the word "and" the words
5 "members of boards of the State Treasurer,";

6 _____

7 _____

8 _____

9 and on page 1, line 19,

10 by deleting "G.S. 143-300.6(c)"

11 and substituting "G.S. 143-300.6(a)"

12 _____

13 _____

14 _____

15 _____

16 _____

17 _____

18 _____

19 _____

SIGNED

by A. Mendenhall

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

D

SENATE BILL 517*
PROPOSED COMMITTEE SUBSTITUTE S517-CSTK-6 [v.1]

4/12/2011 3:13:11 PM

Short Title: Freedom to Negotiate Health Care Rates.

(Public)

Sponsors:

Referred to:

April 6, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO ALLOW HEALTH PROVIDERS AND HEALTH INSURERS TO FREELY
3 NEGOTIATE REIMBURSEMENT RATES BY PROHIBITING CONTRACT
4 PROVISIONS THAT RESTRICT RATE NEGOTIATIONS.

5 The General Assembly of North Carolina enacts:

6 SECTION 1. Part 7 of Article 50 of Chapter 58 of the General Statutes is amended
7 by adding a new section to read:

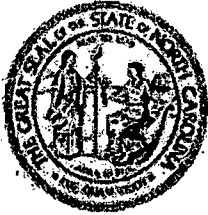
8 "**§ 58-50-290. Prohibited contract provisions related to reimbursement rates.**

9 **No contract for the provision of health care services shall do any of the following:**

- 10 (1) **Prohibit, or grant a health carrier an option to prohibit, a participating**
11 **provider from contracting with another health carrier to provide health care**
12 **services at a rate that is equal to or lower than the payment specified in the**
13 **contract.**
14 (2) **Require a participating provider to accept a lower payment rate in the event**
15 **the participating provider agrees to provide health care services to any other**
16 **health carrier at a rate that is equal to or lower than the payment specified in**
17 **the contract.**
18 (3) **Require, or grant a health carrier an option to require, termination or**
19 **renegotiation of the existing health care contract in the event a participating**
20 **provider agrees to provide health care services to any other health carrier at a**
21 **rate that is equal to or lower than the payment specified in the contract.**
22 (4) **Require, or grant a health carrier an option to require, a participating**
23 **provider to disclose, directly or indirectly, the participating provider's**
24 **contractual rates with another health carrier.**
25 (5) **Require, or grant a health carrier an option to require, the nonnegotiated**
26 **adjustment by the issuer of a participating provider's contractual rate to equal**
27 **the lowest rate the provider has agreed to charge any other health carrier.**
28 (6) **Require, or grant a health carrier an option to require, a participating**
29 **provider to charge another health carrier a rate that is equal to or more than**
30 **the reimbursement rate specified in the contract."**

31 SECTION 2. This act becomes effective October 1, 2011.





SENATE BILL 517: Freedom to Negotiate Health Care Rates

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Sen. Apodaca
Analysis of: PCS to First Edition
S517-CSTK-6

Date: April 12, 2011
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *The PCS to Senate Bill 517 would prohibit contract provisions that create specified rate negotiations between health benefit plans and health care provider.*

CURRENT LAW: G.S. 58-50-270 provides the following definitions that are applicable to this bill:

- **Contract** – an agreement between an insurer and a health care provider for the provision of health care services by the provider on a preferred or in-network basis.
- **Health care Provider** – an individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes and is owned or operated by the State in which health care services are provided to patients.

BILL ANALYSIS: The only change to the PCS is technical. The placement of the new statute is now the more appropriate location of G.S. 58-50-290.

Senate Bill 517 adds a new section to Part 7 of Article 50 of Chapter 58 of the General Statutes regarding contracts between health benefit plans and health care providers. The bill states that no contract for the provision of health care services can do any of the following:

- Prohibit a participating provider from contracting with another health carrier to provide services at a rate equal to or lower than the payment specified in the contract.
- Require a participating provider to accept a lower payment rate in the event that the provider agrees to provide services to any other carrier at a rate equal to or lower than that specified in the contract.
- Require termination or renegotiation of the contract if the provider agrees to provide services to any other carrier at a rate equal to or lower than that specified in the contract.
- Require the disclosure of a participating provider's contractual rates with another carrier.
- Require the non-negotiated adjustment by the issuer of a participating provider's contractual rate to equal the lowest rate the provider has agreed to charge another carrier.
- Require a participating provider to charge another carrier a rate that is equal to or greater than the rates specified in the contract.

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

S517-SMTK-16(CSTK-6) v3

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

D

SENATE BILL 609
PROPOSED COMMITTEE SUBSTITUTE S609-CSTK-23 [v.2]

6/6/2011 5:23:40 PM

Short Title: Facilitate Locum Tenens Physicians.

(Public)

Sponsors:

Referred to:

April 19, 2011

A BILL TO BE ENTITLED

AN ACT TO AMEND THE INSURANCE LAWS IN ORDER TO FACILITATE THE USE
OF LOCUM TENENS PHYSICIANS TO ENSURE NORTH CAROLINA'S MEDICAL
PROFESSIONALS ARE CAPABLE OF SERVING THE STATE'S EXPANDING
POPULATION.

The General Assembly of North Carolina enacts:

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

"§ 58-3-231. Payment under locum tenens arrangements.

(a) As used in this section, the following definitions apply:

- (1) Covered visit services. – All office visits, emergency visits, and any related service performed by a physician that is covered by the insurer.
- (2) Insurer. – Defined in G.S. 58-3-167(a).
- (3) Locum tenens agency. – A company authorized to conduct business in North Carolina that provides, through contract, locum tenens placement and administrative services for regular physicians, locum tenens physicians, medical groups, and hospitals.
- (4) Locum tenens physician. – A physician who substitutes for a regular physician on a temporary basis and is not an employee of the regular physician.
- (5) Regular physician. – The physician that is normally scheduled to see a patient, including physician specialists and a physician who has left a group practice for whom a locum tenens physician is retained.

(b) An insurer that provides a health benefit plan shall establish and maintain a process to allow a patient's regular physician to submit a claim and, if the claim is accepted, receive payment for covered visit services that the regular physician or a locum tenens agency arranges to be provided by a locum tenens physician, provided the following are true:

- (1) The regular physician is unavailable to provide the covered visit services or the locum tenens physician is assisting the regular physician in providing covered visit services.
- (2) The insured patient has arranged or seeks to receive the covered visit services from the regular physician.



* S 6 0 9 - C S T K - 2 3 - V - 2 *

- 1 (3) The locum tenens physician does not provide the covered visit services to
2 insured patients of a single regular physician for more than 90 consecutive
3 days.
4 (4) The regular physician identifies the covered visit services as locum tenens
5 physician services meeting the requirements of this section by entering the
6 proper code required by the insurer after the procedure code.
7 (5) The regular physician pays for the locum tenens physician's covered visit
8 services on a per diem or similar fee-for-time basis.
9 (6) The regular physician maintains a record of each covered visit service
10 provided by the locum tenens physician and makes this record available to
11 the insurer upon request.

12 (c) A medical group or hospital may submit claims for the covered visit services of a
13 locum tenens physician substituting for a regular physician who is a member of the group or an
14 employee of the hospital if the requirements of subsection (b) of this section are met. For
15 purposes of these requirements, per diem or similar fee-for-time compensation that the group or
16 hospital pays for the locum tenens physician is considered paid by the regular physician. A
17 physician who has left the group and for whom the group has engaged a locum tenens
18 physician as a temporary replacement may bill for the temporary physician for up to 90
19 consecutive days.

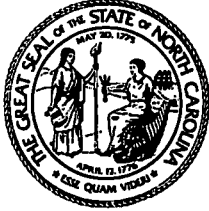
20 (d) An insurer shall allow a locum tenens physician credentialed with that insurer to
21 substitute for a regular physician in accordance with this section without a statement of
22 supervision if (i) the regular physician is a solo practitioner or (ii) there is not otherwise a
23 regular physician who is able to provide a statement of supervision.

24 (e) Locum tenens agencies may contract with regular physicians, medical groups,
25 hospitals, and locum tenens physicians to provide placement and administrative services related
26 to the locum tenens substitution, provided the following are true:

- 27 (1) The locum tenens agency charges fees that are reasonably related to the
28 value of the services that the locum tenens agency provides.
29 (2) The locum tenens agency does not interfere with or attempt to influence the
30 clinical judgment of a physician providing locum tenens services."

31 **SECTION 2.** Insurers shall establish within 180 days after the effective date of this
32 act the process required by G.S. 58-3-231, as enacted by this act.

33 **SECTION 3.** This act becomes effective October 1, 2011.



SENATE BILL 609: Facilitate Locum Tenens Physicians

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Sens. Rouzer, Rabon
Analysis of: PCS to First Edition
S609-CSTK-23

Date: June 3, 2011
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *The PCS for Senate Bill 609 directs an insurer that provides a health benefit plan to establish a process to allow a patient's regular physician to submit a claim and receive payment for covered visits that are provided by a locum tenens physician under certain conditions.*

BILL ANALYSIS:

Senate Bill 609 defines a "locum tenens physician" as a physician who substitutes for a regular physician on a temporary basis and is not an employee of the regular physician. A "locum tenens agency" is a company that provides, through contract, locum tenens placement and administrative services for regular physicians, locum tenens physicians, medical groups, and hospitals.

Within 180 days of the effective date of the act, Senate Bill 609 requires an insurer that provides a health benefit plan to establish and maintain a process to allow a patient's regular physician, a medical group, or a hospital to submit a claim, and if accepted, receive payment for covered visit services provided by a locum tenens physician if:

- The regular physician is unavailable to provide the services or the locum tenens physician is assisting the physician.
- The patient has arranged or seeks to receive the visit services from the regular physician.
- The locum tenens physician does not provide visit services for an individual physician for more than 90 days.
- The proper code is used when submitting the claim to the insurer.
- The locum tenens physician is paid on a per diem or a fee-for-time basis.
- The regular physician maintains a record of each service provided by the locum tenens physician, which is available upon the insurer's request.

Locum tenens agencies may contract with regular physicians, medical groups, hospitals, and locum tenens physicians if:

- The agency charges fees that are reasonably related to the value of services.
- The agency does not interfere with or attempt to influence the clinical judgment of a physician.

The PCS makes only technical changes.

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

S609-SMTK-34(CSTK-23) v4

PUBLIC BILL

S.B. 609

SESSION LAW _____

A BILL TO BE ENTITLED

AN ACT TO AMEND THE INSURANCE LAWS IN ORDER TO FACILITATE THE USE OF LOCUM
TENENS PHYSICIANS TO ENSURE NORTH CAROLINA'S MEDICAL PROFESSIONALS ARE
CAPABLE OF SERVING THE STATE'S EXPANDING POPULATION.

Introduced by Senator(s)

Rouzer

Rabon

(Primary Sponsors)

Principal Clerk's Use Only
FILED APR 14 2011

PASSED 1st READING

APR 198 2011

AND REFERRED TO COMMITTEE
ON Health Care

**WITH UNANIMOUS CONSENT
WITHDRAWN FROM**

Health Care

APR 27 2011

RE-REFERRED TO

Insurance

SEQUENTIAL REFERRAL:

Insurance

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

D

SENATE BILL 647
PROPOSED COMMITTEE SUBSTITUTE S647-CSMH-12 [v.6]

6/3/2011 1:40:47 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 section 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

1 the policyholders, the Commissioner may approve the proposed plan of reorganization and may
2 require as a condition of approval such modifications of the proposed plan of reorganization as
3 the Commissioner finds necessary for the protection of the policyholders' interests. The
4 Commissioner may retain consultants as provided in G.S. 58-10-285 to assist in the review of
5 the proposed plan. The Commissioner shall retain jurisdiction over a mutual insurance holding
6 company organized under this Part to assure that policyholder interests are protected. All of the
7 initial shares of the capital stock of the reorganized insurance company shall be issued to the
8 mutual insurance holding company. The membership interests of the policyholders of the
9 reorganized insurance company shall become membership interests in the mutual insurance
10 holding company, pursuant to the terms and conditions of the plan of reorganization approved
11 by the Commissioner. Policyholders of the reorganized insurance company shall be members
12 of the mutual insurance holding company in accordance with the articles of incorporation and
13 bylaws of the mutual insurance holding company. The mutual insurance holding company shall
14 at all times own a majority of the voting shares of the capital stock of the reorganized insurance
15 company.

16 (b) A domestic mutual insurance company, after approval by the Commissioner, may
17 reorganize by merging its policyholders' membership interests into a mutual insurance holding
18 company formed under subsection (a) of this section and continuing the corporate existence of
19 the reorganizing insurance company as a stock insurance company subsidiary of the mutual
20 insurance holding company. If the Commissioner is satisfied that the interests of the
21 policyholders are properly protected and that the merger of interests is fair and equitable to the
22 policyholders, the Commissioner may approve the proposed merger of interests and may
23 require as a condition of approval such modifications of the proposed merger of interests as the
24 Commissioner finds necessary for the protection of the policyholders' interests. The
25 Commissioner may retain consultants as provided in G.S. 58-10-285. The Commissioner has
26 jurisdiction over the mutual insurance holding company organized under this Part to assure that
27 policyholder interests are protected. All of the initial shares of the capital stock of the
28 reorganized insurance company shall be issued to the mutual insurance holding company. The
29 membership interests of the policyholders of the reorganized insurance company shall, pursuant
30 to the terms and conditions of the plan of reorganization approved by the Commissioner,
31 become membership interests in the mutual insurance holding company. Policyholders of the
32 reorganized insurance company shall be members of the mutual insurance holding company in
33 accordance with subsection (a) and the articles of incorporation and bylaws of the mutual
34 insurance holding company. The mutual insurance holding company shall at all times own a
35 majority of the voting shares of the capital stock of the reorganized insurance company.

36 (c) A mutual insurance holding company resulting from the reorganization of a
37 domestic mutual insurance company that was organized under Articles 7 and 8 and other
38 applicable provisions of this Chapter shall be incorporated under this Chapter. The articles of
39 incorporation and any amendments to such articles of the mutual insurance holding company
40 shall be subject to approval of the Commissioner in the same manner as those of a mutual
41 insurance company.

42 (d) A mutual insurance holding company is an insurer subject to Article 30 of this
43 Chapter and shall automatically be a party to any proceeding under Article 30 of this Chapter
44 involving an insurance company which, as a result of a reorganization under subsection (a) or
45 (b) of this section, is a subsidiary of the mutual insurance holding company. In any proceeding
46 under Article 30 of this Chapter involving the reorganized insurance company, the assets of the
47 mutual insurance holding company are deemed to be assets of the estate of the reorganized
48 insurance company for purposes of satisfying the claims of the reorganized insurance
49 company's policyholders. A mutual insurance holding company shall not dissolve or liquidate

1 without the approval of the Commissioner or as ordered by the court pursuant to Article 30 of
2 this Chapter.

3 (e) G.S. 58-10-10 and G.S. 58-10-12 are not applicable to a reorganization or merger of
4 interests under this Part. G.S. 58-10-10 and G.S. 58-10-12 are applicable to demutualization of
5 a mutual insurance holding company that resulted from the reorganization of a domestic mutual
6 insurance company organized under this Chapter as if the mutual insurance holding company
7 was a mutual insurance company.

8 (f) A membership interest in a domestic mutual insurance holding company shall not
9 constitute a security as defined in Chapter 78A of the General Statutes.

10 (g) The majority of the voting shares of the capital stock of the reorganized insurance
11 company, which is required by this section to be at all times owned by a mutual insurance
12 holding company, shall not be conveyed, transferred, assigned, pledged, subjected to a security
13 interest or lien, encumbered, or otherwise hypothecated or alienated by the mutual insurance
14 holding company or intermediate holding company. Any conveyance, transfer, assignment,
15 pledge, security interest, lien, encumbrance, or hypothecation or alienation of, in, or on the
16 majority of the voting shares of the reorganized insurance company is a violation of this section
17 and shall be void in inverse chronological order of the date of such conveyance, transfer,
18 assignment, pledge, security interest, lien, encumbrance, or hypothecation or alienation, as to
19 the shares necessary to constitute a majority of such voting shares. The majority of the voting
20 shares of the capital stock of the reorganized insurance company shall not be subject to
21 execution and levy as provided in Chapter 1 of the General Statutes. The shares of the capital
22 stock of the surviving or new company resulting from a merger or consolidation of two or more
23 reorganized insurance companies or two or more intermediate holding companies that were
24 subsidiaries of the same mutual insurance holding company are subject to the same
25 requirements, restrictions, and limitations to which the shares of the merging or consolidating
26 reorganized insurance companies or intermediate holding companies were subject by this
27 section prior to the merger or consolidation. The ownership of a majority of the voting shares
28 of the capital stock of the reorganized insurance company that are required by this section to be
29 at all times owned by a parent mutual insurance holding company includes indirect ownership
30 through one or more intermediate holding companies in a corporate structure approved by the
31 Commissioner. However, indirect ownership through one or more intermediate holding
32 companies shall not result in the mutual insurance holding company owning less than the
33 equivalent of a majority of the voting shares of the capital stock of the reorganized insurance
34 company. The Commissioner shall have jurisdiction over an intermediate holding company as
35 if it were a mutual insurance holding company.

36 (h) The applicant's articles of incorporation or bylaws, as appropriate, shall require a
37 policyholder vote of approval of the reorganization by a two-thirds majority of the domestic
38 mutual insurance company's policyholders voting on it in person, by proxy, or by mail at a
39 meeting called for the purpose of voting on the reorganization.

40 **"§ 58-10-285. Application; contents; process.**

41 (a) An application shall be designated as either a limited application or a standard
42 application. The filing of a limited application shall not preclude the subsequent filing of an
43 application for approval of an initial sale of stock as provided in G.S. 58-10-315.

44 (b) The application shall be filed in triplicate with the Commissioner and shall include
45 the following items:

46 (1) Designation as a limited or standard application.

47 (2) A plan of reorganization as set forth in G.S. 58-10-290.

48 (3) A plan to obtain the approval of the policyholders in accordance with this
49 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). 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).

"§ 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.**

1 (a) The Commissioner shall at all times retain jurisdiction over the mutual insurance
2 holding company, its intermediate holding company subsidiaries with stock insurance company
3 subsidiaries, and its stock insurance company subsidiaries.

4 (b) Following any public comment period or hearing pursuant to G.S. 58-10-285, the
5 Commissioner by order shall approve, conditionally approve, or deny an application. The
6 Commissioner may require, as a condition of approval of the proposed reorganization,
7 modifications of the proposed plan of reorganization that the Commissioner finds necessary.
8 The applicant shall accept the required modifications by filing appropriate amendments to the
9 proposed plan of reorganization with the Commissioner within 30 days of the date of the
10 Commissioner's order requiring the modifications. If the applicant does not accept the required
11 modifications by failing to file the required amendments to the proposed plan of reorganization
12 within 30 days, the proposed reorganization shall be deemed denied.

13 (c) An approval or conditional approval of a plan of reorganization shall expire if the
14 reorganization is not completed within 210 days after the approval or conditional approval
15 unless the time period is extended by the Commissioner upon a showing of good cause.

16 (d) The Commissioner may revoke approval or conditional approval of an applicant's
17 plan of reorganization in the event the Commissioner finds the applicant has failed to comply
18 with the plan of reorganization. The Commissioner may compel completion of a plan of
19 reorganization unless the plan is abandoned in its entirety, in accordance with the applicant's
20 provisions for governance.

21 (e) Upon completion of all elements of a plan of reorganization, the applicant shall
22 provide a notice of completion to the Commissioner.

23 **"§ 58-10-300. Special financial requirements.**

24 (a) Mutual insurance holding companies and their insurance company subsidiaries and
25 affiliates shall comply with the provisions of Article 19 of this Chapter except as expressly
26 provided in this Part. Mutual insurance holding companies' investments in subsidiaries,
27 including intermediate holding companies, shall not be subject to any of the restrictions on
28 investment activities set forth in G.S. 58-19-10.

29 (b) When a mutual insurance holding company acquires or plans to acquire more than
30 fifty percent (50%) of a stock insurance company, the mutual insurance holding company shall
31 submit to the Commissioner a plan describing any membership interests of policyholders.

32 (c) Each mutual insurance holding company shall supply to the Commissioner, by April
33 1 of each year, an annual statement consisting of the following:

34 (1) An income statement.

35 (2) A balance sheet.

36 (3) A cash flow statement.

37 (4) Complete information on the status of any closed block formed as a part of a
38 plan of reorganization.

39 (5) An investment plan covering all assets.

40 (6) A statement disclosing any intention to pledge, borrow against, alienate,
41 hypothecate, or in any way encumber the assets of the mutual insurance
42 holding company.

43 (d) At least fifty percent (50%) of the net worth of the mutual insurance holding
44 company, based upon generally accepted accounting practices, shall be invested in insurance
45 company subsidiaries. The Commissioner may waive the fifty percent (50%) limitation upon a
46 showing of good cause.

47 (e) No policyholder who is a member of a mutual insurance holding company shall
48 receive on account of such membership interest any payment of a policy credit, dividend, or
49 other distribution unless the payment has been approved by the Commissioner. The
50 Commissioner, if satisfied the proposed payment is fair and equitable to policyholders who are

1 members, may approve the proposed payment and may require as a condition of the approval
2 modification of the proposed payment that the Commissioner finds necessary for the protection
3 of the policyholders.

4 (f) Mutual insurance holding companies shall comply with Part 3 of this Article and
5 shall be considered a domestic insurer for the purposes of compliance with Part 3.

6 **"§ 58-10-305. Reorganization of domestic mutual insurer with mutual insurance holding**
7 **company.**

8 A domestic mutual insurance company may apply to reorganize by merging its
9 policyholders' membership interests into a mutual insurance holding company by filing with the
10 Commissioner a joint application with the mutual insurance holding company complying with
11 the provisions of G.S. 58-10-285.

12 **"§ 58-10-310. Mergers of mutual insurance holding companies.**

13 A mutual insurance holding company may apply to merge with another mutual insurance
14 holding company by filing with the Commissioner a plan of merger and complying with the
15 provisions of Article 19 of this Chapter.

16 **"§ 58-10-315. Stock offerings.**

17 (a) No stock offering by a mutual insurance holding company, an insurance company
18 subsidiary of a mutual insurance holding company, an intermediate holding company
19 subsidiary of a mutual insurance holding company, or an insurance company subsidiary of an
20 intermediate holding company subsidiary to a mutual insurance holding company shall occur
21 without the prior approval of the Commissioner.

22 (b) Every application for approval of a stock offering shall contain the following
23 information:

- 24 (1) A description of the stock intended to be offered by the applicant, including
25 a description of all shareholder rights.
- 26 (2) The total number of shares authorized to be issued, the estimated number the
27 applicant requests permission to offer, and the intended date or range of
28 dates for the offer.
- 29 (3) A justification for a uniform planned offering price or a justification of the
30 method by which the offering price will be determined.
- 31 (4) The name or names of any underwriter, syndicate member, or placement
32 agent involved and, if known, the name or names of each entity, person, or
33 group of persons to whom the stock offering is to be made who will control
34 five percent (5%) of the total outstanding class of shares, and the manner in
35 which the offer is to be tendered. If any such entity or person is a corporation
36 or business organization, the name of each member of its board of directors
37 or equivalent management team shall be provided along with the name of
38 each member of the board of directors of the offeror. Copies of any filings
39 with the United States Securities and Exchange Commission disclosing
40 intended acquisitions of the stock shall be included in the application.
- 41 (5) A description of stock subscription rights to be afforded members of the
42 mutual insurance holding company in conjunction with the stock offering.
- 43 (6) A detailed description of all expenses to be incurred in conjunction with the
44 stock offering.
- 45 (7) An explanation of how funds raised by the stock offering are to be used.
- 46 (8) Any other information requested by the Commissioner.

47 (c) No application regarding a planned stock offering shall be approved unless the plan
48 contains the following provisions:

- 49 (1) Prohibiting officers, directors, and insiders of the mutual insurance holding
50 company and its subsidiaries and affiliates from purchase or ownership of

1 shares of the stock offering, or issuance of stock options to or for the benefit
2 of such officers, directors, and insiders, in excess of five percent (5%) of the
3 stock offering. The Commissioner may waive this requirement upon a
4 showing of good cause. This subdivision does not limit the rights of officers,
5 directors, and insiders from exercising subscription rights that are generally
6 accorded members of the mutual insurance holding company. However,
7 pursuant to those subscription rights, the officers, directors, and insiders of
8 the mutual insurance holding company and its subsidiaries and affiliates may
9 not purchase or own, in the aggregate, more than five percent (5%) of the
10 stock offering.

11 (2) Requiring that, after the initial stock offering, a majority of the board of
12 directors of the mutual insurance holding company be persons who are not
13 interested persons of the mutual insurance holding company or of an
14 affiliated person of the company. For purposes of this subdivision, a member
15 of the mutual insurance holding company or a policyholder of any of its
16 insurance company subsidiaries shall not be considered an "interested
17 person" or an "affiliated person." The Commissioner may waive this
18 requirement upon a showing of good cause.

19 (3) For the mutual insurance holding company to adopt articles of incorporation
20 prohibiting any waiver of dividends from stock subsidiaries except under
21 conditions specified in its articles of incorporation and after approval of the
22 waiver by the board of directors of the mutual insurance holding company
23 and the Commissioner.

24 (4) Requiring that, after the initial stock offering by an insurance company
25 subsidiary of a mutual insurance holding company, an intermediate holding
26 company subsidiary of a mutual insurance holding company, or an insurance
27 company subsidiary of an intermediate holding company subsidiary of a
28 mutual insurance holding company, the boards of directors of each insurance
29 company or intermediate holding company include at least three directors
30 who are not interested persons of the mutual insurance holding company.
31 The Commissioner may waive this requirement upon a showing of good
32 cause.

33 (5) Establishing, within the board of directors of the corporation offering stock,
34 a pricing committee consisting exclusively of directors who are not members
35 of management of the insurance company subsidiary whose responsibility is
36 to evaluate and approve the price of any stock offering.

37 (d) An insurance company subsidiary of a mutual insurance holding company, an
38 intermediate holding company subsidiary of a mutual insurance holding company, or an
39 insurance company subsidiary of an intermediate holding company subsidiary to a mutual
40 insurance holding company may issue more than one class of stock, provided, however, that the
41 issuer complies with all of the following requirements:

42 (1) At all times a majority of the voting stock is held by the mutual insurance
43 holding company or its subsidiary.

44 (2) No class of common stock may possess greater dividend or other rights than
45 the class held by the mutual insurance holding company or its subsidiary.

46 (e) The Commissioner may retain, at the expense of the person filing the application,
47 any attorneys, actuaries, economists, accountants, consultants, or other professional advisors
48 not otherwise a part of the Commissioner's staff to assist the Commissioner in reviewing the
49 application. These contracts are personal professional service contracts exempt from Articles 3
50 and 3C of Chapter 143 of the General Statutes.

1 (f) The expenses of mailing any notices and other materials required by this section
2 shall be borne by the person filing the application.

3 (g) Upon receipt and review by the Commissioner of all information provided under
4 this section, the Commissioner may establish a period during which the Department will
5 receive and consider public comments about the proposed offering. The Commissioner shall
6 inform the public of the offering by posting information about the application in a manner
7 deemed appropriate by the Commissioner. The Commissioner may hold a public hearing
8 concerning the application or the proposed offering. Following any public comment period or
9 hearing, if applicable, the Commissioner may approve, conditionally approve, or deny the
10 application. The Commissioner may approve the application if the following apply:

11 (1) The offering complies with this Part and other provisions of law.

12 (2) The method for establishing the price of a stock offering is consistent with
13 generally accepted market or industry practices for establishing stock
14 offering prices in similar transactions.

15 (3) The plan and offering will not unfairly impact the interests of members of
16 the mutual insurance holding company.

17 Nothing in this subsection shall be deemed to prohibit the filing of a registration statement
18 with the United States Securities and Exchange Commission before or concurrently with the
19 giving of notice to members.

20 (h) Notwithstanding the provisions of subsections (a) through (g) of this section, stock
21 offerings which are not an initial stock offering, and which are proposed by entities with a class
22 of securities regularly traded on the New York Stock Exchange, the American Stock Exchange,
23 or another exchange approved by the Commissioner, or designated on the National Association
24 of Securities Dealers Automated Quotations national market system (NASDAQ), may be sold
25 in accordance with the following procedure: if a mutual insurance holding company, an
26 insurance company subsidiary of a mutual insurance holding company, an intermediate holding
27 company, or an insurance company subsidiary of an intermediate holding company intends to
28 make a stock offering which would be governed by the provisions of this subsection, that entity
29 shall deliver to the Commissioner, not less than 60 days prior to the offering, a notice of the
30 planned stock offering and all of the following information:

31 (1) The total number of shares intended to be offered.

32 (2) The intended date of sale.

33 (3) Evidence the stock is regularly traded on one of the public exchanges
34 specified in this subsection.

35 (4) A record of the trading price and trading volume of the stock during the prior
36 52 weeks.

37 The Commissioner shall be deemed to have approved the sale unless, within 60 days
38 following receipt of such notice, the Commissioner issues an objection to the sale. If the
39 Commissioner issues an objection to the sale, the application process set forth in subsections
40 (a) through (g) of this section shall be followed to determine whether the Commissioner
41 approves of the proposed sale.

42 (i) Approval of a stock offering obtained under either subsection (g) or (h) of this
43 section shall expire 120 days following the date of the approval or deemed approval, except as
44 otherwise provided by order of the Commissioner.

45 (j) No prospectus, information, sales material, or sales presentation by the applicant, or
46 by any representative, agent, or affiliate of the applicant, shall contain a representation that the
47 Commissioner has endorsed the price, price range, or any other information relating to the
48 stock.

49 (k) No company making a stock offering under this section shall engage in any of the
50 following practices:

- 1 (1) Borrow funds from the mutual insurance holding company, or its
2 subsidiaries and affiliates, to finance the purchase of any portion of a stock
3 offering.
4 (2) Pay any commissions, "special fees," or any other special payments or
5 extraordinary compensation to officers, directors, interested persons, and
6 affiliates for arranging, promoting, aiding, or assisting in reorganization to a
7 mutual insurance holding company or for arranging, promoting, aiding,
8 assisting, or participating in the structuring and placement of a stock
9 offering.
10 (3) Enter into an understanding or agreement transferring legal or beneficial
11 ownership of stock to another person to avoid the requirements of this Part.

12 **"§ 58-10-320. Regulation of holding company system.**

13 (a) All material transactions, as that term is defined under Part 3 of this Article,
14 between or among subsidiaries and affiliates of the mutual insurance holding company, must,
15 after review and exercise of director duties by the directors of the mutual insurance-holding
16 company, be approved by a majority of the directors of the mutual insurance holding company
17 as being fair and reasonable.

18 (b) If the Commissioner determines that activities within a mutual insurance holding
19 company system have violated provisions of the General Statutes of North Carolina or the
20 North Carolina Administrative Code or acted to circumvent requirements or prohibitions
21 contained in the General Statutes or Administrative Code, the Commissioner may prohibit or
22 order rescission of any transaction relating to those activities.

23 **"§ 58-10-325. Reporting of stock ownership and transactions.**

24 (a) Any director or officer of a mutual insurance holding company, its subsidiary, or
25 affiliate, who acquires directly or indirectly the beneficial ownership of any security issued by
26 any intermediate holding company or any insurance company subsidiary of an intermediate
27 holding company or mutual insurance holding company shall, within 15 days following the
28 transaction, file with the Commissioner a statement of the transaction on the form prescribed by
29 the Commissioner.

30 (b) A mutual insurance holding company, and its subsidiaries and affiliates, shall file
31 with the Commissioner, within 15 days of receipt, copies of Form 3, Form 4, and Schedule
32 13D, or any equivalent filings, such filings made under the federal Securities Exchange Act of
33 1934, as amended."

34 **SECTION 2.** This act is effective when it becomes law.



SENATE BILL 647: Mutual Insurance Holding Companies

2011-2012 General Assembly

Committee:	Senate Ref to Insurance. If fav, re-ref to Finance	Date:	June 3, 2011
Introduced by:	Sen. Rucho	Prepared by:	Tim Hovis
Analysis of:	PCS to First Edition S647-CSMH-12		Committee Counsel

SUMMARY: A "mutual insurance company" is a company that is owned by its policyholders. No stock is available for purchase. The Proposed Committee Substitute 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. 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

Senate PCS 647

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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.

Senate PCS 647

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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 Proposed Committee Substitute for Senate Bill 647 is effective when it becomes law.

S647-SMRG-27(CSMH-12) v10

Finance

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

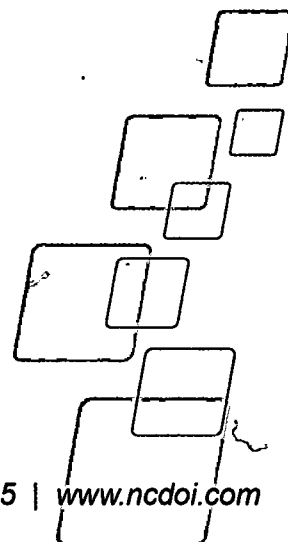
Dear Senator Rucho,

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
NC Commissioner of Insurance



GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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D

SENATE BILL 656
PROPOSED COMMITTEE SUBSTITUTE S656-CSTK-24 [v.3]

6/6/2011 11:53:02 AM

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



1 policyholder, insured, or beneficiary must choose a provider of the services
2 within the network in order to obtain the higher level of benefits.

3 (a2) Whenever any policy of insurance governed by Articles 1 through 64 of this
4 Chapter provides for certification of disability that is within the scope of practice of a duly
5 licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly
6 licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly licensed
7 physical therapist, a duly licensed clinical social worker, a duly certified substance abuse
8 professional, a duly licensed professional counselor, a duly licensed psychologist, a duly
9 certified fee-based practicing pastoral counselor, a duly licensed marriage and family therapist,
10 or an advanced practice registered nurse, the insured or other persons entitled to benefits under
11 the policy shall be entitled to payment of or reimbursement for the disability whether the
12 disability be certified by a duly licensed physician, or a provider listed in this subsection,
13 notwithstanding any provisions contained in the policy. The policyholder, insured, or
14 beneficiary shall have the right to choose the provider of the services notwithstanding any
15 provision to the contrary in any other statute; provided that for plans that require the use of
16 network providers either as a condition of obtaining benefits under the plan or policy or to
17 access a higher level of benefits under the plan or policy, the policyholder, insured, or
18 beneficiary must choose a provider of the services within the network, subject to the
19 requirements of the plan or policy.

20 ...

21 (c4) For purposes of this section, a "duly licensed marriage and family therapist" is a
22 person licensed by the North Carolina Marriage and Family Therapy Licensure Board pursuant
23 to Article 18C of Chapter 90 of the General Statutes.

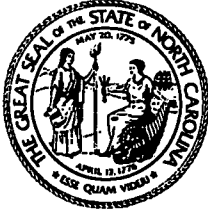
24 (c5) For purposes of this section, a "duly licensed physical therapist" is a person licensed
25 by the North Carolina Board of Physical Therapy Examiners pursuant to Article 18B of
26 Chapter 90 of the General Statutes.

27"

28 **SECTION 2.** G.S. 135-48.51(12) as enacted by S.L. 2011-85, reads as rewritten:

29 "(12) G.S. 58-50-30, Right to choose services of optometrist, podiatrist, licensed
30 clinical social worker, certified substance abuse professional, licensed
31 professional counselor, dentist, physical therapist, chiropractor,
32 psychologist, pharmacist, certified fee-based practicing pastoral counselor,
33 advanced practice nurse, licensed marriage and family therapist, or physician
34 assistant."

35 **SECTION 3.** Section 2 of this act becomes effective January 1, 2012. The
36 remainder of this act becomes effective October 1, 2011.



SENATE BILL 656: Right to Choose Physical Therapist

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Sen. Davis
Analysis of: PCS to First Edition
S656-CSTK-24

Date: June 3, 2011
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY:

The PCS to 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.

BACKGROUND:

G.S. §58-50-30 lists the various provider types from which a policy holder, insured, or beneficiary has the right to choose the provider of services under a health benefit plan, subscriber contract, or policy of insurance. The services must be of a nature that the benefit plan, contract, or policy provides coverage of, or payment or reimbursement for the services. If the plan requires use of network providers, the policy holder must choose a provider of services within the network. If the plan requires use of network providers as a condition of obtaining a higher level of benefits, the policy holder 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 of insurance 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 policy holder has the right to choose the provider of services.

BILL ANALYSIS:

Senate Bill 656 defines a "duly licensed physical therapist" as a person licensed by the North Carolina Board of Physical Therapy Examiners pursuant to Article 18B of Chapter 90 of the General Statutes.

Senate Bill 656 amends G.S. §58-50-30 to include "a duly licensed physical therapist" to the list of providers from which a policy holder, insured, or beneficiary has the right to choose the provider of services under a health benefit plan, subscriber contract, or policy of insurance.

Section 2 of Senate Bill 656 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:

Section 2 of this act becomes effective January 1, 2012. The remainder of this act becomes effective October 1, 2011.

S656-SMTK-39(CSTK-24) v3

PUBLIC BILL

S.B. 656

SESSION LAW _____

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT PATIENTS HAVE THE RIGHT TO CHOOSE THEIR PHYSICAL THERAPISTS
UNDER THEIR HEALTH BENEFIT PLANS.

Introduced by Senator(s)

Davis

J. Davis

Bill Baker *Purcell*

Principal Clerk's Use Only

FILED APR 19 2011

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APR 20 2011

AND REFERRED TO COMMITTEE

ON: Insurance

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 738
PROPOSED COMMITTEE SUBSTITUTE S738-CSRG-19 [v.6]

6/6/2011 9:47:56 PM

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.A. 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:

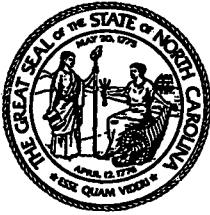
"§ 18B-123.B. Notification of lapse or cancellation required.

An insurance company that issues a policy of liability insurance under G.S. 18B-123.A 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.



* S 7 3 8 - C S R G - 1 9 - V - 6 *



SENATE BILL 738: Liability Insurance Required for ABC Permits

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Sen. Goolsby
Analysis of: Proposed Committee Substitute
S738-CSR-19

Date: June 6, 2011
Prepared by: Tim Hovis
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.A 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 or cancellation of liability insurance coverage.

Section 3 adds G.S. 18B-123.B 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.A 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-31(e1) v5

PUBLIC BILL

S.B. 738

SESSION LAW _____

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT ANY PERSON OR ESTABLISHMENT THAT HOLDS AN ALCOHOL BEVERAGE CONTROL PERMIT HAVE AT LEAST ONE MILLION DOLLARS IN LIABILITY INSURANCE.

Introduced by Senator(s)

Paul E. H. H.

Goolsby

A. S. Goolsby

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APR 20 2011

AND REFERRED TO COMMITTEE

ON: Insurance

VISITOR REGISTRATION SHEET

INSURANCE

June 6, 2011

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jay Peters	JPASSOC
Katherine Ross	PPAB
Jake Cashion	NC Chamber
Philip T. Long	NCA
M. Foster	PRZeb
Chris Valauri	NC Beer & Wine Wholesalers
Matt Twiford	Democracy NC
Dana Fenton	City of Charlotte
Kathryn Westcott	ACEC/NC
Laetitia Cheltenham	NMMS
Amit Bhagwandass	NMMS

VISITOR REGISTRATION SHEET

INSURANCE	June 6, 2011
Name of Committee	Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ken Lewis	First Cardiac Care
Paul Stone	NCSDA
DR. Matt Hensley	HeartWalkers Physical Therapy Specialists
BRUCE CASCIERE	ELECTROCARDIOLOGIC TESTING SERVICES
Jesse Miller	Self
Fred Gregory	ABC
Robert Paschal	Young Moore
Sherman McCoy	Nationwide
Ed Smith	Brooks Nurse
Tom Fitzgerald	Fitzgerald Strategic
Swan Vick	FSP
Andy Ellen	NCLM

VISITOR REGISTRATION SHEET

INSURANCE	June 6, 2011
Name of Committee	Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DAN A. MYERS, M.D.	1106 WALKER DRIVE, KINSTON NC 28501
James Norment	Ward and South PA, Raleigh
Emily Grimm	MNC
John Derrin	Governor's Office
Rose Williams	NC DOI /
Jean Holliday	NC DOI
Chris Evans	BCBSNC
Kathryn Mellican	BCBSNC
Mark Elmy	BCBSNC
Ken Melton	K.M.A.
Gutcoy	WMRS

VISITOR REGISTRATION SHEET

INSURANCE

June 6, 2011

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 Ins 411 W. Chapel Hill Durham
Steven Sawyer	Medical Mutual Ins Co of NC Raleigh, NC
Dale Jenkins	Medical Mutual Insurance Co of N.C.
Gary Harris	NC Petroleum & Convenience Mktrs
MICHAEL HEAVY	SMITH ANDERSON
Amy Whited	NC Med Society
BJ Miller	Cone Health
Man W. W.	Norant
Mary Bocock	AHIP
Paul Fultz	NCAJ
Piggie Potter	NCPDA & NCDS

VISITOR REGISTRATION SHEET

INSURANCE	June 6, 2011
Name of Committee	Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barton Candler	BSCOR
John Bowditch	Astra Zeneca
Harry Kopf	MWC
Lois Atanes	LATA
Daniel Baum	TRATMAN SANDERS
Chp Bryant	NCRMS
Dana Am	QA
Bill Scoborn	TIS
Jeri Hays	NCHBA
Elizabeth Robinson	NCRMA
Jennifer Wu	IT-NC

SENATE INSURANCE COMMITTEE
Thursday, June 9th at 8:00 AM
Room 1124, Legislative Building

MINUTES

The Senate Insurance Committee met at 8:07 AM on June 9th, 2011, in Room 1124 of the Legislative Building. Eleven members of the committee were present. Senator's Apodaca and Meredith presided. Tucker Loflin from Greensboro, Addie Griffin from Louisburg, Mariah Bishop from Apex, Ashley Gorman from Greensboro; Bethany Spivey from Greensboro.

H.B. 298- Insurance Amendments- AB

Senator Apodaca recognized Tim Hovis, NCGA Staff, to explain the bill. Senator Hise made a motion for a favorable report to the House Committee Substitute bill. The summary and House Committee Substitute is attached.

S.B. 236- Local Events Priority/Convention Center

Senator Apodaca recognized Senator White's motion to consider the PCS of SB 236. Senator Apodaca recognized Senator Goolsby to explain the local bill. Senator Meredith moved for an unfavorable report to the original bill, but favorable to the PCS. The PCS and summary is attached.

H.B. 709- Protect and Put NC Back to Work

Senator Apodaca recognized Representative Folwell to explain the bill. Paul Cooley, Advocates for Justice, spoke to endorse the bill. John McAllister, NC Chamber, spoke to endorse the bill. Andy Ellen, Retail Merchants, spoke to endorse the bill. Chip Baggett, NC Medical Society, spoke to endorse the bill. James Andrew, AFLCIO, spoke to endorse the bill. Rep. Hager spoke as a co-sponsor to endorse the bill. Senator Jackson made a motion for favorable report as to the House Committee Substitute Bill and the motion passed. The House Committee Substitute, summary, and press release from Representative Dale Folwell is attached.

S.B. 656- Right to Choose Physical Therapist

Senator Apodaca recognized Senator Gunn. Senator Gunn's motion to bring the PCS before the committee passed. Senator Davis was recognized to give a summary of the bill. Senator East moved unfavorable as to the original bill and favorable as to the PCS. The motion passed. The PCS and summary are attached.

S.B. 744- Transparency in the Cost of Health Care

Senator Apodaca recognized Senator Newton's motion to consider the PCS and the motion passed. Senator Goolsby was recognized to explain the PCS. Amy Jo Johnson, NCGA staff, was recognized to provide a summary of the PCS. Harry Kaplan, NC Association of

Health Plans, endorsed the bill. Senator Gunn moved unfavorable to the original bill, favorable as to the PCS. The PCS and summary is attached.

The meeting adjourned at 9:01 AM.

A large, stylized handwritten signature in black ink, likely belonging to Senator Tom Apodaca.

Senator Tom Apodaca, Presiding Chair
Senate Insurance Committee

A handwritten signature in black ink, likely belonging to Nicole McGuinness.

Nicole McGuinness, Committee Clerk

A handwritten signature in black ink, likely belonging to Debbie Lown.

Debbie Lown, Committee Clerk

Senate Insurance Committee
Thursday, June 9, 2011, 8:00 AM
1027 LB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 298	Insurance Amendments.-AB	Representative Dockham
HB 709	Protect and Put NC Back to Work.	Representative Folwell
		Representative Crawford, Jr.
		Representative Dollar
		Representative Hager
SB 656	Right to Choose Physical Therapist.	Senator Davis
SB 744	Transparency in the Cost of Health Care.	Senator Goolsby

Presentations

Other Business

Adjournment

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

**INSURANCE COMMITTEE REPORT
Senator Tom Apodaca, Co-Chair
Senator Wesley Meredith, Co-Chair**

Thursday, June 09, 2011

Senator MEREDITH,
submits the following with recommendations as to passage:

FAVORABLE

H.B.	298	Insurance Amendments.-AB	
		Sequential Referral:	None
		Recommended Referral:	None
H.B.(CS #1)	709	Protect and Put NC Back to Work.	
		Sequential Referral:	None
		Recommended Referral:	None

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B.	236	9th Senatorial District Local Act.	
		Draft Number:	75181
		Sequential Referral:	None
		Recommended Referral:	None
		Long Title Amended:	Yes
S.B.	656	Right to Choose Physical Therapist.	
		Draft Number:	35271
		Sequential Referral:	None
		Recommended Referral:	None
		Long Title Amended:	No
S.B.	744	Transparency in the Cost of Health Care.	
		Draft Number:	85222
		Sequential Referral:	None
		Recommended Referral:	None
		Long Title Amended:	No

TOTAL REPORTED: 5

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H

D

HOUSE BILL 298
Committee Substitute Favorable 4/27/11
PROPOSED COMMITTEE SUBSTITUTE H298-PCS50347-SVf-18

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 of 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



1 awarded by the Commissioner under this subsection a standard clause which provides that the
2 State Auditor and internal auditors of the Commissioner may audit the records of the contractor
3 during the term of the agreement or contract to verify accounts and data affecting fees and
4 performance. The Commissioner shall not award a cost plus percentage of cost agreement or
5 contract for any purpose."

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

8 **"§ 58-2-31. Seniors' Health Insurance Information Program.**

9 The Seniors' Health Insurance Information Program is established within the Department as
10 a statewide health benefits counseling program to provide the State's Medicare beneficiaries
11 with counseling in Medicare, Medicare supplement insurance, long-term care insurance, and
12 related health care coverage plans."

13 **SECTION 3.** G.S. 58-3-150 reads as rewritten:

14 **"§ 58-3-150. Forms to be approved by Commissioner.**

15 (a) It is unlawful for any insurance company licensed and admitted to do business in
16 this State to issue, sell, or dispose of any policy, contract, ~~or~~ certificate, or certificate of
17 insurance, or use applications in connection therewith, until the forms of the same have been
18 submitted to and approved by the Commissioner, and copies filed in the Department. If a policy
19 form filing is disapproved by the Commissioner, the Commissioner may return the filing to the
20 filer. As used in this section, "policy form" includes endorsements, riders, or amendments to
21 policies that have already been approved by the Commissioner.

22 (b) With respect to group and blanket accident and health insurance, group life
23 insurance, and group annuity policies issued and delivered to a trust or to an association outside
24 of this State and covering persons resident in this State, the group certificates to be delivered or
25 issued for delivery in this State shall be filed with and approved by the Commissioner pursuant
26 to subsection (a) of this section.

27 (c) If not submitted electronically, all contracts, literature, advertising materials, letters,
28 and other documents submitted to the Department to comply with the filing requirements of
29 this Chapter or an administrative rule adopted pursuant to this Chapter shall be submitted on
30 paper eight and one-half inches by eleven inches. Brochures and pamphlets shall not be stapled
31 or bound.

32 (d) As used in this section, "certificate of insurance" means a document prepared or
33 issued by an insurance company or producer that is used to verify or evidence the existence of
34 property or casualty insurance coverage. "Certificate" or "certificate of insurance" shall not
35 include a document prepared or issued by an insurance company or producer that is used to
36 verify or evidence the existence of property insurance provided to a lender covering real or
37 personal property which serves as the lender's security for commercial mortgages. For
38 purposes of this section, "commercial mortgages" shall mean mortgages or other instruments
39 given for the purpose of creating a lien encumbering office, multiunit residential, apartments,
40 commercial, or industrial properties. Commercial mortgages shall not include a lien
41 encumbering one- to four-family residential properties.

42 (e) A certificate of insurance is not a policy of insurance and does not amend, extend,
43 or alter the coverage afforded by the policy to which the certificate of insurance makes
44 reference. A certificate of insurance shall not confer to a certificate of insurance holder new or
45 additional rights beyond what the referenced policy of insurance expressly provides.

46 (f) It is unlawful for any person to knowingly prepare, issue, request, or require a
47 certificate of insurance that meets any of the following criteria:

48 (1) Has not been filed with and approved by the Commissioner.

49 (2) Contains any false or misleading information concerning the policy of
50 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 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) "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

1 of the child. Nothing in this section shall require an insurer to offer nondependent child
2 coverage or maternity coverage within an offer of nondependent child coverage.

3 (c) The Commissioner shall adopt rules as necessary or proper to implement the
4 provisions of this section.

5 (d) Nothing in this section shall prohibit an insurer from adjusting the initial premium
6 charged an individual afforded coverage under this section based upon medical underwriting to
7 the extent that such an adjustment is in compliance with the applicable product's current rate
8 filing approved by the Commissioner."

9 SECTION 6. G.S. 58-12-2 reads as rewritten:

10 "§ 58-12-2. Definitions.

11 As used in this Article, the following terms have the following meanings:

- 12 (1) Adjusted risk-based capital report. – A risk-based capital report that has been
13 adjusted by the Commissioner under G.S. 58-12-6.
- 14 (2) Corrective order. – An order issued by the Commissioner specifying
15 corrective actions that the Commissioner has determined are required.
- 16 (3) Domestic insurer. – Any insurance company or health organization
17 organized in this State under ~~Article 7,~~ Article 7 of this Chapter as specified
18 in subdivisions (4b) and (5a) of this section or under Article 15, 65, or 67 of
19 this Chapter.
- 20 (4) Foreign insurer. – Any insurance company or health organization that is
21 admitted to do business in this State under Article 16 or 67 of this Chapter
22 but is not domiciled in this State.
- 23 (4a) Health organization. – Any insurer which is required by the Commissioner
24 to use the NAIC Health Annual Statement Blank when filing the annual
25 statement prescribed by G.S. 58-2-165 or any health maintenance
26 organization, limited health service organization, dental or vision plan,
27 hospital, medical, or dental indemnity or service corporation, or other
28 organization licensed under Article 65 or 67 of this Chapter. "Health
29 organization" does not include an insurer that is licensed as either a life or
30 health insurer or a property or casualty insurer under this Chapter and that is
31 otherwise subject to either the life or property and casualty risk-based capital
32 requirements.
- 33 (4b) Life or health insurer. – Any insurance company licensed to write the kinds
34 of insurance specified in G.S. 58-7-15(1), (2), or (3); or a licensed property
35 and casualty insurer writing only the kinds of insurance specified in
36 G.S. 58-7-15(3). "Life or health insurer" does not mean any insurer that is
37 required by the Commissioner to use the NAIC Health Annual Statement
38 Blank when it files the annual statement prescribed by G.S. 58-2-165.
- 39 (5) Negative trend. – A negative trend, with respect to a life or health insurer,
40 over a period of time, as determined in accordance with the "trend test
41 calculation" included in the risk-based capital instructions.
- 42 (5a) Property or casualty insurer. – Any insurance company licensed to write the
43 kinds of insurance specified in G.S. 58-7-15(4) through (22); but not
44 monoline mortgage guaranty insurers, financial guaranty insurers, or title
45 ~~insurers; insurers;~~ nor any insurer that is required by the Commissioner to use
46 the NAIC Health Annual Statement Blank when filing the annual statement
47 prescribed by G.S. 58-2-165.
- 48 (6) Risk-based capital instructions. – The risk-based capital report including
49 risk-based capital instructions adopted by the NAIC, as those risk-based
50 capital instructions may be amended by the NAIC from time to time in
51 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:
- "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.
 - "Regulatory action level risk-based capital" means the product of 1.5 and its authorized control level risk-based capital.
 - "Authorized control level risk-based capital" means the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.
 - "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:
- 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
 - 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:

- The filing of a risk-based capital report by an insurer that indicates that:
 - 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~~
 - ~~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
 - 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.
- 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.
- 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)

1 include in all contracts to be awarded by the Commissioner under this
2 subdivision a standard clause which provides that the State Auditor and
3 internal auditors of the Commissioner may audit the records of the
4 contractor during the term of the contract to verify accounts and data
5 affecting fees and performance. The Commissioner shall not award a cost
6 plus percentage of cost contract for any purpose.

7 (6) In addition to the examinations for the kinds of insurance specified in
8 G.S. 58-33-25(c)(1) and (2), before any resident may sell Medicare
9 supplement or long-term care insurance policies defined respectively in
10 Articles 54 and 55 of this Chapter, the resident must take and pass a
11 supplemental written examination according to requirements prescribed by
12 the Commissioner.

13 (7) An individual who fails to appear for the examination as scheduled or fails
14 to pass the examination shall reapply for an examination and remit all
15 required fees and forms before being rescheduled for another examination."

16 **SECTION 10.** Article 4 of Chapter 97 of the General Statutes reads as rewritten:

17 "Article 4.

18 "North Carolina Self-Insurance Security Association.

19 **"§ 97-130. Definitions.**

20 As used in this Article:

21 (1) "Association" means the North Carolina Self-Insurance Security Association
22 established by G.S. 97-131.

23 (1a) "Association Aggregate Security System" means the security system
24 established by the Association under G.S. 97-133 whereby individual
25 self-insurers collectively secure their aggregate self-insured workers'
26 compensation liabilities through the North Carolina Self-Insurance Security
27 Association.

28 (2) "Board" means the Board of Directors of the Association established by
29 G.S. 97-132.

30 (3) "Commissioner" means the North Carolina Commissioner of Insurance.

31 (4) "Covered claim" means an unpaid claim against an insolvent individual
32 self-insurer or group self-insurer that relates to an injury that occurs while
33 the individual self-insurer or group self-insurer is a member of the
34 Association and that is compensable under this Chapter.

35 (5) "Fund" means the North Carolina Self-Insurance Security Fund established
36 by G.S. 97-133.

37 (5a) "Group" or "Group self-insurer" means a group self-insurer licensed by the
38 Commissioner under Part 1, Article 47 of Chapter 58 of the General Statutes.

39 (5b) "Individual self-insurer" means an individual employer licensed by the
40 Commissioner under Article 5 of this Chapter.

41 (6) "Member self-insurer" or "member" means an individual self-insurer or
42 group self-insurer that is required to be a member of the Association under
43 this Article or Part 1, Article 47 of Chapter 58 of the General Statutes.

44 (7) "Plan" means the Plan of Operation authorized by G.S. 97-134.

45 (8) Repealed by Session Laws 2005-400, s. 1.2, effective January 1, 2006.

46 (9) "Servicing facility" means those persons delegated by the Board ~~and~~
47 ~~approved by the Commissioner~~ to settle or compromise claims and to
48 expend Fund assets to pay claims.

49 **"§ 97-131. Creation.**

50 ...

(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

1 authorized to secure insurance, primary excess insurance, reinsurance,
2 bonds, other insurance, financial guarantees and related financial instruments
3 to effectuate the purposes of the Association. The Board will invest the Fund
4 assets pursuant to an investment policy adopted by the Board and reviewed
5 and approved annually by the Department of the State Treasurer. The
6 earnings from investment of Fund assets shall be placed in or credited to the
7 Fund.

8 (2) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

9 (2a) ~~Establish, operate, and maintain~~ Establish and operate the Association
10 Aggregate Security System as defined in G.S. 97-130 and G.S. 97-165 as
11 follows:

12 a. ~~The Association shall annually prepare and submit to the~~
13 ~~Commissioner a written plan to operate and~~ provide an Association
14 Aggregate Security System through a combination of cash on deposit
15 in the Fund, securities, surety bonds, irrevocable letters of credit,
16 ~~insurance-insurance, reinsurance,~~ or other financial instruments or
17 guarantees owned or entered into by the Association and acceptable
18 ~~to the Commissioner.~~ Association. ~~The written plan shall include, but~~
19 ~~not be limited to, (i) a description of the institutions that will issue or~~
20 ~~guarantee the securities, surety bonds, irrevocable letters of credit,~~
21 ~~insurance or other financial instruments or guarantees, including, but~~
22 ~~not limited to, the credit rating, financial strength, and AM best~~
23 ~~rating, if applicable to the institutions (ii) applicable cash flow~~
24 ~~information and financial assumptions (iii) a description of the~~
25 ~~methodology to be used by the Association to assess and collect the~~
26 ~~Association Aggregate Security System assessments to be made~~
27 ~~pursuant to subdivision (3a) of this subsection and (iv) a proposed~~
28 ~~timetable for the release of existing individual company deposits~~
29 ~~posted pursuant to G.S. 97-185(e), provided, however, that no~~
30 ~~individual company deposits posted pursuant to G.S. 97-185(e) shall~~
31 ~~be released without the written consent of the Commissioner. The~~
32 ~~noncash elements of the composite security may be one year or~~
33 ~~multiple year instruments.~~

34 b. ~~Within 90 days following the submission of the initial plan under~~
35 ~~sub-subdivision a. of this subdivision, the Commissioner shall either~~
36 ~~approve or disapprove the initial plan and shall notify the Association~~
37 ~~in writing. If the Commissioner does not approve or disapprove the~~
38 ~~initial plan within 90 days following submission, then the initial plan~~
39 ~~shall be deemed to be approved by the Commissioner. All~~
40 ~~subsequent plans shall be either approved or disapproved within 60~~
41 ~~days following submission.~~

42 c. ~~The Commissioner shall also determine the total undiscounted claims~~
43 ~~liability of each individual self insurer that will participate in the~~
44 ~~Association Aggregate Security System as well as the aggregate total~~
45 ~~undiscounted outstanding claims liabilities of all the individual~~
46 ~~self insurers that are to participate in the Association Aggregate~~
47 ~~Security System and shall notify the Association of this~~
48 ~~determination.~~

49 d. ~~Upon approval by the Commissioner of the Association's plan for the~~
50 ~~Association Aggregate Security System, the~~ The Association shall
51 assess the individual self-insurers that participate in the Association

- 1 Aggregate Security System pursuant to subdivision (3a) of this
2 subsection.
- 3 e. ~~If the Commissioner disapproves the plan for any year, If the~~
4 ~~Association determines it is not feasible or practical to operate the~~
5 ~~Association Aggregate Security System in any given year, it may~~
6 ~~terminate or suspend the Association Aggregate Security System and~~
7 ~~shall notify the Commissioner at least 90 days prior to the~~
8 ~~termination or suspension of the Association Aggregate Security~~
9 ~~System for that particular year. During any period that the Associate~~
10 ~~Aggregate Security System is terminated or suspended, every~~
11 self-insurer shall deposit with the Commissioner, or continue to
12 deposit, the amount required by G.S. 97-185(b3) in the manner
13 prescribed by G.S. 97-185(c).
- 14 f. Group self-insurers shall not participate in the Association Aggregate
15 Security System.
- 16 (3) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.
- 17 (3a) Assess members of the Association as follows:
- 18 a. Association Aggregate Security System assessments. – The
19 Association shall assess each individual self-insurer participating in
20 the Association Aggregate Security System a security system
21 assessment. The amount of the security system assessment charged to
22 each individual self-insurer participating in the Association
23 Aggregate Security System shall be based on the Association's
24 reasonable consideration of all of the following factors:
- 25 1. The total amount of assessments necessary to provide
26 aggregate security for all participating individual
27 self-insurers.
- 28 2. The individual self-insurer's total workers' compensation
29 liabilities under the Act.
- 30 3. The financial strength and creditworthiness of the
31 participating individual self-insurer.
- 32 4. Any other relevant factors.
- 33 b. Special assessment. – In the event that there are covered claims
34 against an insolvent member or members and the assets of the Fund
35 are not sufficient to pay the obligations of the Association, then the
36 Association may collect a special assessment from the members in an
37 amount sufficient to pay the aggregate value of such covered claims.
38 Each member's special assessment shall be determined by the Board
39 and shall be based on the proportion of the member's total obligations
40 under the Act to the aggregate total of all members' obligations under
41 the Act.
- 42 c. Initial assessments. – An individual self-insurer that becomes a
43 member and does not initially participate in the Association
44 Aggregate Security System shall pay an initial assessment to the
45 Association in an amount determined by the Board. A group
46 self-insurer, upon receiving its initial license from the Commissioner,
47 shall pay an initial assessment to the Association in an amount
48 determined by the Board.
- 49 d. Each member shall be notified of assessments no later than 30 days
50 before the assessment is due.

- 1 e. Delinquent assessments, except as otherwise provided, shall bear
2 interest at a rate to be established by the Board.
- 3 f. Group assessments. – The Association may annually assess each
4 member group self-insurer in an amount not to exceed two percent
5 (2%) of the group self-insurer's annual gross premiums for the
6 preceding calendar year, as determined under G.S. 105-228.5(b),
7 (b1), and (c).
- 8 (4) Be obligated to pay covered claims.
- 9 (5) After paying any covered claim, be subrogated to the rights of the injured
10 employee and dependents and be entitled to enforce liability against the
11 self-insurer or any third party by any appropriate action brought in its own
12 name or in the name of the injured employee and dependents.
- 13 (6) Expend Fund assets in amounts necessary to pay all of the following:
- 14 a. The obligations of the Association under this Article subsequent to
15 an insolvency.
- 16 b. The expenses of handling covered claims subsequent to an
17 insolvency.
- 18 c. The cost of examinations under G.S. 97-137.
- 19 d. The costs of implementing and operating the Association Aggregate
20 Security System.
- 21 e. All other expenses authorized by this Article.
- 22 (7) Investigate claims brought against the Association and adjust, compromise,
23 settle, and pay covered claims to the extent of the Association's obligation;
24 and deny all other claims. The Association may review settlements to which
25 the insolvent member was a party to determine the extent to which such
26 settlements may be properly contested.
- 27 (8) Notify such persons as the Commissioner directs under G.S. 97-136.
- 28 (9) Handle claims through its directors, its employees, or through one or more
29 members or other persons designated as servicing facilities. Designation of a
30 ~~servicing facility is subject to the approval of the Commissioner, but~~
31 ~~designation~~ of a member as a servicing facility may be declined by such
32 member.
- 33 (10) Reimburse each servicing facility for obligations of the Association paid by
34 the facility and for expenses incurred by the facility while handling claims
35 on behalf of the Association.
- 36 (11) Pay any other expenses of the Association authorized by this section.
- 37 (12) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.
- 38 (13) Require each member to annually determine its total undiscounted workers'
39 compensation claims liability and require each member to notify the
40 Association of this determination.
- 41 (b) The Association may:
- 42 (1) Employ or retain such persons, including, but not limited to, adjustors,
43 brokers, accountants, attorneys, financial advisors, investment bankers,
44 placement agents, and consultants, as the Board may determine are
45 necessary to handle claims, perform other duties of, provide services to, and
46 consult with the Association.
- 47 (2) Borrow funds necessary to effect the purposes of this Article in accord with
48 the Plan, including entering into standby lines of credit.
- 49 (3) Sue or be sued.
- 50 (4) Negotiate and become a party to such contracts as are necessary to carry out
51 the purpose of this section.

- 1 (5) Perform such other acts as are necessary or proper to effectuate the purpose
2 of this section.
- 3 (6) ~~Reimburse the Department of Insurance up to twenty thousand dollars~~
4 ~~(\$20,000) for consultants retained by the Department to review the initial~~
5 ~~plan submitted pursuant to G.S. 97-133(a)(2a).~~
- 6 (c) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.
- 7 (c1) The Association shall provide in its Plan that the functions of administration and
8 adjusting claims shall not be performed by the same entity that provides legal representation to
9 the Association for claims.
- 10 (d) Repealed by Session Laws 2005-400, s. 4, effective January 1, 2006.

11 **"§ 97-134. Plan of Operation.**

12 The Plan is as follows:

- 13 (1) ~~The Association Board shall submit to the Commissioner adopt a Plan of~~
14 ~~Operation and any amendments necessary or suitable to assure the fair,~~
15 ~~reasonable, and equitable administration of the Association. The Plan and~~
16 ~~any amendments become effective upon approval in writing by the~~
17 ~~Commissioner. If the Association at any time fails to submit a suitable Plan~~
18 ~~or suitable amendment to the Plan the Commissioner shall, after notice and~~
19 ~~hearing, adopt such reasonable rules as are necessary or advisable to~~
20 ~~effectuate this Article. The rules shall continue in force until modified by the~~
21 ~~Commissioner or superseded by a Plan submitted by the Association and~~
22 ~~approved by the Commissioner.~~
- 23 (2) All member self-insurers shall comply with the Plan.
- 24 (3) The Plan shall:
- 25 a. Establish the procedures whereby all the powers and duties of the
- 26 Association under G.S. 97-133 will be performed.
- 27 b. Establish procedures for investing and managing Fund assets.
- 28 c. Adopt a reasonable mechanism and procedure to achieve equity in
- 29 assessing members under G.S. 97-133.
- 30 d. Establish the amount and method of reimbursing members of the
- 31 Board under G.S. 97-132.
- 32 e. Establish procedures by which claims may be filed with the
- 33 Association and establish acceptable forms of proof of covered
- 34 claims.
- 35 f. Establish regular places and times for meetings of the Board.
- 36 g. Establish procedures for records to be kept of all financial
- 37 transactions of the Association, its agents, and the Board.
- 38 h. Provide that any member self-insurer aggrieved by any final action or
- 39 decision of the Association may appeal to the Commissioner within
- 40 30 days after the action or decision.
- 41 ~~i. Establish the procedures whereby selections for the Board shall be~~
42 ~~submitted to the Commissioner.~~
- 43 j. Contain additional provisions necessary or proper for the execution
- 44 of the powers and duties of the Association.

45 ...
46 **"§ 97-136. Powers and duties of the Commissioner.**

47 (a) The Commissioner shall:

- 48 (1) Notify the Association of the existence of an insolvent member self-insurer
49 not later than 30 days after he receives notice of an insolvency pursuant to
50 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

- 1 becomes effective July 1, 2012, and applies to licenses issued on or after that date. The
- 2 remainder of this act is effective when it becomes law.



HOUSE BILL 298: Insurance Amendments.-AB

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Rep. Dockham
Analysis of: Third Edition

Date: June 8, 2011
Prepared by: Tim Hovis
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.*

BILL SUMMARY: 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 defined as a document prepared or issued by an insurer short summary of a policy provided by an insurer upon request to verify the existence of property coverage. The bill provides that a certificate of insurance "shall not include a document prepared or issued by an insurance company or producer that is used to verify or evidence the existence of property insurance provided to a lender covering real or personal property which serves as the lender's security for commercial mortgages." The term "commercial mortgages" means "mortgages or other instruments given for the purpose of creating a lien encumbering office, multi-unit residential, office, apartments, commercial or industrial properties" and does not include a lien encumbering one-to-four family residential properties.

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.

House Bill 298

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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 multiline limited assessable 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, these 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-34(e3) v1

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

S

D

**SENATE BILL 236
PROPOSED COMMITTEE SUBSTITUTE S236-PCS75181-RW-54**

Short Title: Local Events Priority/Convention Center.

(Public)

Sponsors:

Referred to:

March 8, 2011

**A BILL TO BE ENTITLED
AN ACT TO GIVE PRIORITY TO LOCAL EVENTS AT SPECIFIED PUBLICLY OWNED
CONVENTION CENTERS.**

The General Assembly of North Carolina enacts:

SECTION 1. Definitions. – The following definitions apply in this act:

- (1) **Black-out period.** – A period provided in a booking contract during which a directly competing event can be blocked from using the same publicly owned convention facility as the event provided for in the booking contract.
- (2) **External event.** – An exhibition or event planned, coordinated, financed, and promoted by a sponsor whose principal business location is outside the jurisdiction of the public owner/operator and which utilizes fewer than 500 hotel room nights.
- (3) **Local event.** – An exhibition or event planned, coordinated, financed, and promoted by a local sponsor which utilizes fewer than 500 hotel room nights.
- (4) **Local sponsor.** – An organization the principal business location of which is located within the jurisdiction of the public owner/operator, with a membership of at least 100 businesses and individuals, with at least ten percent (10%) of its membership being composed of local businesses or individuals subject to the taxing authority of the public owner/operator, and with an annual budget averaged over the preceding three years of no less than one hundred fifty thousand dollars (\$150,000).
- (5) **Public owner/operator.** – A city government subject to Chapter 160A of the General Statutes or a county government subject to Chapter 153A of the General Statutes with a population, as measured in the most recent census, of at least 100,000 and no more than 300,000 or regional authorities comprised of two or more city or county governments representing a cumulative population of at least 250,000 and no more than 500,000 that own or operate a publicly owned convention facility.
- (6) **Publicly owned convention facility.** – A convention or civic center facility for which at least fifty percent (50%) of the cost of construction was paid for, or guaranteed, by public funds, including, without limitation, special purpose or general obligation bonds.



1 **SECTION 2.** Publicly Owned Convention Center Booking Policy. – Any public
2 owner/operator shall promulgate and enforce booking policies for its publicly owned
3 convention facility which accommodate the needs of local sponsors. Such booking policies
4 shall provide a higher priority category for local events than for external events. This
5 requirement shall not be interpreted to require priority for local events over priority categories
6 based on utilization of 500 or more hotel room nights. Any booking policy and any
7 management agreement entered into by the public owner/operator shall require:

- 8 (1) That a priority category be created for local events, distinct from external
9 events.
10 (2) That the priority category for local events provide at a minimum that local
11 events cannot be blocked by tentative scheduling of other local events or
12 external events.
13 (3) That black-out periods be limited to periods of 30 days or less before and
14 after the event for local events and external events.

15 **SECTION 2.** This act is effective when it becomes law.



SENATE BILL 236: Local Events Priority/Convention Center

2011-2012 General Assembly

Committee: Rules and Operations of the Senate
Introduced by: Sen. Goolsby
Analysis of: First Edition

Date: June 8, 2011
Prepared by: Giles S. Perry
Committee Counsel

SUMMARY: *Senate Bill 236 (proposed committee substitute) gives priority to local events at specified publicly owned convention centers.*

BILL ANALYSIS:

Senate Bill (PCS) 236 provides that:

- A public owner/operator of a publicly owned convention facility must use booking policies that accommodate the needs of local sponsors.
- The booking policies must provide a higher priority category for local events than for external events. This requirement shall not be interpreted to require priority for local events over priority categories based on utilization of 500 or more hotel room nights.
- Any booking policy and any management agreement entered into by the public owner require:
 - That a priority category be created for local events, distinct from external events.
 - That the priority category for local events provide at a minimum that local events cannot be blocked by tentative scheduling of other local events or external events.
 - That black out periods be limited to periods of 30 days or less before and after the event for local events and external events.

EFFECTIVE DATE: This act is effective when it becomes law.

S236-SMRW-149(e1) v3

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H

2

HOUSE BILL 709*
Committee Substitute Favorable 5/27/11

Short Title: Protect and Put NC Back to Work.

(Public)

Sponsors:

Referred to:

April 7, 2011

A BILL TO BE ENTITLED
AN ACT PROTECTING AND PUTTING NORTH CAROLINA BACK TO WORK BY
REFORMING THE WORKERS' COMPENSATION ACT.

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known as the "Protecting and Putting North Carolina Back to Work Act."

SECTION 2. G.S. 97-2 reads as rewritten:

"§ 97-2. Definitions.

When used in this Article, unless the context otherwise ~~requires~~ requires:

...
(19) **Medical Compensation.** – The term "medical compensation" means medical, surgical, hospital, nursing, and rehabilitative ~~services~~ services, including, but not limited to, attendant care services prescribed by a health care provider authorized by the employer or subsequently by the Commission, vocational rehabilitation, and medicines, sick travel, and other treatment, including medical and surgical supplies, as may reasonably be required to effect a cure or give relief and for such additional time as, in the judgment of the Commission, will tend to lessen the period of disability; and any original artificial members as may reasonably be necessary at the end of the healing period and the replacement of such artificial members when reasonably necessitated by ordinary use or medical circumstances.

...
(22) **Suitable employment.** – The term "suitable employment" means employment offered to the employee or, if prohibited by the Immigration and Nationality Act, 8 U.S.C. § 1324a, employment available to the employee that (i) prior to reaching maximum medical improvement is within the employee's work restrictions, including rehabilitative or other noncompetitive employment with the employer of injury approved by the employee's authorized health care provider or (ii) after reaching maximum medical improvement is employment that the employee is capable of performing considering the employee's preexisting and injury-related physical and mental limitations, vocational skills, education, and experience and is located within a 50-mile radius of the employee's residence at the time of injury or the employee's current residence if the employee had a legitimate reason to relocate since the date of injury. No one factor shall be considered exclusively in determining suitable employment."



* H 7 0 9 - V - 2 *

1 **SECTION 3.** Article 1 of Chapter 97 of the General Statutes is amended by adding
2 a new section to read:

3 **"§ 97-12.1. Willful misrepresentation in applying for employment.**

4 No compensation shall be allowed under this Article for injury by accident or occupational
5 disease if the employer proves that (i) at the time of hire or in the course of entering into
6 employment, (ii) at the time of receiving notice of the removal of conditions from a conditional
7 offer of employment, or (iii) during the course of a post-offer medical examination:

8 (1) The employee knowingly and willfully made a false representation as to the
9 employee's physical condition;

10 (2) The employer relied upon one or more false representations by the
11 employee, and the reliance was a substantial factor in the employer's
12 decision to hire the employee; and

13 (3) There was a causal connection between false representation by the employee
14 and the injury or occupational disease."

15 **SECTION 4.** G.S. 97-17 is amended by adding a new subsection to read:

16 "(e) Nothing in this section prevents the parties from reaching a separate
17 contemporaneous agreement resolving issues not covered by this Article."

18 **SECTION 5.** G.S. 97-18 is amended by adding a new subsection to read:

19 "(k) In addition to any other methods for reinstatement of compensation available under
20 the Act, whenever the employer or insurer has admitted the employee's right to compensation,
21 or liability has been established, the employee may move for reinstatement of compensation on
22 a form prescribed by the Commission. If the employer or insurer contests the employee's
23 request for reinstatement, the matter shall be scheduled on a preemptive basis. This subsection
24 shall not apply to a request for a review of an award on the grounds of a change in condition
25 pursuant to G.S. 97-47."

26 **SECTION 6.** G.S. 97-25 reads as rewritten:

27 **"§ 97-25. Medical treatment and supplies.**

28 ~~Medical compensation shall be provided by the employer. In case of a controversy arising~~
29 ~~between the employer and employee relative to the continuance of medical, surgical, hospital,~~
30 ~~or other treatment, the Industrial Commission may order such further treatments as may in the~~
31 ~~discretion of the Commission be necessary.~~

32 ~~The Commission may at any time upon the request of an employee order a change of~~
33 ~~treatment and designate other treatment suggested by the injured employee subject to the~~
34 ~~approval of the Commission, and in such a case the expense thereof shall be borne by the~~
35 ~~employer upon the same terms and conditions as hereinbefore provided in this section for~~
36 ~~medical and surgical treatment and attendance.~~

37 Upon the written request of the employee to the employer, the employer may agree to
38 authorize and pay for a second opinion examination with a duly qualified physician licensed to
39 practice in North Carolina, or licensed in another state if agreed to by the parties or ordered by
40 the Commission. If, within 14 calendar days of the receipt of the written request, the request is
41 denied or the parties, in good faith, are unable to agree upon a health care provider to perform a
42 second opinion examination, the employee may request that the Industrial Commission order a
43 second opinion examination. The expense thereof shall be borne by the employer upon the
44 same terms and conditions as provided in this section for medical compensation.

45 Provided, however, if the employee so desires, an injured employee may select a health
46 care provider of the employee's own choosing to attend, prescribe, and assume the care and
47 charge of the employee's case subject to the approval of the Industrial Commission. In addition,
48 in case of a controversy arising between the employer and the employee, the Industrial
49 Commission may order necessary treatment. In order for the Commission to grant an
50 employee's request to change treatment or health care provider, the employee must show by a
51 preponderance of the evidence that the change is reasonably necessary to effect a cure, provide

1 relief, or lessen the period of disability. When deciding whether to grant an employee's request
2 to change treatment or health care provider, the Commission may disregard or give less weight
3 to the opinion of a health care provider from whom the employee sought evaluation, diagnosis,
4 or treatment before the employee first requested authorization in writing from the employer,
5 insurer, or Commission.

6 The refusal of the employee to accept any ~~medical, hospital, surgical or other treatment or~~
7 ~~rehabilitative procedure~~ medical compensation when ordered by the Industrial Commission
8 shall bar ~~said the~~ employee from further compensation until such refusal ceases, and no
9 compensation shall at any time be paid for the period of suspension unless in the opinion of the
10 Industrial Commission the circumstances justified the ~~refusal, in which case, the Industrial~~
11 ~~Commission may order a change in the medical or hospital service refusal.~~ Any order issued by
12 the Commission suspending compensation pursuant to G.S. 97-18.1 shall specify what action
13 the employee should take to end the suspension and reinstate the compensation.

14 If in an emergency on account of the employer's failure to provide ~~the medical or other care~~
15 ~~as herein specified~~ compensation, a physician other than provided by the employer is called to
16 treat the injured employee, the reasonable cost of such service shall be paid by the employer if
17 so ordered by the Industrial Commission.

18 ~~Provided, however, if he so desires, an injured employee may select a physician of his own~~
19 ~~choosing to attend, prescribe and assume the care and charge of his case, subject to the~~
20 ~~approval of the Industrial Commission."~~

21 SECTION 7. G.S. 97-25.6 reads as rewritten:

22 "§ 97-25.6. Reasonable access to medical information.

23 (a) Notwithstanding any provision of G.S. 8-53 to the contrary, and because discovery
24 is limited pursuant to G.S. 97-80, it is the policy of this State to protect the employee's right to a
25 confidential physician-patient relationship while allowing the parties to have reasonable access
26 to all relevant medical information, including medical records, reports, and information
27 necessary to the fair and swift administration and resolution of workers' compensation claims,
28 while limiting unnecessary communications with and administrative requests to health care
29 providers.

30 (b) As used in this section, "relevant medical information" means any medical record,
31 report, or information that is:

- 32 (1) restricted to the particular evaluation, diagnosis, or treatment of the injury or
33 disease for which compensation, including medical compensation, is sought;
34 (2) reasonably related to the injury or disease for which the employee claims
35 compensation; or
36 (3) related to an assessment of the employee's ability to return to work as a
37 result of the particular injury or disease.

38 (c) Relevant medical information shall be requested and provided subject to the
39 following provisions:

- 40 (1) Medical records. – An employer is entitled, without the express
41 authorization of the employee, to obtain the employee's medical records
42 containing relevant medical information from the employee's health care
43 providers. In a claim in which the employer is not paying medical
44 compensation to a health care provider from whom the medical records are
45 sought, or in a claim denied pursuant to G.S. 97-18(c), the employer shall
46 provide the employee with contemporaneous written notice of the request for
47 medical records. The employer shall provide the employee with a copy of
48 any records received in response to this request within 30 days of its receipt
49 by the employer.
50 (2) Written communications with health care providers. – An employer may
51 communicate with the employee's authorized health care provider in writing,

without the express authorization of the employee, to obtain relevant medical information not available in the employee's medical records. The employer shall provide the employee with contemporaneous written notice of the written communication. The employer may request the following additional information:

- a. The diagnosis of the employee's condition;
- b. The appropriate course of treatment;
- c. The anticipated time that the employee will be out of work;
- d. The relationship, if any, of the employee's condition to the employment;
- e. Work restrictions resulting from the condition;
- f. The kind of work for which the employee may be eligible;
- g. The anticipated time the employee will be restricted; and
- h. Any permanent impairment as a result of the condition.

The employer shall provide a copy of the health care provider's response to the employee within 10 business days of its receipt by the employer.

- (3) Oral communications with health care providers. – An employer may communicate with the employee's authorized health care provider by oral communication to obtain relevant medical information not contained in the employee's medical records, not available through written communication, and not otherwise available to the employer, subject to the following:

- a. The employer must give the employee prior notice of the purpose of the intended oral communication and an opportunity for the employee to participate in the oral communication at a mutually convenient time for the employer, employee, and health care provider.
- b. The employer shall provide the employee with a summary of the communication with the health care provider within 10 business days of any oral communication in which the employee did not participate.

(d) Additional Information Submitted by the Employer. – Notwithstanding subsection (c) of this section, an employer may submit additional relevant medical information not already contained in the employee's medical records to the employee's authorized health care provider and may communicate in writing with the health care provider about the additional information in accordance with the following procedure:

- (1) The employer shall first notify the employee in writing that the employer intends to communicate additional information about the employee to the employee's health care provider. The notice shall include the employer's proposed written communication to the health care provider and the additional information to be submitted.
- (2) The employee shall have 10 business days from the postmark or verifiable facsimile or electronic mail either to consent or object to the employer's proposed written communication.
- (3) Upon consent of the employee or in the absence of the employee's timely response, the employer may submit the additional information directly to the health care provider.
- (4) Upon making a timely objection, the employee may request a protective order to prevent the written communication, in which case the employer shall refrain from communicating with the health care provider until the Commission has ruled upon the employee's request. In deciding whether to allow the submission of additional information to the health care provider, in

part or in whole, the Commission shall determine whether the proposed written communication and additional information are pertinent to and necessary for the fair and swift administration and resolution of the workers' compensation claim and whether there is an alternative method to discover the information. If the Industrial Commission determines that any party has acted unreasonably by initiating or objecting to the submission of additional information to the health care provider, the Commission may assess costs associated with any proceeding, including reasonable attorneys' fees and deposition costs, against the offending party.

(e) Any medical records or reports that reflect evaluation, diagnosis, or treatment of the particular injury or disease for which compensation is sought or are reasonably related to the injury or disease for which the employee seeks compensation that are in the possession of a party shall be furnished to the requesting party by the opposing party when requested in writing, except for records or reports generated by a retained expert.

(f) Upon motion by an employee or the health care provider from whom medical records, reports, or information are sought, or with whom oral communication is sought, or upon its own motion, for good cause shown, the Commission may make any order which justice requires to protect an employee, health care provider, or other person from unreasonable annoyance, embarrassment, oppression, or undue burden or expense.

(g) Other forms of communication with a health care provider may be authorized by order of the Industrial Commission issued upon a showing that the information sought is necessary for the administration of the employee's claim and is not otherwise reasonably obtainable under this section.

(h) The employer may communicate with the health care provider to request medical bills or a response to a pending written request, or about nonsubstantive administrative matters without the express authorization of the employee.

(i) The Commission shall establish annually an appropriate medical fee to compensate health care providers for time spent communicating with the employer or employee. Each party shall bear its own costs for said communication.

(j) No cause of action shall arise and no health care provider shall incur any liability as a result of the release of medical records, reports, or information pursuant to this Article.

(k) For purposes of this section, the term "employer" means the employer, the employer's attorney, and the employer's insurance carrier or third-party administrator; and the term "employee" means the employee, legally appointed guardian, or any attorney representing the employee.

~~Notwithstanding the provisions of G.S. 8-53, any law relating to the privacy of medical records or information, and the prohibition against ex parte communications at common law, an employer or insurer paying medical compensation to a provider rendering treatment under this Article may obtain records of the treatment without the express authorization of the employee. In addition, with written notice to the employee, the employer or insurer may obtain directly from a medical provider medical records of evaluation or treatment restricted to a current injury or current condition for which an employee is claiming compensation from that employer under this Article.~~

~~Any medical records or reports, restricted to conditions related to the injury or illness for which the employee is seeking compensation, in the possession of the employee shall be furnished by the employee to the employer when requested in writing by the employer.~~

~~An employer or insurer paying compensation for an admitted claim or paying without prejudice pursuant to G.S. 97-18(d) may communicate with an employee's medical provider in writing, limited to specific questions promulgated by the Commission, to determine, among other information, the diagnosis for the employee's condition, the reasonable and necessary treatment, the anticipated time that the employee will be out of work, the relationship, if any, of~~

1 the employee's condition to the employment, the restrictions from the condition, the kind of
2 work for which the employee may be eligible, the anticipated time the employee will be
3 restricted, and the permanent impairment, if any, as a result of the condition. When these
4 questions are used, a copy of the written communication shall be provided to the employee at
5 the same time and by the same means as the communication is provided to the provider.

6 Other forms of communication with a medical provider may be authorized by (i) a valid
7 written authorization voluntarily given and signed by the employee, (ii) by agreement of the
8 parties, or (iii) by order of the Commission issued upon a showing that the information sought
9 is necessary for the administration of the employee's claim and is not otherwise reasonably
10 obtainable under this section or through other provisions for discovery authorized by the
11 Commission's rules. In adopting rules or authorizing employer communications with medical
12 providers, the Commission shall protect the employee's right to a confidential physician-patient
13 relationship while facilitating the release of information necessary to the administration of the
14 employee's claim.

15 Upon motion by an employee or provider from whom medical records or reports are sought
16 or upon its own motion, for good cause shown, the Commission may make any order which
17 justice requires to protect an employee or other person from unreasonable annoyance,
18 embarrassment, oppression, or undue burden or expense."

19 **SECTION 8.** G.S. 97-26 is amended by adding a new subsection to read:

20 "(g1) Administrative Simplification. – The applicable administrative standards for code
21 sets, identifiers, formats, and electronic transactions to be used in processing electronic medical
22 bills under this Article shall comply with 45 C.F.R. § 162. The Commission shall adopt rules to
23 require electronic medical billing and payment processes, to standardize the necessary medical
24 documentation for billing adjudication, to provide for effective dates and compliance, and for
25 further implementation of this subsection."

26 **SECTION 9.** G.S. 97-27 reads as rewritten:

27 "**§ 97-27. Medical examination; facts not privileged; refusal to be examined suspends
28 compensation; other medical opinions; autopsy.**

29 (a) After an injury, and so long as he ~~the~~ employee claims compensation, the employee,
30 if so requested by his or her employer or ordered by the Industrial Commission, shall, ~~subject to~~
31 ~~the provisions of subsection (b),~~ submit himself to examination, independent medical
32 examinations, at reasonable times and places, by a duly qualified physician ~~or surgeon who is~~
33 licensed and practicing in North Carolina and is designated and paid by the employer or the
34 Industrial Commission. ~~Commission,~~ even if the employee's claim has been denied pursuant to
35 G.S. 97-18(c). The independent medical examination shall be subject to the following
36 provisions:

37 (1) The injured employee shall have ~~has~~ the right to have present at such ~~the~~
38 independent medical examination any duly qualified physician or surgeon
39 provided and paid by him ~~the employee.~~

40 (2) Notwithstanding the provisions of G.S. 8-53, no fact communicated to or
41 otherwise learned by any physician or surgeon or hospital or hospital
42 employee who may have attended or examined the employee, or who may
43 have been present at any examination, shall be privileged in any workers'
44 compensation case with respect to a claim pending for hearing before the
45 Industrial Commission.

46 (3) Notwithstanding the provisions of G.S. 97-25.6 to the contrary, an employer
47 or its agent shall be allowed to openly communicate either orally or in
48 writing with an independent medical examiner chosen by the employer
49 regardless of whether the examiner physically examined the employee.

50 (4) If the examiner physically examined the employee, the employer must
51 produce the examiner's report to the employee within 10 business days of

1 receipt by the employer, along with a copy of all documents and written
2 communication sent to the independent medical examiner pertaining to the
3 employee.

4 (5) If the employee refuses to submit himself to or in any way obstructs such an
5 independent medical examination requested by and provided for by the
6 employer, his the employee's right to compensation and his right to take or
7 prosecute any proceedings under this Article shall be suspended pursuant to
8 G.S. 97-18.1 until such the refusal or objection ceases, and no compensation
9 shall at any time be payable for the period of obstruction, unless in the
10 opinion of the Industrial Commission the circumstances justify the refusal or
11 obstruction. When the employer seeks to suspend compensation under this
12 subdivision, it shall not be necessary for the employer to have first obtained
13 an order compelling the employee to submit to the proposed independent
14 medical examination. Any order issued by the Commission suspending
15 compensation pursuant to G.S. 97-18.1 shall specify what action the
16 employee should take to end the suspension and reinstate the compensation.
17 The employer, or the Industrial Commission, shall have the right in any case
18 of death to require an autopsy at the expense of the party requesting the
19 same.

20 (b) In those cases any case arising under this Article in which there is a question as to
21 the employee is dissatisfied with the percentage of permanent disability suffered by an
22 employee, if any employee, required to submit to a physical examination under the provisions
23 of subsection (a) is dissatisfied with such examination or the report thereof, he shall be entitled
24 to have as provided by G.S. 97-31 and determined by the authorized health care provider, the
25 employee is entitled to have another examination solely on the percentage of permanent
26 disability provided by a duly qualified physician or surgeon licensed and practicing of the
27 employee's choosing who is licensed to practice in North Carolina or by a duly qualified
28 physician or surgeon licensed to practice in South Carolina, Georgia, Virginia and Tennessee
29 provided said nonresident physician or surgeon shall have been approved by the North Carolina
30 Industrial Commission and his name placed on the Commission's list of approved nonresident
31 physicians and surgeons, Carolina, or licensed in another state if agreed to by the parties or
32 ordered by the Commission, and designated by him and the employee. That physician shall be
33 paid by the employer or the Industrial Commission in the same manner as physicians health
34 care providers designated by the employer or the Industrial Commission are paid. The
35 Industrial Commission must either disregard or give less weight to the opinions of the duly
36 qualified physician chosen by the employee pursuant to this subsection on issues outside the
37 scope of the G.S. 97-27(b) examination. No fact that is communicated to or otherwise learned
38 by any physician who attended or examined the employee, or who was present at any
39 examination, shall be privileged with respect to a claim before the Industrial Commission.
40 Provided, however, that all travel expenses incurred in obtaining said examination shall be paid
41 by said employee. The employer shall have the right to have present at such examination a duly
42 qualified physician or surgeon provided and paid by him. No fact communicated to or
43 otherwise learned by any physician or surgeon who may have attended or examined the
44 employee, or who may have been present at any examination, shall be privileged, either in
45 hearings provided for by this Article or any action at law.

46 (c) The employer, or the Industrial Commission, has the right in any case of death to
47 require an autopsy at its expense."

48 SECTION 10. G.S. 97-29 reads as rewritten:

49 "**§ 97-29. Compensation rates-Rates and duration of compensation for total incapacity.**

50 (a) When an employee qualifies for total disability, Except as hereinafter otherwise
51 provided, where the incapacity for work resulting from the injury is total, the employer shall

1 pay or cause to be paid, as hereinafter provided by subsections (b) through (d) of this section, to
2 the injured employee ~~during such total disability~~ a weekly compensation equal to sixty-six and
3 two-thirds percent (662/3%) of his average weekly wages, but not more than the amount
4 established annually to be effective ~~October-January 1~~ as provided herein, nor less than thirty
5 dollars (\$30.00) per week.

6 (b) When a claim is compensable pursuant to G.S. 97-18(b), paid without prejudice
7 pursuant to G.S. 97-18(d), agreed by the parties pursuant to G.S. 97-82, or when an employee
8 proves by a preponderance of the evidence that the employee is unable to earn the same wages
9 the employee had earned before the injury, either in the same or other employment, the
10 employee qualifies for temporary total disability subject to the limitations noted herein. The
11 employee shall not be entitled to compensation pursuant to this subsection greater than 500
12 weeks from the date of first disability unless the employee qualifies for extended compensation
13 under subsection (c) of this section.

14 (c) An employee may qualify for extended compensation in excess of the 500-week
15 limitation on temporary total disability as described in subsection (b) of this section only if (i)
16 at the time the employee makes application to the Commission to exceed the 500-week
17 limitation on temporary total disability as described in subsection (b) of this section, 425 weeks
18 have passed since the date of first disability and (ii) pursuant to the provisions of G.S. 97-84,
19 unless agreed to by the parties, the employee shall prove by a preponderance of the evidence
20 that the employee has sustained a total loss of wage-earning capacity. If an employee makes
21 application for extended compensation pursuant to this subsection and is awarded extended
22 compensation by the Commission, the award shall not be stayed pursuant to G.S. 97-85 or
23 G.S. 97-86 until the full Commission or an appellate court determines otherwise. Upon its own
24 motion or upon the application of any party in interest, the Industrial Commission may review
25 an award for extended compensation in excess of the 500-week limitation on temporary total
26 disability described in subsection (b) of this section, and, on such review, may make an award
27 ending or continuing extended compensation. When reviewing a prior award to determine if the
28 employee remains entitled to extended compensation, the Commission shall determine if the
29 employer has proven by a preponderance of the evidence that the employee no longer has a
30 total loss of wage-earning capacity. When an employee is receiving full retirement benefits
31 under section 202(a) of the Social Security Act, after attainment of retirement age, as defined in
32 section 216(l) of the Social Security Act, the employer may reduce the extended compensation
33 by one hundred percent (100%) of the employee's retirement benefit. The reduction shall
34 consist of the employee's primary benefit paid pursuant to section 202(a) of the Social Security
35 Act but shall not include any dependent or auxiliary benefits paid pursuant to any other section
36 of the Social Security Act, if any, or any cost-of-living increases in benefits made pursuant to
37 section 215(i) of the Social Security Act.

38 (d) An injured employee may qualify for permanent total disability only if the
39 employee has one or more of the following physical or mental limitations resulting from the
40 injury:

- 41 (1) The loss of both hands, both arms, both feet, both legs, both eyes, or any two
42 thereof, as provided by G.S. 97-31(17).
- 43 (2) Spinal injury involving severe paralysis of both arms, both legs, or the trunk.
- 44 (3) Severe brain or closed head injury as evidenced by severe and permanent:
 - 45 a. Sensory or motor disturbances;
 - 46 b. Communication disturbances;
 - 47 c. Complex integrated disturbances of cerebral function; or
 - 48 d. Neurological disorders.
- 49 (4) Second-degree or third-degree burns to thirty-three percent (33%) or more of
50 the total body surface.

An employee who qualifies for permanent total disability pursuant to this subsection shall be entitled to compensation, including medical compensation, during the lifetime of the injured employee, unless the employer shows by a preponderance of the evidence that the employee is capable of returning to suitable employment as defined in G.S. 97-2(22). Provided, however, the termination or suspension of compensation because the employee is capable of returning to suitable employment as defined in G.S. 97-2(22) does not affect the employee's entitlement to medical compensation. An employee who qualifies for permanent total disability under subdivision (1) of this subsection is entitled to lifetime compensation, including medical compensation, regardless of whether or not the employee has returned to work in any capacity. In no other case shall an employee be eligible for lifetime compensation for permanent total disability.

~~In cases of total and permanent disability, compensation, including medical compensation, shall be paid for by the employer during the lifetime of the injured employee. If death results from the injury then the employer shall pay compensation in accordance with the provisions of G.S. 97-38.~~

(e) An employee shall not be entitled to benefits under this section or G.S. 97-30 and G.S. 97-31 at the same time.

(f) Where an employee can show entitlement to compensation pursuant to this section or G.S. 97-30 and a specific physical impairment pursuant to G.S. 97-31, the employee shall not collect benefits concurrently pursuant to both this section or G.S. 97-30 and G.S. 97-31, but rather is entitled to select the statutory compensation which provides the more favorable remedy.

~~In cases of total and permanent disability, compensation, including medical compensation, shall be paid for by the employer during the lifetime of the injured employee. If death results from the injury then the employer shall pay compensation in accordance with the provisions of G.S. 97-38.~~

(g) The weekly compensation payment for members of the North Carolina National Guard and the North Carolina State Defense Militia shall be the maximum amount established annually in accordance with the last paragraph of this section per week as fixed herein. The weekly compensation payment for deputy sheriffs, or those acting in the capacity of deputy sheriffs, who serve upon a fee basis, shall be thirty dollars (\$30.00) a week as fixed herein.

(h) An officer or member of the State Highway Patrol shall not be awarded any weekly compensation under the provisions of this section for the first two years of any incapacity resulting from an injury by accident arising out of and in the course of the performance by him of his official duties if, during such incapacity, he continues to be an officer or member of the State Highway Patrol, but he shall be awarded any other benefits to which he may be entitled under the provisions of this Article.

(i) Notwithstanding any other provision of this Article, on July 1 of each year, a maximum weekly benefit amount shall be computed. The amount of this maximum weekly benefit shall be derived by obtaining the average weekly insured wage in accordance with G.S. 96-8(22), by multiplying such average weekly insured wage by 1.10, and by rounding such figure to its nearest multiple of two dollars (\$2.00), and this said maximum weekly benefit shall be applicable to all injuries and claims arising on and after January 1 following such computation. Such maximum weekly benefit shall apply to all provisions of this Chapter and shall be adjusted July 1 and effective January 1 of each year as herein provided.

(j) If death results from the injury or occupational disease, then the employer shall pay compensation in accordance with the provisions of G.S. 97-38."

SECTION 11. G.S. 97-30 reads as rewritten:

"§ 97-30. Partial incapacity.

Except as otherwise provided in G.S. 97-31, where the incapacity for work resulting from the injury is partial, the employer shall pay, or cause to be paid, as hereinafter provided, to the

1 injured employee during such disability, a weekly compensation equal to sixty-six and
2 two-thirds percent (66 2/3%) of the difference between his average weekly wages before the
3 injury and the average weekly wages which he is able to earn thereafter, but not more than the
4 amount established annually to be effective ~~October-January 1~~ as provided in G.S. 97-29 a
5 week, and in no case shall the ~~period covered by such compensation be greater~~ employee
6 receive more than 300-500 weeks of payments under this section. Any weeks of payments
7 made pursuant to G.S. 97-29 shall be deducted from the 500 weeks of payments available
8 under this section. from the date of injury. In case the partial disability begins after a period of
9 total disability, the latter period shall be deducted from the maximum period herein allowed for
10 partial disability. An officer or member of the State Highway Patrol shall not be awarded any
11 weekly compensation under the provisions of this section for the first two years of any
12 incapacity resulting from an injury by accident arising out of and in the course of the
13 performance by him of his official duties if, during such incapacity, he continues to be an
14 officer or member of the State Highway Patrol, but he shall be awarded any other benefits to
15 which he may be entitled under the provisions of this Article."

16 **SECTION 12.** G.S. 97-32 reads as rewritten:

17 "**§ 97-32. Refusal of injured employee to accept suitable employment as suspending**
18 **compensation.**

19 If an injured employee refuses ~~employment procured for him suitable to his capacity~~ he
20 suitable employment as defined by G.S. 97-2(22), the employee shall not be entitled to any
21 compensation at any time during the continuance of such refusal, unless in the opinion of the
22 Industrial Commission such refusal was justified. Any order issued by the Commission
23 suspending compensation pursuant to G.S. 97-18.1 on the ground of an unjustified refusal of an
24 offer of suitable employment shall specify what actions the employee should take to end the
25 suspension and reinstate the compensation. Nothing in this Article prohibits an employer from
26 contacting the employee directly about returning to suitable employment with
27 contemporaneous notice to the employee's counsel, if any."

28 **SECTION 13.** Article 1 of Chapter 97 of the General Statutes is amended by
29 adding a new section to read:

30 "**§ 97-32.2. Vocational rehabilitation.**

31 (a) In a compensable claim, the employer may engage vocational rehabilitation services
32 at any point during a claim, regardless of whether the employee has reached maximum medical
33 improvement to include, among other services, a one-time assessment of the employee's
34 vocational potential. If the employee (i) has not returned to work or (ii) has returned to work
35 earning less than seventy-five percent (75%) of the employee's average weekly wages and is
36 receiving benefits pursuant to G.S. 97-30, the employee may request vocational rehabilitation
37 services, including education and retraining in the North Carolina community college or
38 university systems so long as the education and retraining are reasonably likely to substantially
39 increase the employee's wage-earning capacity following completion of the education or
40 retraining program. Provided, however, the seventy-five percent (75%) threshold is for the
41 purposes of qualification for vocational rehabilitation benefits only and shall not impact a
42 decision as to whether a job is suitable per G.S. 97-2(22). The expense of vocational
43 rehabilitation services provided pursuant to this section shall be borne by the employer in the
44 same manner as medical compensation.

45 (b) Vocational rehabilitation services shall be provided by either a qualified or
46 conditional rehabilitation professional approved by the Industrial Commission. Unless the
47 parties mutually agree to a vocational rehabilitation professional, the employer may make the
48 initial selection. At any point during the vocational rehabilitation process, either party may
49 request that the Industrial Commission order a change of vocational rehabilitation professional
50 for good cause.

1 (c) Vocational rehabilitation services shall include a vocational assessment and the
2 formulation of an individualized written rehabilitation plan with the goal of substantially
3 increasing the employee's wage-earning capacity, and subject to the following provisions:

4 (1) When performing a vocational assessment, the vocational rehabilitation
5 professional should evaluate the employee's medical and vocational
6 circumstances, the employee's expectations and specific requests for
7 vocational training, benefits expected from vocational services, and other
8 information significant to the employee's employment potential. The
9 assessment should also involve a face-to-face interview between the
10 employee and the vocational rehabilitation professional to identify the
11 specific type and sequence of appropriate services. If, at any point during
12 vocational rehabilitation services, the vocational rehabilitation professional
13 determines that the employee will not benefit from vocational rehabilitation
14 services, the employer may terminate said services unless the Commission
15 orders otherwise.

16 (2) Following assessment, and after receiving input from the employee, the
17 vocational rehabilitation professional shall draft an individualized written
18 rehabilitation plan. The plan should be individually tailored to the employee
19 based on the employee's education, skills, experience, and aptitudes, with
20 appropriate recommendations for vocational services, which may include
21 appropriate retraining, education, or job placement. The plan may be
22 changed or updated by mutual consent at any time during rehabilitation
23 services. A written plan is not necessary if the vocational rehabilitation
24 professional has been retained to perform a one-time assessment.

25 (d) Specific vocational rehabilitation services may include, but are not limited to,
26 vocational assessment, vocational exploration, sheltered workshop or community supported
27 employment training, counseling, job analysis, job modification, job development and
28 placement, labor market survey, vocational or psychometric testing, analysis of transferable
29 skills, work adjustment counseling, job seeking skills training, on-the-job training, or training
30 or education through the North Carolina community college or university systems.

31 (e) Vocational rehabilitation services may be terminated by agreement of the parties or
32 by order of the Commission.

33 (f) Job placement activities may commence after completion of an individualized
34 written rehabilitation plan. Return-to-work options should be considered, with order of priority
35 given to returning the employee to suitable employment with the current employer, returning
36 the employee to suitable employment with a new employer, and, if appropriate, formal
37 education or vocational training to prepare the employee for suitable employment with the
38 current employer or a new employer.

39 (g) The refusal of the employee to accept or cooperate with vocational rehabilitation
40 services when ordered by the Industrial Commission shall bar the employee from further
41 compensation until such refusal ceases, and no compensation shall at any time be paid for the
42 period of suspension, unless in the opinion of the Industrial Commission the circumstances
43 justified the refusal. Any order issued by the Commission suspending compensation per
44 G.S. 97-18.1 shall specify what action the employee should take to end the suspension and
45 reinstate the compensation."

46 **SECTION 14. G.S. 97-38 reads as rewritten:**

47 **"§ 97-38. Where death results proximately from compensable injury or occupational**
48 **disease; dependents; burial expenses; compensation to aliens; election by**
49 **partial dependents.**

50 **If death results proximately from a compensable injury or occupational disease and within**
51 **six years thereafter, or within two years of the final determination of disability, whichever is**

1 later, the employer shall pay or cause to be paid, subject to the provisions of other sections of
2 this Article, weekly payments of compensation equal to sixty-six and two-thirds percent (66
3 2/3%) of the average weekly wages of the deceased employee at the time of the accident, but
4 not more than the amount established annually to be effective October 1 as provided in
5 G.S. 97-29, nor less than thirty dollars (\$30.00), per week, and burial expenses not exceeding
6 ~~three thousand five hundred dollars (\$3,500),~~ ten thousand dollars (\$10,000), to the person or
7 persons entitled thereto as follows:

8 ...

- 9 (3) If there is no person wholly dependent, and the person or all persons
10 partially dependent is or are within the classes of persons defined as "next of
11 kin" in G.S. 97-40, whether or not such persons or such classes of persons
12 are of kin to the deceased employee in equal degree, and all so elect, he or
13 they may take, share and share alike, the commuted value of the amount
14 provided for whole dependents in (1) above instead of the proportional
15 payment provided for partial dependents in (2) above; provided, that the
16 election herein provided may be exercised on behalf of any infant partial
17 dependent by a duly qualified guardian; provided, further, that the Industrial
18 Commission may, in its discretion, permit a parent or person standing in loco
19 parentis to such infant to exercise such option in its behalf, the award to be
20 payable only to a duly qualified guardian except as in this Article otherwise
21 provided; and provided, further, that if such election is exercised by or on
22 behalf of more than one person, then they shall take the commuted amount
23 in equal shares.

24 When weekly payments have been made to an injured employee before
25 his death, the compensation to dependents shall begin from the date of the
26 last of such payments. Compensation payments due on account of death
27 shall be paid for a period of ~~400~~500 weeks from the date of the death of the
28 employee; provided, however, after said ~~400-week~~ 500-week period in case
29 of a widow or widower who is unable to support herself or himself because
30 of physical or mental disability as of the date of death of the employee,
31 compensation payments shall continue during her or his lifetime or until
32 remarriage and compensation payments due a dependent child shall be
33 continued until such child reaches the age of 18.

34 Compensation payable under this Article to aliens not residents (or about
35 to become nonresidents) of the United States or Canada, shall be the same in
36 amounts as provided for residents, except that dependents in any foreign
37 country except Canada shall be limited to surviving spouse and child or
38 children, or if there be no surviving spouse or child or children, to the
39 surviving father or mother."

40 **SECTION 15. G.S. 97-40 reads as rewritten:**

41 **"§ 97-40. Commutation and payment of compensation in absence of dependents; "next of**
42 **kin" defined; commutation and distribution of compensation to partially**
43 **dependent next of kin; payment in absence of both dependents and next of kin.**

44 Subject to the provisions of G.S. 97-38, if the deceased employee leaves neither whole nor
45 partial dependents, then the compensation which would be payable under G.S. 97-38 to whole
46 dependents shall be commuted to its present value and paid in a lump sum to the next of kin as
47 herein defined. For purposes of this section and G.S. 97-38, "next of kin" shall include only
48 child, father, mother, brother or sister of the deceased employee, including adult children or
49 adult brothers or adult sisters of the deceased, but excluding a parent who has willfully
50 abandoned the care and maintenance of his or her child and who has not resumed its care and
51 maintenance at least one year prior to the first occurring of the majority or death of the child

1 and continued its care and maintenance until its death or majority. For all such next of kin who
2 are neither wholly nor partially dependent upon the deceased employee and who take under this
3 section, the order of priority among them shall be governed by the general law applicable to the
4 distribution of the personal estate of persons dying intestate. In the event of exclusion of a
5 parent based on abandonment, the claim for compensation benefits shall be treated as though
6 the abandoning parent had predeceased the employee. For all such next of kin who were also
7 partially dependent on the deceased employee but who exercise the election provided for partial
8 dependents by G.S. 97-38, the general law applicable to the distribution of the personal estate
9 of persons dying intestate shall not apply and such person or persons upon the exercise of such
10 election, shall be entitled, share and share alike, to the compensation provided in G.S. 97-38 for
11 whole dependents commuted to its present value and paid in a lump sum.

12 If the deceased employee leaves neither whole dependents, partial dependents, nor next of
13 kin as hereinabove defined, then no compensation shall be due or payable on account of the
14 death of the deceased employee, except that the employer shall pay or cause to be paid the
15 burial expenses of the deceased employee not exceeding ~~three thousand five hundred dollars~~
16 (\$3,500)-ten thousand dollars (\$10,000) to the person or persons entitled thereto."

17 **SECTION 16.** G.S. 97-77(a) reads as rewritten:

18 "(a) There is hereby created a commission to be known as the North Carolina Industrial
19 Commission, consisting of ~~seven-six~~ commissioners who shall devote their entire time to the
20 duties of the Commission. The Governor shall appoint the members of the ~~Commission, one for~~
21 ~~a term of two years, one for a term of four years, one for a term~~ Commission for terms of six
22 years. ~~Of the additional appointments made in 1994, one shall be for a term expiring June 30,~~
23 ~~1996, one for a term expiring June 30, 1998, and two for terms expiring June 30, 2000. Upon~~
24 ~~the expiration of each term as above mentioned, the Governor shall appoint a successor for a~~
25 ~~term of six years, and thereafter the term of office of each commissioner shall be six years. Not~~
26 ~~more than three-Three appointees-commissioners~~ shall be persons who, on account of their
27 previous vocations, employment or affiliations, can be classed as representatives of employers,
28 ~~and not more than three-employers. Three appointees-commissioners~~ shall be persons who, on
29 account of their previous vocations, employment or affiliations, can be classed as
30 representatives of employees. No person may serve more than two terms on the Commission,
31 including any term served prior to the effective date of this section. In calculating the number
32 of terms served, a partial term that is less than three years in length shall not be included."

33 **SECTION 17.** G.S. 97-77 is amended by adding a new subsection to read:

34 "(a1) Appointments of commissioners are subject to confirmation by the General
35 Assembly by joint resolution. The names of commissioners to be appointed by the Governor
36 shall be submitted by the Governor to the General Assembly for confirmation by the General
37 Assembly on or before March 1 of the year of expiration of the term. If the Governor fails to
38 timely submit nominations, the General Assembly shall appoint to fill the succeeding term
39 upon the joint recommendation of the President Pro Tempore of the Senate and the Speaker of
40 the House of Representatives in accordance with G.S. 120-121 not inconsistent with this
41 section.

42 In case of death, incapacity, resignation, or any other vacancy in the office of any
43 commissioner prior to the expiration of the term of office, a nomination to fill the vacancy for
44 the remainder of the unexpired term shall be submitted by the Governor within four weeks after
45 the vacancy arises to the General Assembly for confirmation by the General Assembly. If the
46 Governor fails to timely nominate a person to fill the vacancy, the General Assembly shall
47 appoint a person to fill the remainder of the unexpired term upon the joint recommendation of
48 the President Pro Tempore of the Senate and the Speaker of the House of Representatives in
49 accordance with G.S. 120-121 not inconsistent with this section. If a vacancy arises or exists
50 pursuant to this subsection when the General Assembly is not in session, and the appointment is
51 deemed urgent by the Governor, the commissioner may be appointed and serve on an interim

1 basis pending confirmation by the General Assembly. For the purpose of this subsection, the
2 General Assembly is not in session only (i) prior to convening of the Regular Session, (ii)
3 during any adjournment of the Regular Session for more than 10 days, and (iii) after sine die
4 adjournment of the Regular Session.

5 No person while in office as a commissioner may be nominated or appointed on an interim
6 basis to fill the remainder of an unexpired term, or to a full term that commences prior to the
7 expiration of the term that the commissioner is serving."

8 **SECTION 18.** Article 1 of Chapter 97 of the General Statutes is amended by
9 adding a new section to read:

10 **"§ 97-78.1. Standards of judicial conduct to apply to commissioners and deputy**
11 **commissioners.**

12 The Code of Judicial Conduct for judges of the General Court of Justice and the procedure
13 for discipline of judges in Article 30 of Chapter 7A of the General Statutes shall apply to
14 commissioners and deputy commissioners. Commissioners and deputy commissioners shall be
15 liable for impeachment for the causes and in the manner provided for judges of the General
16 Court of Justice in Chapter 123 of the General Statutes."

17 **SECTION 19.** G.S. 97-80(a) reads as rewritten:

18 "(a) The Commission may make shall adopt rules, in accordance with Article 2A of
19 Chapter 150B of the General Statutes and not inconsistent with this Article, for carrying out the
20 provisions of this Article. The Commission shall request the Office of State Budget and
21 Management to prepare a fiscal note for a proposed new or amended rule that has a substantial
22 economic impact, as defined in G.S. 150B-21.4(b1). The Commission shall not take final action
23 on a proposed rule change that has a substantial economic impact until at least 60 days after the
24 fiscal note has been prepared.

25 Processes, procedure, and discovery under this Article shall be as summary and simple as
26 reasonably may be."

27 **SECTION 20.** G.S. 97-84 reads as rewritten:

28 **"§ 97-84. Determination of disputes by Commission or deputy.**

29 The Commission or any of its members shall hear the parties at issue and their
30 representatives and witnesses, and shall determine the dispute in a summary manner. The
31 Commission shall decide the case and issue findings of fact based upon the preponderance of
32 the evidence in view of the entire record. The award, together with a statement of the findings
33 of fact, rulings of law, and other matters pertinent to the questions at issue shall be filed with
34 the record of the proceedings, within 180 days of the close of the hearing record unless time is
35 extended for good cause by the Commission, and a copy of the award shall immediately be sent
36 to the parties in dispute. The parties may be heard by a deputy, in which event the hearing shall
37 be conducted in the same way and manner prescribed for hearings which are conducted by a
38 member of the Industrial Commission, and said deputy shall proceed to a complete
39 determination of the matters in dispute, file his written opinion within 180 days of the close of
40 the hearing record unless time is extended for good cause by the Commission, and the deputy
41 shall cause to be issued an award pursuant to such determination."

42 **SECTION 21.(a)** G.S. 150B-1(c) reads as rewritten:

43 "(c) Full Exemptions. – This Chapter applies to every agency except:

- 44 (1) The North Carolina National Guard in exercising its court-martial
45 jurisdiction.
- 46 (2) The Department of Health and Human Services in exercising its authority
47 over the Camp Butner reservation granted in Article 6 of Chapter 122C of
48 the General Statutes.
- 49 (3) The Utilities Commission.
- 50 (4) ~~The Industrial Commission.~~
- 51 (5) The Employment Security Commission.

(6) The State Board of Elections in administering the HAVA Administrative Complaint Procedure of Article 8A of Chapter 163 of the General Statutes.

(7) The North Carolina State Lottery.

(8) **(Expires June 30, 2012)** Except as provided in G.S. 150B-21.1B, any agency with respect to contracts, disputes, protests, and/or claims arising out of or relating to the implementation of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5)."

SECTION 21.(b) G.S. 150B-1(e) is amended by adding a new subdivision to read:

"(e) Exemptions From Contested Case Provisions. – The contested case provisions of this Chapter apply to all agencies and all proceedings not expressly exempted from the Chapter. The contested case provisions of this Chapter do not apply to the following:

...

(18) The Industrial Commission."

SECTION 21.(c) Any existing rule contained in Title 4 of Chapter 10 of the North Carolina Administrative Code that has not been readopted in accordance with Article 2A of Chapter 150B of the General Statutes on or before December 31, 2012, shall expire. Any rule that has been readopted by the Industrial Commission in accordance with G.S. 150B-21.2(g) on or before December 31, 2012, shall remain in effect until the rule becomes effective pursuant to G.S. 150B-21.3.

SECTION 22. As of February 1, 2011, the terms of the seven members of the Industrial Commission are as follows:

(1) One serves a term expiring April 30, 2011.

(2) Two serve terms expiring June 30, 2012.

(3) One serves a term expiring April 30, 2013.

(4) One serves a term expiring June 30, 2014.

(5) One serves a term expiring April 30, 2015.

(6) One serves a term expiring June 30, 2016.

The reduction from seven commissioners to six commissioners provided by Section 16 of this act shall be effected by not filling one of the two offices that expire June 30, 2012, pursuant to subdivision (2) of this section.

SECTION 23. Notwithstanding G.S. 97-31.1, this act is effective when it becomes law. Sections 4, 5, 6, 7, and 9 apply to claims pending on or after the effective date of this act. Sections 2, 3, 10, 11, 12, 13, 14, 15, and 20 apply to claims arising on or after the effective date of this act. Section 21 applies to rules adopted on or after the effective date of this act.



HOUSE BILL 709: Protect and Put NC Back to Work

2011-2012 General Assembly

Committee:	Senate Insurance	Date:	June 7, 2011
Introduced by:	Reps. Folwell, Dollar, Hager, Crawford	Prepared by:	Bill Patterson
Analysis of:	Second Edition		Staff Attorney

SUMMARY: *House Bill 709 makes numerous changes to the Workers Compensation Act.*

[As introduced, this bill was identical to S544, as introduced by Sens. Brown, Apodaca, and Davis, which is currently in Senate Insurance.]

CURRENT LAW:

Under the Workers Compensation Act, Article 1 of Chapter 97 of the General Statutes ("the Act"), an employee who sustains a compensable injury by accident or occupational disease is eligible for several types of benefits, including indemnity (wage-replacement) and medical benefits. The Industrial Commission is charged with carrying out the Act's provisions. Seven commissioners appointed by the Governor make the Commission's rules and hear appeals from decisions of deputy commissioners in contested cases. Pursuant to G.S. 150B-1(c)(4), the Commission is exempt from all provisions of the Administrative Procedures Act.

In addition to medical compensation, an employee whose injury has resulted in a loss of wage-earning capacity is entitled to weekly compensation for either total or partial incapacity. For a total loss of wage-earning capacity, the employee is entitled under G.S. 97-29 to receive weekly compensation in the amount of 2/3 of his or her average weekly wage for as long as that loss lasts, with no limitation on the duration of the benefits. If the total incapacity is permanent, the employee is entitled to receive this compensation for life. For a partial loss of wage-earning capacity, the employee is entitled under G.S. 97-30 to receive weekly compensation in the amount of 2/3 of the difference in average weekly wage before and after the injury, for as long as the partial loss of wage-earning capacity lasts, but subject to a maximum of 300 weeks.

In addition to weekly compensation for partial or total incapacity, if an employee has a specific physical impairment that falls under the schedule of injuries set forth in G.S. 97-31, the employee is presumed to have suffered a loss of wage-earning capacity. In that case, the employee is entitled to weekly compensation during the "healing period" and, in addition, a lump-sum payment according to the schedule of injuries set forth in the statute.

Employees who are eligible for compensation under G.S. 97-31 for a scheduled injury and who also qualify under either G.S. 97-29 or 97-30 for permanent total or partial disability compensation are permitted to select the more favorable remedy.¹

BILL ANALYSIS:

Section 1 states that the act shall be known as the "Protecting and Putting North Carolina Back to Work Act."

Section 2 amends G.S. 97-2(19)'s definition of "medical compensation" to include attendant care services if prescribed by a physician or ordered by the Commission, and vocational rehabilitation, and

¹ Whitley v. Columbia Lumber Mfg. Co., 318 N.C. 89, 348 S.E.2d 336 (1986); Gupton v. Builders Transport, 320 N.C. 38, 357 S.E.2d 674 (1987).

House Bill 709

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adds new G.S. 97-2(22) to define the term "suitable employment" as any employment offered to the employee that is

- within the employee's work restrictions before the employee has reached maximum medical improvement, or
- that the employee is capable of performing after reaching maximum medical improvement given the employee's pre-existing physical and mental limitations, vocational skills, education and experience

and that is within a 50 mile radius of the employee's residence at the time of the injury, or current residence if the employee had a legitimate reason to relocate since the date of the accident. This section applies to claims arising on or after the effective date of the act.

Section 3 enacts new G.S. 97-12.1, which disqualifies an employee from receiving compensation under the Act if, in connection with being hired, the employee willfully made a false representation regarding his or her physical condition, the employer relied upon the representation, and there was a causal connection between the representation and the injury or occupational disease for which the employee seeks compensation. This section applies to claims arising on or after the effective date of the act.

Section 4 amends G.S. 97-17, which governs settlements of claims brought under the Act, to clarify that nothing in this section prevents the parties from reaching a separate contemporaneous agreement resolving issues not covered by the Act. This section applies to claims pending on or after the effective date of the act.

Section 5 adds a new subsection (k) to G.S. 97-18, which governs payment of compensation, to provide a procedure for reinstatement of compensation for any reason other than a change in condition, whenever the employer or insurer has admitted the employee's right to compensation or liability has been established. Any challenge to the employee's request for reinstatement must be scheduled on a preemptive basis. This section applies to claims pending on or after the effective date of the act.

Section 6 amends G.S. 97-25 applicable to medical treatment, by deleting the current provision permitting an employee to select a physician of his own choosing subject to Commission approval, and requiring the employee to show by a preponderance of the evidence that the requested change of treatment or health care provider is reasonably necessary to effect a cure, provide relief or lessen the period of disability. In making this decision, the Commission may disregard or give lesser weight to the opinion of any health care provider not authorized to evaluate, diagnose, or treat the employee before the employee filed the request for a change in treatment or provider. This section also gives the employee a right to request a second opinion evaluation, and provides that if an employer refuses the request or if the parties are unable to agree on who will perform the examination, the employee may request that the Commission order a second opinion examination. This section applies to claims pending on or after the effective date of the act.

Section 7 rewrites G.S. 97-25.6, which governs access to an employee's medical information, to set forth the procedure by which employers, their attorneys, and their insurers can obtain relevant medical information relating to an employee without the employee's prior authorization. "Relevant medical information" is defined as any medical record, report, or information that is:

- restricted to the particular evaluation, diagnosis, or treatment of the injury or disease for which compensation, including medical compensation, is sought;
- reasonably related to the injury or disease for which the employee claims compensation; or

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- related to an assessment of the employee's ability to return to work as a result of the particular injury or disease. the medical records of an employee making a claim under the Act.

Under the new procedure, the employer must first request medical records, and then can make a written request for information not contained in the records, and then can make a request for oral communication to obtain information not contained in the medical records or available through written communication or otherwise. The employer must provide contemporaneous written notice to the employee of requests for medical records or written requests for additional information, and must give the employee prior notice of any request for oral communication and an opportunity to participate in the communication. The employer must also provide the employee with a copy of the records or written response received from the provider and a summary of any oral communication in which the employee did not participate.

This section also requires advance notice to the employee before the employer submits to a provider any relevant medical information not contained in the employee's medical records, with an opportunity for a hearing before the Commission if the employee does not consent.

An employer may contact a provider without the employee's authorization to request medical bills, follow-up on a prior written request for information, or to request information about other non-substantive matters.

This section applies to claims pending on or after the effective date of the act.

Section 8 adds a new subsection to G.S. 97-26 requiring the Commission to adopt rules requiring electronic medical billing and payment processes and requiring applicable administrative standards for processing electronic medical bills to comply with HIPAA billing procedures.

Section 9 amends G.S. 97-27, relating to medical examinations, to provide that:

- the employee must submit to an independent medical examination after an injury and for so long as the employee claims compensation, as requested by the employer or as ordered by the Commission, by a physician licensed and practicing in North Carolina, regardless of whether the employee's claim has been denied by the employer
- any refusal by the employee immediately suspends the employee's right to compensation and right to prosecute any proceedings under the Act, and the Commission is required to state what the employee should do to end the suspension and reinstate compensation
- any employer is permitted to communicate with an independent medical examiner chosen by the employer regardless of whether the examiner physically examined the employee
- the employer must provide the employee with a copy of any written report of an independent medical examination within ten days of its receipt, together with all supporting documents provided to the examiner

This section applies to claims pending on or after the effective date of the act.

Section 10 amends G.S. 97-29 to:

- places a 500 week limit on the duration of compensation, including medical compensation, paid for total disability, measured from the date of first disability
- permit an employee to seek extended compensation beyond 500 weeks if the employee 1) has received at least 425 weeks of compensation at the time of the request, and 2) shows by a

House Bill 709

Page 4

preponderance of the evidence that the employee has sustained a total loss of wage earning capacity

- permit an employer to seek termination of extended benefits by showing by a preponderance of the evidence that the employee no longer has a total loss of wage earning capacity
- reduce compensation payable beyond 500 weeks for extended benefits by any Social Security retirement benefits received by the employee
- require an employee who has reached maximum medical improvement and who has one or more scheduled injuries to elect whether to receive compensation under G.S. 97-31 or receive compensation under either G.S. 97-29 (temporary total disability) or G.S. 97-30 (temporary partial disability)
- provide that an employee may qualify for permanent and total disability only if he employee has one or more of the injuries specified in new subdivisions (c)(1) through (c)(4)
- provide that an employee qualified for permanent and total disability shall receive compensation for life unless the employer shows by a preponderance of the evidence that the employee is capable of returning to suitable employment, in which event compensation other than medical compensation shall be terminated or suspended

This section applies to claims arising on or after the effective date of the act.

Section 11 increases the maximum duration of compensation for partial incapacity under G.S. 97-30 from 300 weeks to 500 weeks from the date of injury, and provides that any compensation received for total incapacity under G.S. 97-29 shall count toward this limit. This section applies to claims arising on or after the effective date of the act.

Section 12 amends G.S. 97-32 to provide that an employee shall not receive compensation for so long as the employee refuses "suitable employment" without justification as determined by the Commission, and clarifies that nothing in the Act prohibits an employer from directly contacting the employee about returning to suitable employment. This section requires the Commission to specify in its order suspending compensation what the employee should do to end the suspension and reinstate compensation. This section applies to claims arising on or after the effective date of the act.

Section 13 enacts a new G.S. 97-32.2, to provide requirements for the provision of, payment for, and termination of vocational rehabilitation services, including a one-time evaluation regardless of whether the employee has reached maximum medical improvement. An employee who has not returned to work or who has returned to work but is earning less than 75% of the pre-injury average weekly wages and is receiving benefits for partial incapacity under G.S. 97-30, may request vocational rehabilitation services, including education and retraining if reasonably likely to substantially increase the employee's wage earning capacity. Refusal of an employee to accept or cooperate with vocational rehabilitation bars the employee from receiving compensation during the period of such refusal, unless the Commission determines the refusal was justified. This section applies to claims arising on or after the effective date of the act.

Section 14 amends G.S. 97-38, applicable when a compensable injury or occupational disease causes the employee's death, by increasing the maximum burial benefits from \$3,500 to \$10,000, and by increasing the weekly benefits payable to dependents after the employee's death from 400 to 500 weeks. This section applies to claims arising on or after the effective date of the act.

House Bill 709

Page 5

Section 15 amends G.S. 97-40 to increase the maximum compensation payable for burial expenses of an employee who dies without dependents from \$3,500 to \$10,000. This section applies to claims arising on or after the effective date of the act.

Section 16 amends G.S. 97-77(a) to reduce the number of commissioners from seven to six, three of whom shall be classed as employer representatives and three of whom shall be classed as employee representatives, based on their previous vocations, employment or affiliations, and no one of whom may serve more than two terms, including terms served prior to the effective date of the act, but not counting a partial term of less than three months in length.

Section 17 adds a new subsection (a1) to G.S. 97-77 requiring legislative confirmation of the Governor's appointments to the Commission, and setting forth the procedure for confirmation of appointments and for filling vacancies in the office of any commissioner prior to expiration of the commissioner's term.

Section 18 creates a new section 97-78.1 subjecting commissioners and deputy commissioners to the Code of Judicial Conduct (was standards of judicial conduct) applicable to judges in the General Courts of Justice, and to the impeachment provisions applicable to judges under Chapter 123 of the General Statutes.

Section 19 amends G.S. 97-80(a) to require the Commission to adopt rules in accordance with Article 2A of the Administrative Procedures Act.

Section 20 amends G.S. 97-84 to expressly state that decisions and findings of fact of the Commission shall be based upon the preponderance of the evidence in view of the entire record. This section applies to claims arising on or after the effective date of the act.

Section 21 deletes the current statutory exemption of the Commission from the APA, adds a provision exempting the Commission from the APA's contested case provisions, requires the Commission to readopt all rules currently in effect pursuant to the procedures in APA Article 2A, and provides that any existing Commission that is not readopted by December 31, 2012 shall expire. This section clarifies that rules readopted on or before December 31, 2012 shall remain in effect until the rule becomes effective pursuant to the APA. This section applies to rules adopted on or after the effective date of the act.

Section 22 establishes the remaining terms of the existing seven commissioners and reduces the number of commissioners from seven to six by providing that one of the two commissioners whose terms expire on June 30, 2012, shall not be replaced.

EFFECTIVE DATE: This act is effective when it becomes law. Sections 4, 5, 6, 7 and 9 apply to claims pending on or after the effective date. Sections 2, 3, 10, 11, 12, 13, 14, 15, and 20 apply to claims arising on or after the effective date. Section 21 applies to rules adopted by the Commission on or after the effective date.

H709-SMTG-35(e2) v2

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 656
PROPOSED COMMITTEE SUBSTITUTE S656-PCS35271-TK-24

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



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1 policyholder, insured, or beneficiary must choose a provider of the services
2 within the network in order to obtain the higher level of benefits.

3 (a2) Whenever any policy of insurance governed by Articles 1 through 64 of this
4 Chapter provides for certification of disability that is within the scope of practice of a duly
5 licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly
6 licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly licensed
7 physical therapist, a duly licensed clinical social worker, a duly certified substance abuse
8 professional, a duly licensed professional counselor, a duly licensed psychologist, a duly
9 certified fee-based practicing pastoral counselor, a duly licensed marriage and family therapist,
10 or an advanced practice registered nurse, the insured or other persons entitled to benefits under
11 the policy shall be entitled to payment of or reimbursement for the disability whether the
12 disability be certified by a duly licensed physician, or a provider listed in this subsection,
13 notwithstanding any provisions contained in the policy. The policyholder, insured, or
14 beneficiary shall have the right to choose the provider of the services notwithstanding any
15 provision to the contrary in any other statute; provided that for plans that require the use of
16 network providers either as a condition of obtaining benefits under the plan or policy or to
17 access a higher level of benefits under the plan or policy, the policyholder, insured, or
18 beneficiary must choose a provider of the services within the network, subject to the
19 requirements of the plan or policy.

20 ...

21 (c4) For purposes of this section, a "duly licensed marriage and family therapist" is a
22 person licensed by the North Carolina Marriage and Family Therapy Licensure Board pursuant
23 to Article 18C of Chapter 90 of the General Statutes.

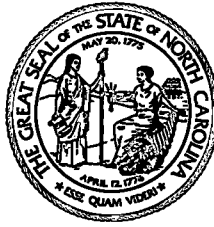
24 (c5) For purposes of this section, a "duly licensed physical therapist" is a person licensed
25 by the North Carolina Board of Physical Therapy Examiners pursuant to Article 18B of
26 Chapter 90 of the General Statutes.

27"

28 **SECTION 2.** G.S. 135-48.51(12), as enacted by S.L. 2011-85, reads as rewritten:

29 "(12) G.S. 58-50-30, Right to choose services of optometrist, podiatrist, licensed
30 clinical social worker, certified substance abuse professional, licensed
31 professional counselor, dentist, physical therapist, chiropractor,
32 psychologist, pharmacist, certified fee-based practicing pastoral counselor,
33 advanced practice nurse, licensed marriage and family therapist, or physician
34 assistant."

35 **SECTION 3.** Section 2 of this act becomes effective January 1, 2012. The
36 remainder of this act becomes effective October 1, 2011.



SPEAKER PRO TEMPORE DALE R. FOLWELL

Dale.Folwell@ncleg.net

Phone Number: 919-733-5787

Room 301F, Legislative Office Building

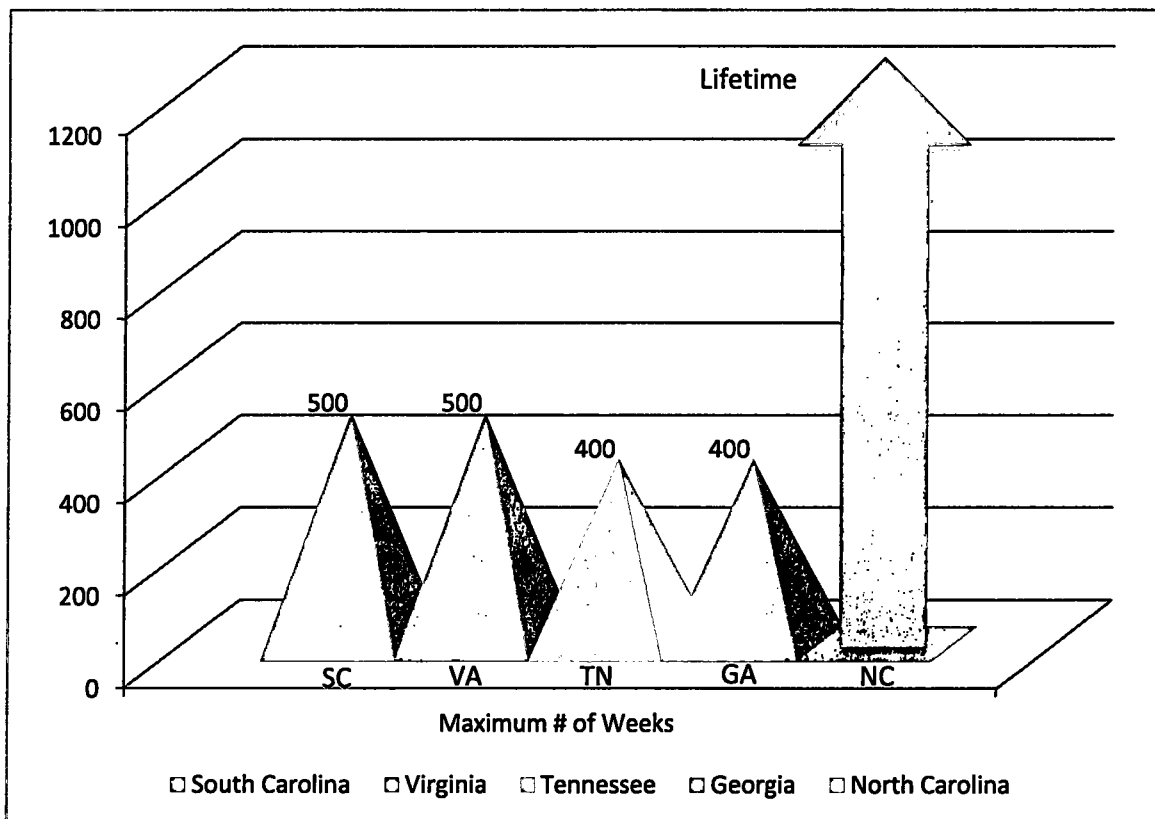
North Carolina House of Representatives

Raleigh, NC 27603-5925

WORKERS' COMPENSATION: PUTTING NORTH CAROLINA BACK TO WORK

Duration of Temporary Total Disability Benefits

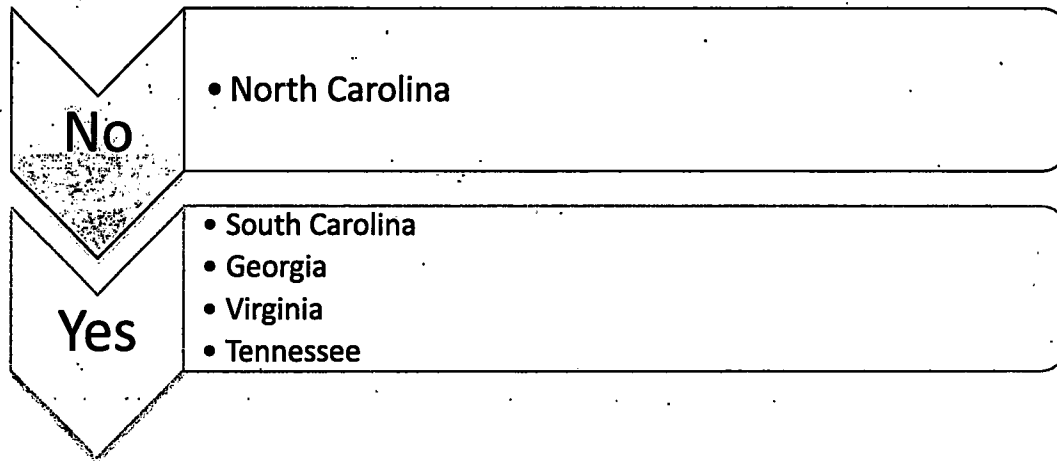
Temporary Total Disability—TTD benefits are paid when a worker is
TEMPORARILY unable to earn wages.



North Carolina hurts its ability to compete by turning our workers' comp system into a retirement system.

Over →

DO THE COMMISSIONERS ADHERE TO THE CODE OF JUDICIAL STANDARDS?



CIVITAS POLL CONDUCTED FEBRUARY 2011

Please tell me if you agree or disagree with the following statement: "A person who is injured on the job should receive workers compensation for the remainder of their life, even if they are able to work at a different job."

12%	Total Agree
85%	Total Disagree
6%	Strongly Agree
6%	Somewhat Agree
19%	Somewhat Disagree
66%	Strongly Disagree
2%	Don't Know/ No Opinion (DO NOT READ)
--	Refused (DO NOT READ)

600 registered voters conducted Feb 10, 12-13 2011 by National Research, Inc. of Holmdel, NJ.

Please Email me at DaleF@ncleg.net to join my mailing list.

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(DaleFolwell)

Over →



SENATE BILL 656: Right to Choose Physical Therapist

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Sen. Davis
Analysis of: PCS to First Edition
S656-CSTK-24

Date: June 3, 2011
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY:

The PCS to 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.

BACKGROUND:

G.S. §58-50-30 lists the various provider types from which a policy holder, insured, or beneficiary has the right to choose the provider of services under a health benefit plan, subscriber contract, or policy of insurance. The services must be of a nature that the benefit plan, contract, or policy provides coverage of, or payment or reimbursement for the services. If the plan requires use of network providers, the policy holder must choose a provider of services within the network. If the plan requires use of network providers as a condition of obtaining a higher level of benefits, the policy holder 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 of insurance 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 policy holder has the right to choose the provider of services.

BILL ANALYSIS:

Senate Bill 656 defines a "duly licensed physical therapist" as a person licensed by the North Carolina Board of Physical Therapy Examiners pursuant to Article 18B of Chapter 90 of the General Statutes.

Senate Bill 656 amends G.S. §58-50-30 to include "a duly licensed physical therapist" to the list of providers from which a policy holder, insured, or beneficiary has the right to choose the provider of services under a health benefit plan, subscriber contract, or policy of insurance.

Section 2 of Senate Bill 656 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:

Section 2 of this act becomes effective January 1, 2012. The remainder of this act becomes effective October 1, 2011.

S656-SMTK-39(CSTK-24) v3

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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D

SENATE BILL 744
PROPOSED COMMITTEE SUBSTITUTE S744-CSTK-26 [v.4]

6/7/2011 4:45:47 PM

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 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 36
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 paid claims experience by month, including claims experience for
medical, dental, and pharmacy benefits, as applicable, including an estimate
of incurred but not reported claims (IBNR).

(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.



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- 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 subdivisions (5) 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. Section 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.'

(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 days of the 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 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.

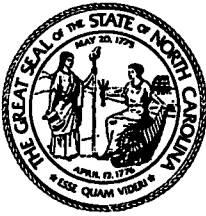
"§ 58-50-320. Compliance with Part does not create liability.

An insurer issuer 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 October 1, 2011.



SENATE BILL 744: Transparency in the Cost of Health Care

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Sen. Goolsby
Analysis of: PCS to First Edition
S744-CSTK-26

Date: June 7, 2011
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *The PCS to 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 provide 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.

The PCS removes the provisions that allowed an employer to request additional information on specific employees.

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

S744-SMTK-43(CSTK-26) v2

VISITOR REGISTRATION SHEET

INSURANCE

Name of Committee

June 9, 2011

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
TED Hamby	NC DOI
Rosewillu	NC DOJ
Steve Leone	NC Med Soc
Will Culpepper	M VII
Mike Okun	re state AECIS
JOE LANIER	NELSON MULLINS
Allison Waller	Nelson Mullins
Philip Foley	NCJ
Lisa Muth	NC Home Builders

VISITOR REGISTRATION SHEET

INSURANCE

Name of Committee

June 9, 2011

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME _____

FIRM OR AGENCY AND ADDRESS

Glen Gillette

PFFPNC

STEPHANIE GAY

AEgis Admin. Services, Inc.

Julia Dixon

Young Moore: Henderson

Whitney Christensen

Jordan Price

✓

VISITOR REGISTRATION SHEET

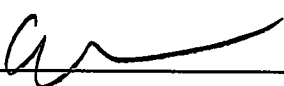
INSURANCE

Name of Committee

June 9, 2011

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Cansler	BCCOR
Michelle Frazier	MF+S
John Mullen	MF+S
Jennifer Cohen	IFNC
John Bode	Monarch Butterfly
	
Kathryn Melican	BES
Meredith Henderson	NCIC
Shir Annmarano	Farah + Annmarano
Hank Patterson	Patterson Haley LLP
David Anders	PFFPNK

SENATE INSURANCE COMMITTEE
Monday, June 13, 2011 at 1:00 PM
Room 1027, Legislative Building
MINUTES

The Senate Insurance Committee met at 1:00 PM on June 13, 2011, in Room 1027 of the Legislative Building. 7 members of the committee were present. Senator Apodaca, presided. There were no pages at this committee meeting.

HB 373 Insurance Changes to Payments & Group Life – Rep. Dockham

Rep. Dockham was not present. Tim Hovis (staff) explained the bill by going through the bill summary. Ted Hamby Deputy Commissioner for the Life and Health Division of the State Insurance also spoke on the bill. Senator Apodaca asked if any member or guests had questions and there were none. Senator Gunn moved for a favorable report and the motion passed. Senator Gunn was assigned to present this bill on the Senate Floor.

HB 453 Allow Salary Protection Insurance – Rep. Dockham

Rep Dockham was not present. Kori Goldsmith (staff) explained the bill. Senator Apodaca asked Ted Hamby the Deputy Commissioner if he had issues with this bill and he responded, "no". Senator East moved for a favorable report with a referral to the Finance Committee and the motion passed.

HB 575 Service Agreements/Allow Reserve Account – Rep. Dockham

Rep Dockham was not present. Tim Hovis explained the bill by using the summary. Senator Apodaca asked George Teague the NCPLA Director if he had an interest in this bill and he responded yes. Senator Apodaca asked Ted Hamby if he had any thoughts on this bill and he responded that it has nothing to do with him. Senator Apodaca then asked George Teague and he made positive comments regarding the bill. Senator East moved for a favorable report and the motion passed. Senator Hise was assigned to present this bill on the Senate Floor.

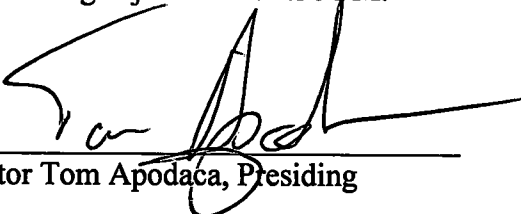
HB 501 Credit Union Ownership of Insurance Company – Rep. Dockham, Rep. Setzer, Rep. Glazier and Rep. Hamilton.

None of the before mentioned were present. Tim Hovis explained the bill using the Summary. Senator Apodaca asked if there were any questions and there were none. Senator Gunn moved for a favorable report and the motion passed. Senator Gunn was assigned to present this bill on the Senate Floor.

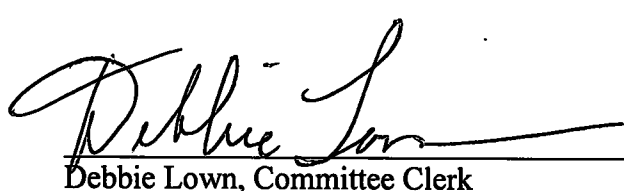
HB 664 Disclosure/Group Life Insurance – Rep. Faison, Rep. Boles, Jr. and Rep. Alexander

None of the before mentioned were present. Senator Apodaca asked Kory Goldsmith to explain the bill. Senator Apodaca asked how DOI was on this bill and Ted Hamby responded positively. Senator Apodaca asked for any questions from the committee or from guests – there were none. Senator East moved for a favorable report and the motion passed. Senator Gunn was assigned to present this bill on the Senate Floor.

The meeting adjourned at 1:30 PM.



Senator Tom Apodaca, Presiding



Debbie Lown, Committee Clerk

Senate Insurance Committee
Monday, June 13, 2011, 10:00 AM
1027 LB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 373	Insurance Changes to Payments & Group Life.	Representative Dockham
HB 453	Allow Salary Protection Insurance.	Representative Dockham
HB 575	Service Agreements/Allow Reserve Account.	Representative Dockham
HB 501	Credit Union Ownership of Ins. Co.	Representative Dockham Representative Setzer Representative Glazier Representative Hamilton
HB 664	Disclosure/Group Life Insurance.	Representative Faison Representative Boles, Jr. Representative Alexander

Presentations

Other Business

Adjournment

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

**INSURANCE COMMITTEE REPORT
Senator Tom Apodaca, Co-Chair
Senator Wesley Meredith, Co-Chair**

Monday, June 13, 2011

Senator MEREDITH,
submits the following with recommendations as to passage:

FAVORABLE

H.B.(CS #1) 373	Insurance Changes to Payments & Group Life. Sequential Referral: None Recommended Referral: None
H.B. 453	Allow Salary Protection Insurance. Sequential Referral: None Recommended Referral: Finance
H.B.(CS #1) 501	Credit Union Ownership of Ins. Co. Sequential Referral: None Recommended Referral: None
H.B.(CS #1) 575	Service Agreements/Allow Reserve Account: Sequential Referral: None Recommended Referral: None
H.B. 664	Disclosure/Group Life Insurance. Sequential Referral: None Recommended Referral: None

TOTAL REPORTED: 5

Committee Clerk Comments: \

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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HOUSE BILL 373
Committee Substitute Favorable 5/31/11

Short Title: Insurance Changes to Payments & Group Life.

(Public)

Sponsors:

Referred to:

March 17, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO AUTHORIZE THE PAYMENT OF INSURANCE PREMIUMS USING DEBIT
3 CARDS, TO FACILITATE THE PAYMENT OF INSURANCE PREMIUMS USING
4 CREDIT AND DEBIT CARDS, AND TO PERMIT THE COMMISSIONER OF
5 INSURANCE TO APPROVE NONTRADITIONAL GROUPS FOR GROUP LIFE
6 INSURANCE.

7 The General Assembly of North Carolina enacts:

8 SECTION 1. G.S. 58-3-145 reads as rewritten:

9 "§ 58-3-145. Solicitation, negotiation or payment of premiums on insurance policies.

10 An insurer, agent, or broker may accept payment of an insurance premium by credit card or
11 debit card if the insurer accepting payment by credit card or debit card meets the following
12 conditions:

13 (1) ~~The insurer makes payment by credit card available to all existing and~~
14 ~~prospective insureds and does not limit the use of credit card payments to~~
15 ~~certain persons.~~ The insurer complies with the prohibition against unfair
16 discrimination contained in G.S. 58-63-15(7).

17 (2) The insurer pays the fees charged by the credit card company or debit card
18 issuer for the payment of premiums by credit card ~~card~~ or debit card."

19 SECTION 2. G.S. 58-58-135 reads as rewritten:

20 "§ 58-58-135. "Group life insurance" defined.

21 No policy of group life insurance shall be delivered in this State unless it conforms to one
22 of the following descriptions:

23 ...
24 (5a) A policy issued to a group other than those described in subdivisions (1)
25 through (5) of this section, subject to the following requirements:

26 a. Either of the following is true:

27 1. The Commissioner has made the following findings:

28 I. The issuance of the group policy is not contrary to the
29 best interest of the public.

30 II. The issuance of the group policy would result in
31 economies of acquisition or administration.

32 III. The benefits are reasonable in relation to the
33 premiums charged.

34 2. Another state having requirements substantially similar to
35 those contained in sub-sub-subdivision 1. of this



* H 3 7 3 - V - 2 *

1 sub-subdivision has made a determination that the
2 requirements have been met.

3 b. The premium for the policy shall be paid from either the
4 policyholder's funds or funds contributed by the covered persons. or
5 from both.

6 c. An insurer may exclude or limit the coverage on any person as to
7 whom evidence of individual insurability is not satisfactory to the
8 insurer.

9 (6) Notwithstanding the provisions of this section, or any other provisions of
10 law to the contrary, a policy may be issued to the employees of the State or
11 any other political subdivision where the entire amount of premium therefor
12 is paid by such employees."

13 **SECTION 3.** This act becomes effective October 1, 2011.



HOUSE BILL 373:

Insurance Changes to Payments & Group Life

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Rep. Dockham
Analysis of: Second Edition

Date: June 13, 2011
Prepared by: Tim Hovis
Committee Counsel

SUMMARY: *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

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

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: 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.

H373-SMRG-25(CSRG-17) v4

Research Division

O. Walker Reagan, Director

(919) 733-2578

PUBLIC BILL

Title Change

Proposed Committee Substitute For
H.B. 373

SESSION LAW _____

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.

Introduced by Representative(s): *Dockham (Primary Sponsor)*

For a complete list of cosponsors for this bill, please see the report inside the bill jacket.

Principal Clerk's Use Only

The Committee on Insurance
a majority being present, having considered
this bill, recommend that it do ☒ pass.

Rep. Dockham
For the Committee

☒ FAVORABLE TO COMM. SUB
☐ UNFAVORABLE TO BILL

MAY 31 2011

AND PLACED ON
CALENDAR FOR

(2-1-11)

116-0 (adj)

Passed 2nd & 3rd Reading

115-0 EV 11

JUN 01 2011

ORDERED SENT TO SENATE

Denise Weeks

RECEIVED

JUN 02 2011

From House of Representatives
By Clerk AL 9:25 (ADP)

PASSED 1st READING

JUN 2 2011

AND REFERRED TO COMMITTEE

ON: Insurance

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H

1

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

1 A BILL TO BE ENTITLED
2 AN ACT TO AUTHORIZE THE PLACEMENT AND ISSUANCE OF SALARY
3 PROTECTION INSURANCE UNDER THE SURPLUS LINES ACT.

4 The General Assembly of North Carolina enacts:

5 SECTION 1. G.S. 58-21-10 reads as rewritten:

6 "§ 58-21-10. Definitions.

7 As used in this Article:

- 8 (1) "Admitted insurer" means an insurer licensed to do an insurance business in
9 this State.
- 10 (2) "Capital", as used in the financial requirements of G.S. 58-21-20, means
11 funds paid in for stock or other evidence of ownership.
- 12 (3) "Eligible surplus lines insurer" means a nonadmitted insurer with which a
13 surplus lines licensee may place surplus lines insurance under
14 G.S. 58-21-20.
- 15 (4) "Export" means to place surplus lines insurance with a nonadmitted insurer.
- 16 (5) "Nonadmitted insurer" means an insurer not licensed to do an insurance
17 business in this State. This definition includes insurance exchanges
18 authorized under the laws of various states.
- 19 (6) "Producing broker" means an agent or broker licensed under Article 33 of
20 this Chapter who deals directly with the party seeking insurance and who
21 may also be a surplus lines licensee.
- 22 (6a) "Salary protection insurance" means insurance against financial loss caused
23 by the cessation of earned income because of disability from sickness,
24 ailment, or bodily injury.
- 25 (7) "Surplus", as used in the financial requirements of G.S. 58-21-20, means
26 funds over and above liabilities and capital of the company for the protection
27 of policyholders.
- 28 (8) "Surplus lines insurance" means any insurance in this State of risks resident,
29 located, or to be performed in this State, permitted to be placed through a
30 surplus lines licensee with a nonadmitted insurer eligible to accept such
31 insurance, ~~other than~~ including salary protection insurance. The term does
32 not include reinsurance, commercial aircraft insurance, wet marine and
33 transportation insurance, insurance independently procured pursuant to
34 G.S. 58-28-5, life and accident or health insurance, and annuities.



* 11 4 5 3 - V - 1 *

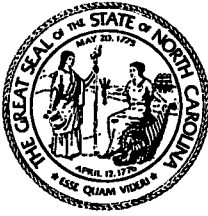
- 1 (9) "Surplus lines licensee" means a person licensed under G.S. 58-21-65 to
2 place insurance on risks resident, located, or to be performed in this State
3 with nonadmitted insurers eligible to accept such insurance.
- 4 (10) "Wet marine and transportation insurance" means:
5 a. Insurance upon vessels, crafts, hulls and of interests therein or with
6 relation thereto;
7 b. Insurance of marine builder's risks, marine war risks and contracts of
8 marine protection and indemnity insurance;
9 c. Insurance of freights and disbursements pertaining to a subject of
10 insurance coming within this subsection; and
11 d. Insurance of personal property and interests therein, in the course of
12 exportation from or importation into any country, or in the course of
13 transportation coastwise or on inland waters including transportation
14 by land, water, or air from point of origin to final destination, in
15 connection with any and all risks or perils of navigation, transit or
16 transportation, and while being prepared for and while awaiting
17 shipment, and during any delays, transshipment, or reshipment
18 incident thereto."

19 **SECTION 2.** Article 21 of Chapter 58 is amended by adding a new section to read:

20 **"§ 58-21-22. Limitation on amount of salary protection insurance.**

21 When salary protection insurance benefits are payable to an individual or an individual's
22 beneficiary, the amount of salary protection insurance plus the amount of any in-force disability
23 income insurance, if the individual can obtain disability insurance from an admitted insurer,
24 shall not exceed seventy-five percent (75%) of the individual's annual earned income. As used
25 in this section, "disability income insurance" has the same meaning as "accident and health
26 insurance" in G.S. 58-7-15(3)."

27 **SECTION 3.** This act becomes effective October 1, 2011.



HOUSE BILL 453: Allow Salary Protection Insurance

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Rep. Dockham
Analysis of: First Edition

Date: June 13, 2011
Prepared by: Kory Goldsmith
Committee Counsel

SUMMARY: *House Bill 453 authorizes surplus lines insurers to offer "salary protection insurance" that insures against the loss of earned income because of disability from sickness, ailment, or bodily injury. The maximum benefit payable to an individual (or an individual's beneficiary) from salary protection insurance and any in-force disability income insurance is 75% of the individual's annual earned 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 Senate Finance.

CURRENT LAW: Surplus lines insurers are allowed to offer coverage that is not available from insurers licensed in the State, referred to as admitted insurers. G.S. 58-21-85 imposes a 5% tax on the gross premiums charged for surplus lines insurance. State law does not currently allow surplus lines insurers to offer salary protection insurance through normal channels such as agents for surplus lines insurers.

G.S. 58-28-5 allows individuals to independently procure (i.e., without the involvement of an agent, broker, or surplus lines licensee) salary protection insurance. Individuals who independently procure insurance must file a report and pay a 5% tax on the gross premiums.

G.S. 58-51-130 gives the standards for disability income insurance offered by admitted insurers.

BILL ANALYSIS: Section 1 of House Bill 453 would amend G.S. 58-21-10 to define "Salary protection insurance" as "insurance against financial loss caused by cessation of earned income because of disability from sickness, ailment, or bodily injury." The definition of "Surplus lines insurance" is expanded to specifically include salary protection insurance.

Section 2 of House Bill 453 would add a new section to Chapter 58 (G.S. 58-21-22) setting the maximum benefit payable to an individual (or an individual's beneficiary) from salary protection insurance and any in-force disability income insurance at 75% of the individual's annual earned income. For the 75% limit on annual earned income, disability income insurance from an admitted insurer is defined as "insurance against death or personal injury by accident or by any specified kinds of accident and insurance against sickness, ailment or bodily injury."

BACKGROUND: As an industry practice, admitted insurers offer disability insurance limited to 60% of an individual's earned income with a monthly maximum benefit of \$15,000. Extremely high earning individuals such as athletes and performers cannot purchase disability insurance sufficient to replace their monthly income due to the \$15,000 monthly maximum benefit. House Bill 453 would allow surplus lines insurers to offer salary protection insurance capped at a statutory maximum of 75% of the individual's annual earned income.

EFFECTIVE DATE: House Bill 453 would become effective October 1, 2011.

H453-SMRC-54(e1) v2

PUBLIC BILL

H.B. 0450

SESSION LAW _____

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE PLACEMENT AND ISSUANCE OF SALARY PROTECTION INSURANCE
UNDER THE SURPLUS LINES ACT.

Dockham
Introduced by Representative(s): Dockham.

For a complete list of cosponsors for this bill, please see the report inside the bill jacket.

Principal Clerk's Use Only

PASSED 1st READING
MAR 24 2011
AND REFERRED TO COMMITTEE
ON Insurance

The Committee on Insurance
a majority being present, having considered
this bill, recommend that it do pass.

Rep. Dockham
For the Committee

and be re-referred to
Finance.

REPORTED FAVORABLY

MAY 10 2011

AND RE-REFERRED TO
FINANCE

The Committee on Finance
a majority being present, having considered
this bill, recommend that it do pass.
Reps. Howard, Folwell, Setzer, and Starnes.

For the Committee

REPORTED FAVORABLY MAY 18 2011

PURSUANT TO RULE 36(b)
MAY 18 2011
OF 5-25-11

Passed 2nd & 3rd Reading
115-0EV LU
MAY 25 2011
ORDERED SENT TO SENATE

Sen. Weeks

RECEIVED

MAY 26 2011

From House of Representatives
By Clerk AP: S (AM)

PASSED 1st READING
MAY 26 2011
AND REFERRED TO COMMITTEE
ON: Insurance

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H

2

HOUSE BILL 575
Committee Substitute Favorable 5/18/11

Short Title: Service Agreements/Allow Reserve Account.

(Public)

Sponsors:

Referred to:

April 4, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO PROVIDE THAT IN LIEU OF CONTRACTUAL LIABILITY INSURANCE, A
3 SERVICE CONTRACT PROVIDER MAY MAINTAIN A FUNDED RESERVE
4 ACCOUNT FOR ITS OBLIGATIONS UNDER SERVICE CONTRACTS ISSUED AND
5 OUTSTANDING IN THIS STATE.

6 The General Assembly of North Carolina enacts:

7 SECTION 1. G.S. 66-373 reads as rewritten:

8 "§ 66-373. Insurance policy requirements.

9 (a) Each company or person subject to this section shall maintain contractual liability
10 insurance or service agreement reimbursement insurance with an authorized insurer for one
11 hundred percent (100%) of claims exposure, including reported and incurred but not reported
12 claims and claims expenses, on business written in this State unless the company or
13 ~~person; person complies with all of the following:~~

14 (1) Maintains an audited net worth of ~~one hundred million dollars~~
15 ~~(\$100,000,000); one hundred million dollars (\$100,000,000).~~

16 (2) Has offered service agreement contracts or warranties, as applicable to the
17 respective company, its parent company, or person, for at least the preceding
18 10 years; ~~and years.~~

19 (3) Either is required to file and has filed an SEC Form 10K or Form 20-F with
20 the Securities and Exchange Commission (SEC) within the last calendar year
21 or, if the company does not file with the SEC, can produce, upon request, a
22 copy of the company's audited financial statements, which show a net worth
23 of the company or person of at least one hundred million dollars
24 (\$100,000,000). A company or person may utilize its parent company's Form
25 10-K, Form 20-F, or audited financial statements to satisfy this requirement
26 if the parent company agrees to guarantee the obligations of the company or
27 person relating to service agreement contracts or warranties, as applicable to
28 the respective company or person, sold by the company or person in this
29 State.

30 In lieu of complying with subdivisions (1), (2), and (3) of this subsection, the company or
31 person may maintain a funded reserve account for the purpose of meeting its obligations under
32 contracts issued and outstanding in this State. The reserves shall not be less than forty percent
33 (40%) of gross consideration received, less claims paid, on the sale of the service contract for
34 all in-force contracts.

35"

36 SECTION 2. This act becomes effective July 1, 2011.



* H 575 - V - 2 *



HOUSE BILL 575:

Service Agreements/Allow Reserve Account

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Rep. Dockham
Analysis of: Second Edition

Date: June 13, 2011
Prepared by: Tim Hovis
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-43(e2) v1

PUBLIC BILL

Proposed Committee Substitute For
H.B. 575

SESSION LAW _____

ID-2B 651

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.

Introduced by Representative(s): Dochham (Primary Sponsor)

For a complete list of cosponsors for this bill, please see the report inside the bill jacket.

Principal Clerk's Use Only

The Committee on Insurance
a majority being present, having considered
this bill, recommend that it do ✓ pass.

Rep. Dochham
For the Committee

☒ FAVORABLE TO COMM. SUB.
☐ UNFAVORABLE TO BILL

MAY 18 2011

366 AND PLACED ON
CALENDAR FOR
8-25-11

Passed 2nd & 3rd Reading
115-067 VV
MAY 25 2011
ORDERED SENT TO SENATE

Kenise Weeks

RECEIVED

MAY 26 2011

From House of Representatives
By Clerk APR 26 PM

PASSED 1st READING

MAY 26 2011

AND REFERRED TO COMMITTEE
ON: Insurance

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H

2

HOUSE BILL 501
Committee Substitute Favorable 5/18/11

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



1 of any such deposit in an insolvent United States bank, savings and loan
2 association, credit union, or trust company, to the extent insured by a federal
3 agency."

4 **SECTION 5.** G.S. 58-7-172 reads as rewritten:

5 **"§ 58-7-172. Cash and deposits.**

6 An insurer may have funds in coin or currency of the United States on hand or on deposit in
7 any solvent national or state bank, savings and loan association, credit union, or trust
8 company."

9 **SECTION 6.** G.S. 58-7-173(14) reads as rewritten:

10 "(14) Share or savings accounts of credit unions, savings and loan associations or
11 building and loan associations."

12 **SECTION 7.** This act becomes effective October 1, 2011.



HOUSE BILL 501: Credit Union Ownership of Ins. Co

2011-2012 General Assembly

Committee:	Senate Insurance	Date:	June 12, 2011
Introduced by:	Reps. Glazier, Dockham, Hamilton, Setzer	Prepared by:	Tim Hovis*
Analysis of:	Second Edition		Committee Counsel

SUMMARY: *House Bill 501 authorizes 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.*

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 an insurance company's deposits 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: 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 bill 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 bill also makes conforming changes to G.S. 58-162(1), 58-172 and 58-173(14) to add "credit unions" to the list of financial institutions referenced in those sections.

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

*This summary was substantially contributed to by Bill Patterson, Staff Attorney, Research Division.

H501-SMRG-41(e2) v3

Research Division

O. Walker Reagan, Director

(919) 733-2578

PUBLIC BILL

Title Change

Proposed Committee Substitute For
H.B. 501

SESSION LAW

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE OWNERSHIP OF INSURANCE COMPANIES BY CREDIT UNIONS.

Introduced by Representative(s): *Glazier, Dockham, Hamilton, and Setzer*
(primary sponsor)

For a complete list of cosponsors for this bill, please see the report inside the bill jacket.

Principal Clerk's Use Only

The Committee on Insurance
a majority being present, having considered
this bill, recommend that it do ☒ pass

Rep. Dockham
For the Committee

and be re-referred
to Finance Banking

FAVORABLE TO COMM. SUB
UNFAVORABLE TO BILL

MAY 18 2011

APPROVED ON
CALENDAR FOR

Banking
Finance

ON MOTION OF REP.
WITHDRAWN FROM

T. Moore
Banking

MAY 18 2011

RECOMMITTED TO

Cal 366
5-25-11

Passed 2nd & 3rd Reading

114-OEV VV

MAY 25 2011

ORDERED SENT TO SENATE

Kenise Weeks

RECEIVED

MAY 26 2011

From House of Representatives
Clerk 19:30 AMPM

PASSED 1st READING

MAY 26 2011

AND REFERRED TO COMMITTEE

ON: Insurance

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H

2

HOUSE BILL 664
Second Edition Engrossed 5/25/11

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

1 A BILL TO BE ENTITLED
2 AN ACT TO PROVIDE CERTAIN INFORMATION REGARDING A DECEASED
3 PERSON'S GROUP LIFE INSURANCE TO A FUNERAL DIRECTOR OR
4 ESTABLISHMENT.

5 The General Assembly of North Carolina enacts:

6 SECTION 1. G.S. 58-58-97 reads as rewritten:

7 "§ 58-58-97. Provision of life insurance information upon notification of insured's death.

8 (a) Any person licensed to practice funeral directing or any employee of a funeral
9 establishment licensed under the provisions of Article 13A of Chapter 90 of the General
10 Statutes providing funeral service, as that term is defined in G.S. 90-210.20, for a deceased
11 person insured or believed to be insured under a contract of life insurance or under a group life
12 insurance policy may request information regarding the deceased person's life insurance
13 contracts by providing an insurer with (i) a copy of a notification of death filed pursuant to
14 ~~G.S. 130A-112 and~~ G.S. 130A-112, (ii) written authorization from the person or persons with
15 legal authority to direct disposition of the deceased's body as prescribed under G.S. 90-210.124
16 or ~~G.S. 130A-420~~ G.S. 130A-420, and (iii) in the case of a person covered or believed to be
17 covered under a group life insurance policy, the affiliation of the deceased entitling them to
18 coverage under the group life insurance policy. As soon as possible after receipt of the request,
19 the life insurance company shall inform the person authorized by this section to make an
20 inquiry of the following:

- 21 (1) The existence of any contract insuring the life of the deceased person.
- 22 (2) Any beneficiaries on record under any life insurance contract insuring the
- 23 life of the deceased person.
- 24 (3) The amount of any liens or loans outstanding on the policy.
- 25 (4) The amount of benefits payable to the beneficiaries.
- 26 (5) Whether the policy has been reinstated within the last 24 months.

27 The insurer shall provide a claim form to any person or assignee making the request.

28 (b) If any person making a written request under subsection (a) of this section who has
29 provided all the information required by subsection (a) of this section does not receive a timely
30 response from the insurer, then the person may refer the request to the Consumer Services
31 Division of the Department, which shall treat the referral as a consumer complaint. The referral
32 shall include all the information provided to the insurer under subsection (a) of this section as
33 well as copies of all communications and information received from the insurer regarding the
34 request for information.



1 (c) If the beneficiary of record under the life insurance contract or group life insurance
2 policy is not the estate of the deceased, then any person authorized to request information under
3 subsection (a) of this section shall make reasonable efforts to locate the beneficiaries within
4 100 hours of receiving information from the insurance carrier regarding any life insurance
5 contracts or group life insurance policies and shall provide to all beneficiaries all documents
6 and information obtained from the insurance carrier. The person obtaining the information also
7 shall inform all beneficiaries in writing in bold print that "THE BENEFICIARY OF A LIFE
8 INSURANCE POLICY HAS NO LEGAL DUTY OR OBLIGATION TO SPEND ANY OF
9 THAT MONEY ON THE FUNERAL, DEBTS, OR OBLIGATIONS OF THE DECEASED"
10 and shall do so before discussing with the beneficiaries financial arrangements for burial of the
11 deceased.

12 (d) Any licensee or employee of a funeral establishment licensed under Article 13A of
13 Chapter 90 of the General Statutes who makes a false request for information under this section
14 or fails to do that required by subsection (c) of this section shall be deemed guilty of fraud or
15 misrepresentation in the practice of funeral service as defined in G.S. 90-210.25(e)(1)b. and
16 unfit to practice funeral service.

17 (e) This section shall apply to life insurance companies as defined in G.S. 58-58-1 and
18 to all contracts subject to the provisions of this Article."

19 **SECTION 2.** This act is effective when it becomes law.



HOUSE BILL 664: Disclosure/Group Life Insurance

2011-2012 General Assembly

Committee:	Senate Insurance	Date:	June 13, 2011
Introduced by:	Reps. K. Alexander, Faison, Boles	Prepared by:	Kory Goldsmith
Analysis of:	Second Edition		Committee Counsel

SUMMARY: *House Bill 664 permits licensed funeral directors and funeral home employees to obtain certain information 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.

It also clarifies that the provisions apply to life insurance companies as defined in G.S. 58-58-1 and to all contracts subject to Article 58 of Chapter 58 of the General Statutes. G.S. 58-58-1 defines a life insurance company as: "[a]ll corporations or associations doing business in this State, under any charter or statute of this or any other state, involving the payment of money or other thing of value to families or representatives of policy and certificate holders or members, conditioned upon the continuance or cessation of human life, or involving an insurance, guaranty, contract, or pledge for the payment of endowments or annuities, or who employ agents to solicit such business." Article 58 of Chapter 58 deals with Life Insurance and Viatical Settlements.

EFFECTIVE DATE: This act is effective when it becomes law.

Bill Patterson, counsel to House Insurance, substantially contributed to this summary.

H664-SMRC-55(e2) v1

PUBLIC BILL

H.B. 9666

SESSION LAW _____

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

Introduced by Representative(s): K. Alexander ^{K.A.}

Faison *Bales* *(Perry)*
Faison *Bales*

For a complete list of cosponsors for this bill, please see the report inside the bill jacket.

Principal Clerk's Use Only

PASSED 1st READING
APR 07 2011
AND REFERRED TO COMMITTEE
ON Insurance

Passed 2nd & 3rd Readings
114-1 EV VV
MAY 25 2011
AND ORDERED ENGROSSED
AND SENT TO SENATE

Sen. Weeks

The Committee on Insurance
a majority being present, having considered
this bill, recommend that it do ☒ pass.

Rep. Dockham
For the Committee

REPORTED FAVORABLY MAY 24 2011

PURSUANT TO RULE 36(b)
MAY 24 2011
PLACED ON CALENDAR
OF 5-25-11

K. Alexander
AMENDMENT NO. 112-1 EV

MAY 25 2011

RECEIVED

MAY 26 2011

From House of Representatives
By Clerk *SP* 8:52 AM PM

PASSED 1st READING
MAY 31 2011
AND REFERRED TO COMMITTEE
ON Insurance

VISITOR REGISTRATION SHEET

INSURANCE

Name of Committee

June 13, 2011

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chp Bygga	NCMS
Arny Whitel	NCMS
N. Gordon Egan	DLC + Assoc
TED HAMBY	NCDOI
JOE LANIER	NELSON MULLINS
Tim KENT	NC Beer & Wine Wholesalers
Py	NCCL
Cynthia Barnett	Legislative rep. for Christian Science in NC
Harry Lyle	DMC
BM Lobb	TSS
Iron Percy	Ragdale Liggett PLLC

VISITOR REGISTRATION SHEET

INSURANCE

Name of Committee

June 13, 2011

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Amy Kullbright	KV states
Harry Dixon	SECU
Suzanne Beasley	SEANC
Camron Soman	NCRFIC
Fred Renard	NCREIL
Heri Bero	NUWC
John Hardin	MFS
MIKE WATERS	NCRPA
Dan Hsu	SA
Doug Lassiter	NCSTA
Payne	Mul

VISITOR REGISTRATION SHEET

INSURANCE

Name of Committee

June 13, 2011

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME**FIRM OR AGENCY AND ADDRESS**

Er Wiederhold

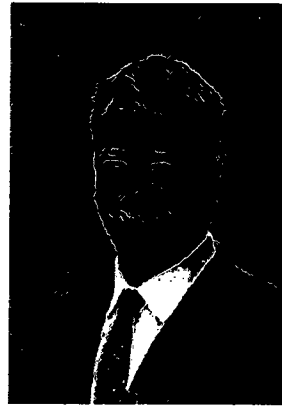
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INSURANCE SENATE COMMITTEE

2011 - 2012



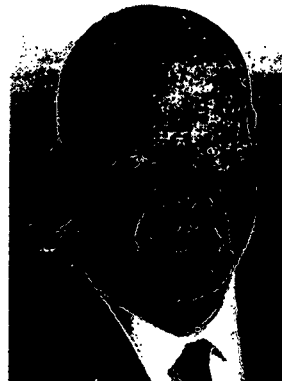
Tom Apodaca
Co-Chair



Wesley Meredith
Co-Chair



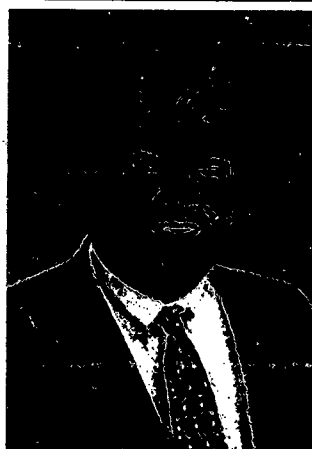
Rick Gunn
Vice-Chair



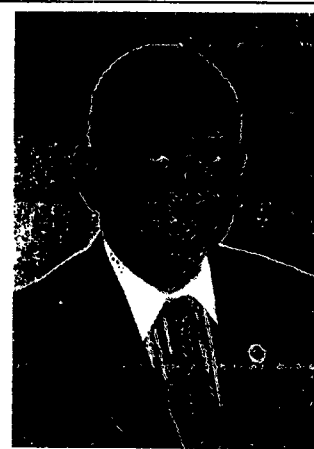
Ralph Hise
Vice-Chair



Bob Atwater



Doug Berger



Floyd McKissick



Jim Davis



Don East



Linda Garrou



Brent Jackson



Buck Newton



David Rouzer



Bob Rucho



Don Vaughan



Michael Walters



Stan White

North Carolina General Assembly
Through Senate Committee on
Insurance

Date: 07/17/2012
Time: 09:09
Page: 001 of 002
Leg. Day: H-138/S-138

2011-2012 Biennium

Bill	Introducer	Short Title	Latest Action	In Date	Out Date
H0138	Dockham	AMEND HEALTH INSURANCE RISK POOL STATUTES.	*SR Ch. SL 2011-58	03-08-11	04-14-11
H0244=	Murry	STATE HEALTH PLAN/ADD SCHOOLS; WHISTLEBLOWERS.	*S Pres. To Gov. 7/3/ 2012	06-09-11	06-06-12
H0298=	Dockham	INSURANCE AMENDMENTS.- AB	*SR Ch. SL 2011-196	05-26-11	06-09-11
H0373	Dockham	INSURANCE CHANGES TO PAYMENTS & GROUP LIFE.	*SR Ch. SL 2011-215	06-02-11	06-13-11
H0453	Dockham	ALLOW SALARY PROTECTION INSURANCE.	SR Ch. SL 2011-370	05-26-11	06-13-11
H0501	Glazier	CREDIT UNION OWNERSHIP OF INS. CO.	*SR Ch. SL 2011-221	05-26-11	06-13-11
H0575=	Dockham	SERVICE AGREEMENTS/ ALLOW RESERVE ACCOUNT.	*SR Ch. SL 2011-222	05-26-11	06-13-11
H0578=	Murry	STATE HEALTH PLAN/ ADDITIONAL CHANGES.	*SR Ch. SL 2011-96	05-02-11	05-18-11
H0664	K. Alexander	DISCLOSURE/GROUP LIFE INSURANCE.	*SR Ch. SL 2011-229	05-31-11	06-13-11
H0709=	Folwell	PROTECT AND PUT NC BACK TO WORK.	*SR Ch. SL 2011-287	06-02-11	06-09-11
H0928	Folwell	STATE HEALTH PLAN SOLVENCY REFORM ACT.	*S Ref To Com On Insurance	06-10-11	
H1044	Shopard	MOTORCYCLE INSURANCE DISCOUNT/MILITARY.	*SR Ch. SL 2012-176	06-21-12	06-26-12
H1085	Dollar	STATE HEALTH PLAN/ STATUTORY CHANGES.-AB	*SR Ch. SL 2012-173	06-13-12	06-26-12
S0006	Doug Berger	STATE HEALTH PLAN/ REFUNDS FOR NO COVERAGE.	*S Re-ref Com On Appropriations/ Base Budget	01-31-11	05-05-11
0115=	William R. Purce	COVERAGE FOR TREATMENT OF AUTISM DISORDERS.	S Ref To Com On Insurance	02-24-11	
S0195	Tom Apodaca	OPERATION OF MOPEDS.	*S Re-ref Com On Finance	03-03-11	04-14-11
S0236	Thom Goolsby	ADOPT STATE BUTTERFLY; FESTIVALS.	*SR Ch. SL 2012-29	06-08-11	06-09-11
S0244	Peter S. Brunste	FIRE AND RESCUE/ SURVIVOR'S BENEFIT.	*SR Ch. SL 2011-92	03-08-11	03-14-11
S0265	Tom Apodaca	STATE HEALTH PLAN/ APPROPRIATIONS AND TRANSFER.	*S Read	03-14-11	03-22-11
S0282=	Josh Stein	STATE HEALTH PLAN/ADD STERLING MONTESSORI.	S Ref To Com On Insurance	03-10-11	
S0285	Tom Apodaca	SHP/ ADMINISTRATIVE COMMISSION APPOINTMENTS.	S Ref To Com On Insurance	03-10-11	
S0321=	Tom Apodaca	SURPLUS LINES/PREMIUM TAX.-AB	*SR Ch. SL 2011-120	03-14-11	04-14-11
\$ S0323=	Tom Apodaca	STATE HLTH PLAN/ APPROPRIATIONS & TRANSFER LL.	*SR Ch. SL 2011-85	03-14-11	03-24-11
S0364	Daniel G. Clodfe	CANCEL AIRCRAFT LIEN W/ SURETY BOND DEPOSIT.	S Re-ref Com On Rules, Calendar, and Operations of	03-17-11	04-07-11

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A bold line indicates the bill is an appropriation bill.

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'=' indicates that the original bill is identical to another bill.

North Carolina General Assembly
Through Senate Committee on
Insurance

Date: 07/17/2012
Time: 09:09
Page: 002 of 002
Leg. Day: H-138/S-138

2011-2012 Biennium

Bill	Introducer	Short Title	Latest Action	In Date	Out Date
			the House		
S0395	Thom Goolsby	PROPERTY INSURANCE RATE REVIEW BOARD.	S Ref To Com On Insurance	03-23-11	
S0477=	Tom Apodaca	REDUCE OVERPOPULATION OF REINSURANCE FACILITY.	S Ref To Com On Insurance	03-31-11	
S0490	Bob Rucho	AUTOMOBILE INSURANCE REGULATORY MODERNIZATION.	S Ref To Com On Insurance	04-04-11	
S0517	Tom Apodaca	FREEDOM TO NEGOTIATE HEALTH CARE RATES.	*S Re-assigned To Judiciary Subcommittee B	04-06-11	06-07-11
S0544=	Harry Brown	PROTECT AND PUT NC BACK TO WORK.	S Ref To Com On Insurance	04-12-11	
S0585	Peter S. Brunste	STATE HEALTH PLAN/ STUDY PRETAX CONTRIBUTION.	S Ref To Com On Insurance	04-14-11	
S0609	David Rouzer	FACILITATE LOCUM TENENS PHYSICIANS.	*SR Ch. SL 2011-315	04-27-11	06-07-11
S0633	Andrew C. Brock	STATE HEALTH PLAN/ LIMITED ABORTION COVERAGE.	S Ref To Com On Insurance	04-19-11	
S0647	Bob Rucho	MUTUAL INSURANCE HOLDING COMPANIES.	*SR Ch. SL 2012-161	04-19-11	06-07-11
S0656	Jim Davis	RIGHT TO CHOOSE PHYSICAL THERAPIST.	*SR Ch. SL 2012-129	04-20-11	06-09-11
S0678	David Rouzer	AUTOMOTIVE GLASS REPAIR/INS. COVERAGE.	S Ref To Com On Insurance	04-20-11	
S0702	Wesley Meredith	DIRECTOR AND OFFICER INSURANCE FOR TREASURER.	*SR Ch. SL 2011-300	04-20-11	06-07-11
S0716	Harry Brown	STUDY STATEWIDE PROPERTY INSURANCE STRUCTURE.	S Ref To Com On Insurance	04-20-11	
S0729	Thom Goolsby	TECHNOLOGY TO CATCH UNINSURED MOTORISTS.	S Ref To Com On Insurance	04-20-11	
S0738	Thom Goolsby	SOLE SOURCE ED. REQUIREMENTS/BAIL BONDSMEN.	*SR Ch. SL 2012-183	04-20-11	06-07-11
S0744	Thom Goolsby	TRANSPARENCY IN THE COST OF HEALTH CARE.	*S Ref To Com On Insurance	04-27-11	06-09-11
S0836=	Harry Brown	IMPROVE PROPERTY INSURANCE RATE MAKING.	*SR Ch. SL 2012-162	05-22-12	06-06-12
S0849	Thom Goolsby	AMEND OFFICER SALARY CONTINUATION.	*S Re-ref Com On Judiciary Subcommittee B	05-22-12	06-06-12
S0852	Warren Daniel	TRANSFER FRAUD UNIT.	S Ref To Com On Insurance	05-22-12	
S0869=	Warren Daniel	REMOVE RESTRICTION/ FIREFIGHTER DISABILITY.	*SR Ch. SL 2012-82	05-23-12	06-06-12

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North Carolina General Assembly
Pending Senate Committee on
Insurance

Date: 07-17-2012
Time: 09:07
Page: 001 of 001
Leg. Day: H-138/S-138

2011-2012 Biennium

Bill	Introducer	Short Title		Date	Latest Action
H 928	Folwell	STATE HEALTH PLAN SOLVENCY REFORM ACT.	*S	06-10-2011	Ref To Com On Insurance
S 115=	Parcell	COVERAGE FOR TREATMENT OF AUTISM DISORDERS.	S	02-24-2011	Ref To Com On Insurance
S 282=	Stein	STATE HEALTH PLAN/ADD STERLING MONTESSORI.	S	03-10-2011	Ref To Com On Insurance
S 285	Apodaca	SHP/ ADMINISTRATIVE COMMISSION APPOINTMENTS.	S	03-10-2011	Ref To Com On Insurance
S 395	Goolsby	PROPERTY INSURANCE RATE REVIEW BOARD.	S	03-23-2011	Ref To Com On Insurance
S 477=	Apodaca	REDUCE OVERPOPULATION OF REINSURANCE FACILITY.	S	03-31-2011	Ref To Com On Insurance
S 490	Rucho	AUTOMOBILE INSURANCE REGULATORY MODERNIZATION.	S	04-04-2011	Ref To Com On Insurance
S 544=	Brown	PROTECT AND PUT NC BACK TO WORK.	S	04-12-2011	Ref To Com On Insurance
S 585	Brunstetter	STATE HEALTH PLAN/STUDY PRETAX CONTRIBUTION.	S	04-14-2011	Ref To Com On Insurance
S 633	Brock	STATE HEALTH PLAN/LIMITED ABORTION COVERAGE.	S	04-19-2011	Ref To Com On Insurance
S 678	Rouzer	AUTOMOTIVE GLASS REPAIR/INS. COVERAGE.	S	04-20-2011	Ref To Com On Insurance
S 716	Brown	STUDY STATEWIDE PROPERTY INSURANCE STRUCTURE.	S	04-20-2011	Ref To Com On Insurance
S 729	Goolsby	TECHNOLOGY TO CATCH UNINSURED MOTORISTS.	S	04-20-2011	Ref To Com On Insurance
S 852	Daniel	TRANSFER FRAUD UNIT.	S	05-22-2012	Ref To Com On Insurance

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ATTENDANCE

Committee: INSURANCE

NAMES	DATES																
Apodaca, Tom Sen. Co-Chair	6.6.12	/															
Meredith, Wesley Sen. Co-Chair	/																
Gunn, Rick Sen. Vice Chairman	/																
Hise, Ralph Sen. Vice Chairman	/																
Atwater, Bob Sen.	/																
Berger, Doug Sen.																	
~~REDACTED~~																	
Davis, Jim Sen.	/																
East, Don Sen.	/																
Garrou, Linda Sen.	/																
Jackson, Brent Sen.	/																
Newton, Buck Sen.																	
Rouzer, David Sen.	/																
Rucho, Bob Sen.	/																
Vaughan, Don Sen.	/																
Walters, Michael Sen.	/																
White, Stan Sen.	/																
McLugan	/																
															</		

SENATE INSURANCE COMMITTEE
Wednesday, June 6, 2012 at 10:00 AM
Room 1027, Legislative Building
MINUTES

The Senate Insurance Committee met at 10:00 AM on June 6, 2012, in Room 1027 of the Legislative Building. 15 members of the committee were present. Senator Apodaca presided. There were 9 pages at this committee meeting.

SB 836 Improve Property Insurance Rate Making – Sen. Brown

Senator Meredith moved to accept the PCS and the members were all in favor. Senator Brown was then introduced to explain the bill. Senator McKissick asked questions regarding effective dates, data being shared, and actuarial analysis. Senator Brown responded satisfying Senator McKissick. Senator Rucho was recognized and addressed Rose Von Williams from the Department of Insurance. She responded. Senator Meredith moved amendment the bill on page 3 line 22. No questions and Senator Meredith moves to adopt the amendment. The amendment was voted on with no opposition. Senator Hise moved negative to the original bill and positive to the PCS as amended – the ayes had it.

HB 244 State Health Plan/Add Schools – Rep. Murray

Senator Meredith moved to bring the PCS for HB 244 for consideration. It was so moved. Rep. Murray introduced the bill. Senator Hise also explained the bill because he assisted with a section and explained this section. Senator Apodaca asked if Senator Stein had introduced a companion bill and was told yes. Senator Garrou expressed that the bill was important and said that the two bills had no relevancy. Senator Apodaca responded that he felt this was an important bill that came after the filing date and he ruled it germane to this bill. Senator Meredith made a motion to pass the PCS negative to the original bill and it passed.

SB 849 Amend Officers Salary Continuation – Senator Goolsby

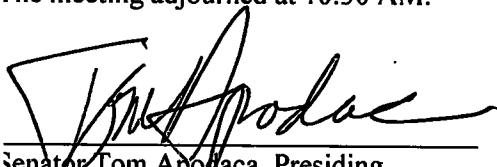
Senator Meredith moved to consider the PCS – the ayes had it. Senator Goolsby explained the bill. Senator McKissick questioned “extreme activity.” Senator Goolsby responded in line of duty injuries would qualify and lesser injuries to workman’s comp. Senator McKissick question the term “extreme activity” and Senator Goolsby explained that was the term that was suggested by the legal team. And that is the better term possible at this time. Senator McKissick had a follow up question and Senator Goolsby responded. Senator East commented that it was reasonable. Cory Goldsmith on staff explained that this language is already being used in the State Statutes. Senator Apodaca asked if there was anyone in the audience that would like to speak on this bill. No one responded. Senator Davis made the motion – unfavorable to the original bill and favorable to the PCS and it passed.

SB 869 Remove Restriction/Firefighter Disability –

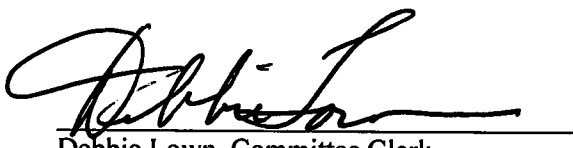
Senator Carney, Senator Newton, and Senator Daniel

Senator Daniel was introduced to speak on the bill. No comments from the committee. Senator Apodaca asked if there were any comments outside the committee. Fireman Kevin Gordon from Senator Daniel’s district spoke. Fireman Gordon supported the bill and then shared various injury statistics and he then introduced two others from the audience; Paul Miller the State Director of the Fireman’s Association who stated that he supports the bill and Kenneth Mullin the Executive Director to the NC Association of Fire Chiefs who stated that he also supported the bill. Senator Daniel also called attention to the fact per the actuarial note that there is no impact to the system with this bill. Senator Meredith moved for a favorable report to SB 869 and it was passed.

The meeting adjourned at 10:30 AM.



Senator Tom Apodaca, Presiding



Debbie Lown, Committee Clerk

Senate Insurance Committee
Wednesday, June 6, 2012, 10:00 AM
1027 LB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB	State Health Plan/Add	Representative
244	Schools.	Murry
SB	Amend Officer Salary	Senator Goolsby
849	Continuation.	
SB	Improve Property Insurance	Senator Brown
836	Rate Making.	
SB	Remove	Senator Carney
869	Restriction/Firefighter	Senator Newton
	Disability.	Senator Daniel

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY

SENATE

INSURANCE COMMITTEE REPORT

Senator Tom Apodaca, Co-Chair

Senator Wesley Meredith, Co-Chair

Wednesday, June 06, 2012

Senator APODACA,

submits the following with recommendations as to passage:

FAVORABLE

S.B. **869** Remove Restriction/Firefighter Disability.

Sequential Referral: None

Recommended Referral: None

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **836** Improve Property Insurance Rate Making.

Draft Number: 95235

Sequential Referral: None

Recommended Referral: None

Long Title Amended: Yes

S.B. **849** Amend Officer Salary Continuation.

Draft Number: 75204

Sequential Referral: None

Recommended Referral: None

Long Title Amended: No

**UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO
SENATE COMMITTEE SUBSTITUTE BILL**

H.B.(CS #1) **244** State Health Plan/Add Schools.

Draft Number: 70288

Sequential Referral: None

Recommended Referral: None

Long Title Amended: Yes

TOTAL REPORTED: 4

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

1

SENATE BILL 836

Short Title: Improve Property Insurance Rate Making.

(Public)

Sponsors: Senator Brown.

Referred to: Insurance.

May 22, 2012

1 A BILL TO BE ENTITLED
2 AN ACT TO IMPROVE THE RATE-MAKING PROCESS AND THE AFFORDABILITY
3 OF PROPERTY INSURANCE FOR LOW-INCOME HOMEOWNERS BY REQUIRING
4 THAT MORE THAN ONE CATASTROPHE MODEL BE USED TO ESTIMATE
5 POTENTIAL LOSSES FOR PURPOSES OF A RATE FILING; AND BY REQUIRING
6 THAT THE RATE BUREAU CREATE A RATING PLAN FOR A PROPERTY
7 INSURANCE POLICY THAT EXCLUDES COVERAGE FOR THE PERILS OF
8 WINDSTORM AND HAIL; AND BY REQUIRING THE DEPARTMENT OF
9 INSURANCE TO ACCEPT PUBLIC COMMENT ON ALL PROPERTY INSURANCE
10 RATE FILINGS; AND BY PROVIDING FOR A PREHEARING CONFERENCE FOR
11 THE COMMISSIONER OF INSURANCE TO SCRUTINIZE CATASTROPHE
12 MODELING WHEN SUCH MODELING IS THE BASIS FOR ANY FACTOR IN A
13 RATE FILING FOR WHICH THE COMMISSIONER HAS ISSUED A NOTICE OF
14 HEARING; AND BY PROVIDING THE COMMISSIONER WITH THE POWER TO
15 SPECIFY THE APPROPRIATE RATE LEVEL OR LEVELS UPON A FINDING THAT
16 A RATE FILING DOES NOT COMPLY WITH APPLICABLE LAW; AND BY
17 REQUIRING THAT, WHEN THE COST OF REINSURANCE IS INCLUDED AS A
18 FACTOR IN A PROPOSED RATE, CERTAIN SUPPORTING INFORMATION BE
19 PROVIDED AND THAT THE FILING INCLUDE ONLY THE REINSURANCE COST
20 SPECIFIC TO PROPERTY INSURANCE LOSSES IN NORTH CAROLINA; AND BY
21 REQUIRING THAT THE RATE BUREAU AND THE DEPARTMENT OF INSURANCE
22 STUDY THE FAIRNESS AND EFFICACY OF THE CURRENT PROPERTY
23 INSURANCE GEOGRAPHIC RATE TERRITORIES, AS RECOMMENDED BY THE
24 LEGISLATIVE RESEARCH COMMISSION COMMITTEE ON PROPERTY
25 INSURANCE RATE MAKING.

26 The General Assembly of North Carolina enacts:

27 SECTION 1. G.S. 58-36-10 reads as rewritten:

28 "§ 58-36-10. Method of rate making; factors considered.

29 The following standards shall apply to the making and use of rates:

- 30 (1) Rates or loss costs shall not be excessive, inadequate or unfairly
31 discriminatory.
32 (2) Due consideration shall be given to actual loss and expense experience
33 within this State for the most recent three-year period for which that
34 information is available; to prospective loss and expense experience within
35 this State; to the hazards of conflagration and catastrophe; to a reasonable



* S 8 3 6 - V - 1 *

margin for underwriting profit and to contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers; to investment income earned or realized by insurers from their unearned premium, loss, and loss expense reserve funds generated from business within this State; to past and prospective expenses specially applicable to this State; and to all other relevant factors within this State: Provided, however, that countrywide expense and loss experience and other countrywide data may be considered only where credible North Carolina experience or data is not available.

(3) In the case of property insurance rates under this Article, consideration may be given to the experience of property insurance business during the most recent five-year period for which that experience is available. In the case of property insurance rates under this Article, consideration shall be given to the insurance public protection classifications of fire districts established by the Commissioner. The Commissioner shall establish and modify from time to time insurance public protection districts for all rural areas of the State and for cities with populations of 100,000 or fewer, according to the most recent annual population estimates certified by the State Budget Officer. In establishing and modifying these districts, the Commissioner shall use standards at least equivalent to those used by the Insurance Services Office, Inc., or any successor organization. The standards developed by the Commissioner are subject to Article 2A of Chapter 150B of the General Statutes. The insurance public protection classifications established by the Commissioner issued pursuant to the provisions of this Article shall be subject to appeal as provided in G.S. 58-2-75, et seq. The exceptions stated in G.S. 58-2-75(a) do not apply. If the Rate Bureau presents any modeled losses with a property insurance rate filing, the Bureau shall present data from more than one catastrophe model."

SECTION 2. 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 3. G.S. 58-44-60 reads as rewritten:

"§ 58-44-60. Notice to property insurance policyholder about flood, earthquake, mudslide, mudflow, ~~and 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

1 YOUR POLICY. YOU SHOULD READ YOUR ENTIRE POLICY TO UNDERSTAND
2 WHAT IS COVERED AND WHAT IS NOT COVERED."

3 (b) As used in this section, "insurer" includes an entity that sells property insurance
4 under Articles 21, 45, or 46 of this Chapter."

5 SECTION 4. G.S. 58-36.20 reads as rewritten:

6 "**§ 58-36-20. Disapproval; hearing, order; adjustment of premium, review of filing.**

7 (a) ~~At any time within 50 days after the date of any filing, the Commissioner may give~~
8 ~~written notice to the Bureau specifying in what respect and to what extent the Commissioner~~
9 ~~contends the filing fails to comply with the requirements of this Article and fixing a date for~~
10 ~~hearing not less than 30 days from the date of mailing of such notice. With respect to any~~
11 property insurance rate filing, except as provided in G.S. 58-36-25, or any Workers'
12 Compensation loss cost filing, a filing made by the Bureau under G.S. 58-36-15 is not effective
13 until approved by the Commissioner or unless 50 days have elapsed since the making of a
14 proper filing under that subsection and the Commissioner has not called for a hearing on the
15 filing. If the Commissioner calls for a hearing, the Commissioner must give written notice to
16 the Bureau, specify in the notice in what respect the filing fails to comply with this Article, and
17 fix a date for the hearing that is not less than 30 days from the date the notice is mailed. Once
18 begun, hearings must proceed without undue delay. At the hearing the burden of proving that
19 the proposed rates or loss costs are not excessive, inadequate, or unfairly discriminatory is on
20 the Bureau. At the hearing the factors specified in G.S. 58-36-10 shall be considered. If the
21 Commissioner after hearing finds that the filing does not comply with the provisions of this
22 Article, he may issue his order determining wherein and to what extent such filing is deemed to
23 be improper and fixing a date thereafter, within a reasonable time, after which the filing shall
24 no longer be effective. Any order issued after a hearing shall be issued within 45 days after the
25 completion of the hearing. If no order is issued within 45 days after the completion of the
26 hearing, the filing shall be deemed to be approved.

27 (b) ~~In the event that no notice of hearing shall be issued within 50 days from the date of~~
28 ~~any such filing, the filing shall be deemed to be approved. If the Commissioner disapproves~~
29 ~~such filing pursuant to subsection (a) as not being in compliance with G.S. 58-36-10, he may~~
30 ~~order an adjustment of the premium to be made with the policyholder either by collection of an~~
31 ~~additional premium or by refund, if the amount exceeds five dollars (\$5.00). The Commissioner~~
32 ~~may thereafter review any filing in the manner provided; but if so reviewed, no adjustment of~~
33 ~~any premium on any policy then in force may be ordered.~~

34 (c) ~~For workers' compensation insurance and employers' liability insurance written in~~
35 ~~connection therewith, the period between the date of any filing and the date the Commissioner~~
36 ~~may give written notice as described in subsection (a) of this section and the period between the~~
37 ~~date of any filing and the deadline for giving notice of hearing as described in subsection (b) of~~
38 ~~this section shall be 60 days.~~

39 (d) All property insurance rate filings shall be open to the public except as provided in
40 this Article where necessary to maintain the confidentiality of certain testimony. At least 30
41 days before a notice of hearing issues, the Department shall accept comments from the public
42 regarding a property insurance rate filing. The comments may be provided to the Department
43 by e-mail, mail, or in person at a time and place set by the Department. All public comments
44 shall be shared with the Rate Bureau in a timely manner. Only comments from the public that
45 are made a part of the Notice of Hearing may be considered by the Commissioner or the
46 Commissioner's designated hearing officer during the hearing.

47 (e) With respect to any property insurance rate filing, except as provided in
48 G.S. 58-36-30, where a catastrophe model is used in the calculation for any factor in the filing
49 and where the Commissioner has called for a hearing, the hearing process shall proceed as
50 follows:

- (1) No earlier than 30 days after a Notice of Hearing is issued, the Commissioner shall schedule a prehearing that may be attended only by the parties to the case and any experts who will present testimony regarding the catastrophe model or models used in the filing. The prehearing shall be called solely for the purpose of providing the Department and its expert witnesses with the opportunity to see and review all materials and documents pertinent to the catastrophe model or models used in the property rate filing. Because the materials and documents subject to discovery may be confidential in nature, the prehearing shall be closed to the public. The Commissioner shall preside over the prehearing and shall resolve any disputes that arise between the parties. A proper record shall be kept at the prehearing, and said record shall be treated as confidential unless a ruling from a court of competent jurisdiction determines that the record of the conference shall be available to the public. Discovery not related to the catastrophe model shall be conducted pursuant to normal hearing procedures.
- (2) At the prehearing, the Rate Bureau and its experts shall present any relevant data, materials, computations, spreadsheets, or documents regarding the catastrophe model or models that were excluded from the filing. Copies of all materials presented at the prehearing shall be provided to the Department and its experts for further analysis. Any materials provided at the prehearing to the Department and its experts that are marked as confidential shall be treated as confidential unless a ruling from a court of competent jurisdiction determines that the materials shall be available to the public. Based upon the materials presented both in the filing and at the prehearing, the Department and its experts may request additional data, materials, computations, spreadsheets, or documents, or may make specific inquiries that require a written explanation in order to further understand the available materials.
- (3) There shall be no limit on the number of discovery materials requested regarding the catastrophe model. However, the Commissioner may make a determination at the prehearing whether the requested materials are relevant, reasonable, and not unduly burdensome.
- (4) The Commissioner shall set a date by which all discovery materials regarding the catastrophe model shall be delivered to the Department. All materials marked by the Rate Bureau as "confidential" shall be individually numbered by the Rate Bureau so that they may be referred to by number, if necessary, by the Commissioner in subsequent documents or orders. The Rate Bureau shall provide an index of the confidential documents marked confidential in order that the documents may be easily identified and referenced in subsequent pleadings, testimony, and orders. All materials marked by the Rate Bureau as "confidential" shall be treated by the Department and its experts as confidential unless a ruling from a court of competent jurisdiction determines that the materials shall be available to the public. Once the requested discovery materials have been delivered to the Department as required, the Commissioner may schedule additional prehearings to address additional discovery materials that may be requested by the Department. Once all of the Department's discovery requests related to the catastrophe model or models have been finalized, the Commissioner shall schedule a final prehearing conference to ensure that there are no other discovery issues pending and that both parties are ready to proceed to hearing. All prehearings shall also be closed to the public in the event that

1 potentially confidential materials may be discussed. Any data from
2 catastrophe models that is not disclosed at the prehearing at least 30 days
3 prior to the submission of prefiled testimony of Department witnesses shall
4 be inadmissible at the hearing on the filing.

5 (5) Once the discovery process for the catastrophe model has been completed,
6 the hearing may proceed pursuant to statute. The Department witnesses shall
7 file all prefiled testimony as required under G.S. 58-36-15(i). However, any
8 prefiled testimony regarding the catastrophe model or models used in the
9 filing shall be filed as a separate document and marked as "confidential."
10 The prefiled testimony of the Department witnesses relating to the
11 catastrophe models may contain references to data, testimony, or exhibits
12 pertaining to confidential materials submitted by the Rate Bureau, and,
13 therefore, shall be treated as confidential by the Department and its experts
14 unless a ruling from a court of competent jurisdiction determines that the
15 prefiled testimony shall be made available to the public. All references to
16 confidential materials used by the Department witnesses shall utilize the
17 individual identification numbers assigned by the Rate Bureau in the
18 discovery materials.

19 (6) Prior to commencement of the hearing, the Commissioner shall determine
20 the order of testimony to be heard at the hearing. However, any oral
21 testimony taken at the hearing on direct, cross-examination, or on rebuttal
22 with regard to the catastrophe model will be closed to the public, if
23 necessary, in order to preserve confidentiality. Transcripts from hearing
24 proceedings closed to the public shall be treated as confidential by the
25 Department, its experts, and by the court reporters unless a ruling from a
26 court of competent jurisdiction determines that the prefiled testimony shall
27 be made available to the public.

28 (7) At the conclusion of the hearing, the Commissioner, in the Commissioner's
29 final order, shall make the Commissioner's determination as to whether the
30 catastrophe model is valid for the purpose it was used in the filing, the
31 weight to be applied to the modeled results, and the extent to which the
32 results of the model should be modified, if at all.

33 (f) If the Commissioner finds that a filing complies with the provisions of this Article,
34 either after the hearing or at any other time after the filing has been properly made, the
35 Commissioner may issue an order approving the filing. If the Commissioner after the hearing
36 finds that the filing does not comply with the provisions of this Article, the Commissioner may
37 issue an order disapproving the filing, determining in what respect the filing is improper, and
38 specifying the appropriate rate level or levels that may be used by the members of the Bureau
39 instead of the rate level or levels proposed by the Bureau filing, unless there has not been data
40 admitted into evidence in the hearing that is sufficiently credible for arriving at the appropriate
41 rate level or levels. Any order issued after a hearing shall be issued within 45 days after the
42 completion of the hearing. If no order is issued within 45 days after the completion of the
43 hearing, the filing shall be deemed to be approved. The Commissioner may thereafter review
44 any filing in the manner provided; but if so reviewed, no adjustment of any premium on any
45 policy then in force may be ordered. The escrow provisions of G.S. 58-36-25(b) apply to an
46 appeal of any order of the Commissioner under this subsection."

47 SECTION 5. G.S. 58-36-15 reads as rewritten:

48 **"§ 58-36-15. Filing loss costs, rates, plans with Commissioner; public inspection of filings.**

49 (a) The Bureau shall file with the Commissioner copies of the rates, loss costs,
50 classification plans, rating plans and rating systems used by its members. Each rate or loss costs
51 filing shall become effective on the date specified in the filing, but not earlier than 210 days

1 from the date the filing is received by the Commissioner: Provided that (1) rate or loss costs
2 filings for workers' compensation insurance and employers' liability insurance written in
3 connection therewith shall not become effective earlier than 210 days from the date the filing is
4 received by the Commissioner or on the date as provided in G.S. 58-36-100, whichever is
5 earlier; and (2) any filing may become effective on a date earlier than that specified in this
6 subsection upon agreement between the Commissioner and the Bureau.

7 (b) A filing shall be open to public inspection immediately upon submission to the
8 Commissioner.

9 (c) The Bureau shall maintain reasonable records, of the type and kind reasonably
10 adapted to its method of operation, of the experience of its members and of the data, statistics
11 or information collected or used by it in connection with the rates, rating plans, rating systems,
12 loss costs and other data as specified in G.S. 58-36-100, underwriting rules, policy or bond
13 forms, surveys or inspections made or used by it.

14 (d) With respect to the filing of rates for nonfleet private passenger motor vehicle
15 insurance, the Bureau shall, on or before February 1 of each year, or later with the approval of
16 the Commissioner, file with the Commissioner the experience, data, statistics, and information
17 referred to in subsection (c) of this section and any proposed adjustments in the rates for all
18 member companies of the Bureau. The filing shall include, where deemed by the
19 Commissioner to be necessary for proper review, the data specified in subsections (c), (e), (g)
20 and (h) of this section. Any filing that does not contain the data required by this subsection may
21 be returned to the Bureau and not be deemed a proper filing. Provided, however, that if the
22 Commissioner concludes that a filing does not constitute a proper filing he shall promptly
23 notify the Bureau in writing to that effect, which notification shall state in reasonable detail the
24 basis of the Commissioner's conclusion. The Bureau shall then have a reasonable time to
25 remedy the defects so specified. An otherwise defective filing thus remedied shall be deemed to
26 be a proper and timely filing, except that all periods of time specified in this Article will run
27 from the date the Commissioner receives additional or amended documents necessary to
28 remedy all material defects in the original filing.

29 (d1) With respect to property insurance rates, the Bureau shall file no later than May 1,
30 2010, a schedule of credits for policyholders based on the presence of mitigation and
31 construction features and on the condition of buildings that it insures in the beach and coastal
32 areas of the State. The Bureau shall develop rules applicable to the operation of the schedule
33 and the mitigation program with approval by the Commissioner. The schedule shall not be
34 unfairly discriminatory and shall be reviewed by the Bureau annually, with the results reported
35 annually to the Commissioner.

36 (d2) The following supporting data, at a minimum, shall be included in any property
37 insurance rate filing where a catastrophe model is used or where a factor for any costs of
38 reinsurance is included in the rate calculations or where both a catastrophe model and a factor
39 for costs of reinsurance are used.

40 (1) Any simulated loss from a catastrophe model should include the following:

- 41 a. An event identifier.
- 42 b. The simulation year.
- 43 c. The annual probability of occurrence for the event.
- 44 d. The gross amount of North Carolina damages before application of
45 any deductible or other applicable policy provisions that impact the
46 coverage, calculated with and without any applicable demand surge
47 adjustments.
- 48 e. The net amount of North Carolina insured loss after application of
49 any deductible or other applicable policy provisions that impact the
50 coverage, calculated with and without any applicable demand surge
51 adjustments.

- f. The State and county of first and any subsequent landfalls.
 - g. The Saffir-Simpson category at first and any subsequent landfalls.
 - h. The maximum sustained windspeed at first and any subsequent landfalls.
 - i. The North Carolina county of first entry, if applicable, whether first entry is from water or land.
 - j. The Saffir-Simpson category at first entry into North Carolina, if applicable, whether first entry is from water or land.
 - k. The maximum sustained windspeed at first entry into North Carolina, if applicable, whether first entry is from water or land.
 - l. For storms with no landfall in North Carolina, the county of closest approach.
 - m. For storms with no landfall in North Carolina, the Saffir-Simpson category at closest approach.
 - n. For storms with no landfall in North Carolina, the maximum sustained windspeed at closest approach.
 - o. Any other information required by rules promulgated by the Commissioner.
- (2) Any factor for cost of reinsurance shall be based upon the aggregated property reinsurance costs of the member companies of the Bureau writing property insurance in North Carolina for the specific lines of insurance covered by the filing. The costs of reinsurance for the North Carolina Insurance Underwriting Association and North Carolina Joint Underwriting Association shall not be considered for any line of property coverage under the jurisdiction of the Bureau. For each of the member companies, the costs of reinsurance that are specific to North Carolina and the line of business for which the filing is being made must be allocated using an appropriate method that shall be stated along with the applicable provisions for the current reinsurance contract that covers the North Carolina line of business for which the filing is being made. Any filing must also take into account expected recoveries from the reinsurance. Use of a model to make the allocation to the appropriate line of business and state shall not be permissible. The Commissioner may promulgate rules setting forth the information needed to evaluate reinsurance costs as well as the method used to determine the cost of reinsurance allocated to North Carolina.
- (e) The Commissioner may require the filing of supporting data including:
- (1) The Bureau's interpretation of any statistical data relied upon;
 - (2) Descriptions of the methods employed in setting the rates;
 - (3) Analysis of the incurred losses submitted on an accident year or policy year basis into their component parts; to wit, paid losses, reserves for losses and loss expenses, and reserves for losses incurred but not reported;
 - (4) The total number and dollar amount of paid claims;
 - (5) The total number and dollar amount of case basis reserve claims;
 - (6) Earned and written premiums at current rates by rating territory;
 - (7) Earned premiums and incurred losses according to classification plan categories; and
 - (8) Income from investment of unearned premiums and loss and loss expense reserves generated by business within this State.
- Provided, however, that with respect to business written prior to January 1, 1980, the Commissioner shall not require the filing of such supporting data which has not been required to be recorded under statistical plans approved by the Commissioner.

(f) On or before September 1 of each calendar year, or later with the approval of the Commissioner, the Bureau shall submit to the Commissioner the experience, data, statistics, and information referred to in subsection (c) of this section and required under G.S. 58-36-100 and a residual market rate or prospective loss costs review based on those data for workers' compensation insurance and employers' liability insurance written in connection therewith. Any rate or loss costs increase for that insurance that is implemented under this Article shall become effective solely to insurance with an inception date on or after the effective date of the rate or loss costs increase.

(g) The following information must be included in policy form, rule, and rate or loss costs filings under this Article and under Article 37 of this Chapter:

(1) A detailed list of the rates, loss costs, rules, and policy forms filed, accompanied by a list of those superseded; and

(2) A detailed description, properly referenced, of all changes in policy forms, rules, prospective loss costs, and rates, including the effect of each change.

(h) Except to the extent the Commissioner determines that this subsection is inapplicable to filings made under G.S. 58-36-100 and except for filings made under G.S. 58-36-30, all policy form, rule, prospective loss costs, and rate filings under this Article and Article 37 of this Chapter that are based on statistical data must be accompanied by the following properly identified information:

(1) North Carolina earned premiums at the actual and current rate level; losses and loss adjustment expenses, each on paid and incurred bases without trending or other modification for the experience period, including the loss ratio anticipated at the time the rates were promulgated for the experience period;

(2) Credibility factor development and application;

(3) Loss development factor derivation and application on both paid and incurred bases and in both numbers and dollars of claims;

(4) Trending factor development and application;

(5) Changes in premium base resulting from rating exposure trends;

(6) Limiting factor development and application;

(7) Overhead expense development and application of commission and brokerage, other acquisition expenses, general expenses, taxes, licenses, and fees;

(8) Percent rate or prospective loss costs change;

(9) Final proposed rates;

(10) Investment earnings, consisting of investment income and realized plus unrealized capital gains, from loss, loss expense, and unearned premium reserves;

(11) Identification of applicable statistical plans and programs and a certification of compliance with them;

(12) Investment earnings on capital and surplus;

(13) Level of capital and surplus needed to support premium writings without endangering the solvency of member companies; and

(14) Such other information that may be required by any rule adopted by the Commissioner.

Provided, however, that no filing may be returned or disapproved on the grounds that such information has not been furnished if insurers have not been required to collect such information pursuant to statistical plans or programs or to report such information to the Bureau or to statistical agents, except where the Commissioner has given reasonable prior notice to the insurers to begin collecting and reporting such information, or except when the information is readily available to the insurers.

(i) The Bureau shall file with and at the time of any rate or prospective loss costs filing all testimony, exhibits, and other information on which the Bureau will rely at the hearing on the rate filing. The Department shall file all testimony, exhibits, and other information on which the Department will rely at the hearing on the rate filing 20 days in advance of the convening date of the hearing. Upon the issuance of a notice of hearing the Commissioner shall hold a meeting of the parties to provide for the scheduling of any additional testimony, including written testimony, exhibits or other information, in response to the notice of hearing and any potential rebuttal testimony, exhibits, or other information. This subsection also applies to rate filings made by the North Carolina Motor Vehicle Reinsurance Facility under Article 37 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 2 and 3 of this act become effective December 1, 2012. Section 6 of this act is effective when it becomes law. The remainder of this act becomes effective July 1, 2012.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 836
PROPOSED COMMITTEE SUBSTITUTE S836-CSR-23 [v.7]

6/5/2012 8:03:24 PM

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 DEPARTMENT OF INSURANCE STUDY THE FAIRNESS AND EFFICACY OF THE CURRENT PROPERTY INSURANCE GEOGRAPHIC RATE TERRITORIES, AS RECOMMENDED BY THE LEGISLATIVE RESEARCH COMMISSION 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 thirty 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



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1 that the filing does not comply with the provisions of this Article, he may issue his order
2 determining wherein and to what extent such filing is deemed to be improper and fixing a date
3 thereafter, within a reasonable time, after which the filing shall no longer be effective. In the
4 event the Commissioner finds that the proposed rates are excessive, the Commissioner shall
5 specify the overall rates, between the existing rates and the rates proposed by the Bureau
6 filing, that may be used by the members of the Bureau instead of the rates proposed by the
7 Bureau filing. In any such order, the Commissioner shall make findings of fact based on the
8 evidence presented in the filing and at the hearing. Any order issued after a hearing shall be
9 issued within 45 days after the completion of the hearing. If no order is issued within 45 days
10 after the completion of the hearing, the filing shall be deemed to be approved."

11 **SECTION 3.** G.S. 58-36-10 is amended by adding a new subdivision to read:

12 "(7) Property insurance rates established under this Article shall include a
13 provision to reflect the cost of reinsurance to protect against catastrophic
14 exposure within this State. Amounts to be paid to reinsurers, ceding
15 commissions to be paid to insurers by reinsurers, expected reinsurance
16 recoveries, North Carolina exposure to catastrophic events relative to other
17 states' exposure, and any other relevant information may be considered when
18 determining the provision to reflect the cost of reinsurance. Such other
19 relevant information may include the cost of reinsurance for insurers,
20 statutory organizations, associations, pools, or other entities writing property
21 insurance solely within this State. The use of catastrophe models and
22 modeled or hypothetical reinsurance programs shall be permissible in
23 determining the provision to reflect the cost of reinsurance. The
24 Commissioner may promulgate rules setting forth the information to be
25 included in support of the provision to reflect the cost of reinsurance."

26 **SECTION 4.** Article 36 of Chapter 58 of the General Statutes is amended by
27 adding a new section to read:

28 **"§ 58-36-42. Development of policy form or endorsement for residential property**
29 **insurance that does not include coverage for perils of windstorm or hail.**

30 With respect to residential property insurance under its jurisdiction, the Bureau shall
31 develop an optional policy form or endorsement to be filed with the Commissioner for approval
32 that provides residential property insurance coverage without coverage for the perils of
33 windstorm or hail. Insurers that sell such policies shall comply with the provisions of
34 G.S. 58-44-60 and through such compliance shall be deemed to have given notice to all insured
35 and persons claiming benefits under such policies that such policies do not include coverage for
36 the perils of windstorm or hail."

37 **SECTION 5.** G.S. 58-44-60 reads as rewritten:

38 **"§ 58-44-60. Notice to property insurance policyholder about flood, earthquake,**
39 **mudslide, mudflow, and landslide, and windstorm or hail insurance coverage.**

40 (a) Every insurer that sells residential or commercial property insurance policies that do
41 not provide coverage for the perils of flood, earthquake, mudslide, mudflow, ~~or landslide~~
42 landslide, or windstorm or hail shall, upon the issuance and renewal of each policy, identify to
43 the policyholder which of these perils are not covered under the policy. The insurer shall print
44 the following warning, citing which peril is not covered, in Times New Roman 16-point font or
45 other equivalent font and include it in the policy on a separate page immediately before the
46 declarations page:

47 "WARNING: THIS PROPERTY INSURANCE POLICY DOES NOT PROTECT YOU
48 AGAINST LOSSES FROM [FLOODS], [EARTHQUAKES], [MUDSLIDES],
49 [MUDFLOWS], ~~[LANDSLIDES]~~, [LANDSLIDES], [WINDSTORM OR HAIL]. YOU
50 SHOULD CONTACT YOUR INSURANCE COMPANY OR AGENT TO DISCUSS YOUR
51 OPTIONS FOR OBTAINING COVERAGE FOR THESE LOSSES. THIS IS NOT A

1 COMPLETE LISTING OF ALL OF THE CAUSES OF LOSSES NOT COVERED UNDER
2 YOUR POLICY. YOU SHOULD READ YOUR ENTIRE POLICY TO UNDERSTAND
3 WHAT IS COVERED AND WHAT IS NOT COVERED."

4 (b) As used in this section, "insurer" includes an entity that sells property insurance
5 under Articles 21, 45, or 46 of this Chapter."

6 **SECTION 6.** The North Carolina Rate Bureau, with the assistance of the
7 Department of Insurance, shall study the current geographic territories established by the
8 Bureau for rating purposes. The study shall address the following issues:

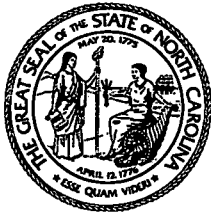
9 (1) Whether risks of the same class and essentially the same hazard are charged
10 premiums that are commensurate with the risk of loss, actuarially correct,
11 and not unfairly discriminatory.

12 (2) Whether geographic territories in the beach and coastal areas (as defined in
13 G.S. 58-45-5) currently meet the standards and mandates set forth in
14 G.S. 58-36-10(6).

15 (3) Whether current technology and statistical data sources make possible any
16 practical and cost-effective alternative to the geographic territory system for
17 property insurance rate setting.

18 The Bureau shall submit a final report, including any recommendations for changes
19 to the geographic territories or alternatives to the geographic territory rating system, to the 2013
20 General Assembly.

21 **SECTION 7.** Sections 4 and 5 of this act become effective December 1, 2012.
22 Section 6 of this act is effective when it becomes law. The remainder of this act becomes
23 effective July 1, 2012.



SENATE BILL 836: Improve Property Insurance Rate Making

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Sen. Brown
Analysis of: PCS to First Edition
S836-CSR-G-23

Date: June 5, 2012
Prepared by: Tim Hovis
Committee Counsel

SUMMARY: *The Proposed Committee Substitute for 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 of the proposed committee substitute 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 recognizes reinsurance costs as a factor in property insurance rates. This section also gives to the Commissioner the authority to require specific information from the Bureau on reinsurance costs, including NC exposure to catastrophic events relative to other states' exposure.

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

Senate PCS 836

Page 2

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 the proposed committee substitute for Senate Bill 836 become effective December 1, 2012. Section 6 is effective when the bill becomes law. The remainder of the bill becomes effective July 1, 2012.

S836-SMRG-53(CSRG-23) v1

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____

DATE _____

S. B. No. ~~836~~ 836

Amendment No. _____

COMMITTEE SUBSTITUTE _____

(to be filled in by
Principal Clerk)

Rep.) Meredith

Sen.)

1 moves to amend the bill on page 3, line 22

2 () WHICH CHANGES THE TITLE

3 by ~~and~~ rewriting the line to read

4 "Sections 6 and 7 of this act

5 are effective when they become law,

6 The remainder of this act becomes"

7 _____

8 _____

9 _____

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19 _____

SIGNED

M. Meredith

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H

D

HOUSE BILL 244
Committee Substitute Favorable 6/7/11
PROPOSED SENATE COMMITTEE SUBSTITUTE H244-PCS70288-ME-35

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 AND THE CASA ESPERANZA MONTESSORI CHARTER 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, 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 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.



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1 Further, it is the policy of this State that persons shall be free of intimidation or harassment
2 when reporting matters of public concern related to the State Health Plan, including offering
3 testimony to or testifying before appropriate legislative panels.

4 (b) Protection From Retaliation. – No employer shall sue, discharge, threaten, or
5 otherwise discriminate against an employee regarding the employee's compensation, terms,
6 conditions, location, or privileges of employment because the employee, or a person acting on
7 behalf of the employee, reports or is about to report, verbally or in writing, any activity
8 described in subsection (a) of this section, unless the employee knows or has reason to believe
9 that the report is inaccurate. No other employee of an employer shall retaliate against another
10 employee because the employee, or a person acting on behalf of the employee, reports or is
11 about to report, verbally or in writing, any activity described in subsection (a) of this section.
12 No person shall sue, terminate a contract, threaten, or otherwise discriminate against a reporting
13 person regarding the reporting person's compensation or terms of contract because the reporting
14 person, or a person acting on behalf of the reporting person, reports or is about to report,
15 verbally or in writing, any activity described in subsection (a) of this section, unless the
16 reporting person knows or has reason to believe that the report is inaccurate.

17 (c) Relief for Violation. – Any person injured by a violation of subsection (b) of this
18 section may maintain an action in superior court for damages, an injunction, or other remedies
19 provided in this section against the person who committed the violation within one year after
20 the occurrence of the alleged violation of this Article.

21 (d) Remedies. – A court, in rendering a judgment in an action brought pursuant to this
22 section, may order an injunction, damages, reinstatement of the employee, the payment of back
23 wages or payments owed under a contract, full reinstatement of fringe benefits and seniority
24 rights, costs, reasonable attorneys' fees, or any combination of these. If an application for a
25 permanent injunction is granted, the person maintaining the action shall be awarded costs and
26 reasonable attorneys' fees. If in an action for damages the court finds that the person
27 maintaining the action was injured by a willful violation of subsection (b) of this section, the
28 court shall award as damages three times the amount of actual damages plus costs and
29 reasonable attorneys' fees against the individual or individuals found to be in violation of
30 subsection (b) of this section."

31 **SECTION 4.** Sections 2 and 3 of this act become effective October 1, 2012. The
32 remainder of this act is effective when it becomes law.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

H

2

**HOUSE BILL 244
Committee Substitute Favorable 6/7/11**

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.



* H 2 4 4 - V - 2 *



HOUSE BILL 244:

State Health Plan/Add Schools; Whistleblowers

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Rep. Murry
Analysis of: PCS to Second Edition
H244-CSME-35

Date: June 5, 2012
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: House Bill 244 would authorize, notwithstanding the time limitation in G.S. 135-45.5, the Boards of Directors of Sterling Montessori Charter School and Casa Esperanza Montessori Charter School to elect to become participating employing units in the State Health Plan. The PCS 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.

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 election must be in writing and filed with the Executive Administrator and Board of Trustees and with the State Board of Education. The board of directors must notify employees in writing as to whether the board elected to become a participating employer in the Plan.

BILL ANALYSIS: Section 1 of the PCS to House Bill 244 allows the Board of Directors of the 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 election to participate must take place within 30 days of the effective date of this act.

Section 2 of the bill adds a new section to Article 1 of Chapter 22B of the General Statutes and would make void any provision in a contract that would prohibit an employee's or contractor's ability to report wrongdoing related to the State Health Plan, as outlined G.S. 135-48.15.

Section 3 of the bill adds a new section to Article 3B of Chapter 135 of the General Statutes. §135-48.15 states that it is the policy of the State to encourage people to report, and to be free from intimidation or harassment when reporting, wrongdoings related to the State Health Plan involving:

- A violation of State or federal law, rule, or regulation.
- Fraud.
- Misappropriation of State resources.
- Gross mismanagement, a gross waste of monies, or gross abuse of authority.

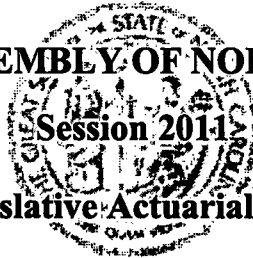
Additionally, under the bill, no employer may sue, discharge, threaten, or discriminate against any employee for reporting wrongdoing involving the State Health Plan unless the employee knows or has reason to believe the report is inaccurate. No other employee may retaliate against another for reporting wrongdoing. No person may sue, terminate a contract, threaten, or discriminate against another for reporting wrongdoing, unless the reporting person knows or has reason to believe the report is inaccurate. If a person is retaliated against, the bill allows an individual to maintain an action in superior court. The action must be brought within one year after a violation of G.S. 135-48.15(b). If the court grants an injunction, the individual will be awarded costs and attorneys' fees. If the retaliation is found to be willful, the court will award treble damages plus costs and attorneys' fees.

Section 2 and 3 of this act are effective Oct. 1, 2012. The remainder is effective when it becomes law.

Tim Hovis, Committee counsel, substantially contributed to this summary.

H244-SMTK-67(CSME-35) v2

GENERAL ASSEMBLY OF NORTH CAROLINA



Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: House Bill 244 (Second Edition)

SHORT TITLE: State Health Plan/Add Schools.

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: 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

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	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

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:

<u>Coverage Type</u>	PPO Basic		PPO Standard	
	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
<u>Coverage Type</u>	PPO Basic		PPO Standard	
	Employee/ Retiree	Employer	Employee/ Retiree	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
<u>Actives</u>				
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%
<u>Retired</u>				
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%
<u>Former Employees with Continuation Coverage</u>				
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%
<u>Firefighters, Rescue Squad & National Guard</u>				
Employees	2	3	5	0.0%
Dependents	1	2	3	0.0%
Sub-total	3	5	8	0.0%
<u>Local Governments</u>				
Employees	486	1,429	1,915	0.3%
Dependents	303	629	932	0.1%
Sub-total	789	2,058	2,847	0.4%
<u>Total</u>				
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:** David Vanderweide**APPROVED BY:** Mark Trogdon, Acting Director
Fiscal Research Division**DATE:** June 2, 2012**Signed Copy Located in the NCGA Principal Clerk's Offices**

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

1

SENATE BILL 849

Short Title: Amend Officer Salary Continuation.

(Public)

Sponsors: Senators Goolsby; Allran, Blake, Brown, Daniel, Davis, Hunt, Jackson, Meredith, Newton, Preston, Rabon, Soucek, Tillman, Tucker, and Westmoreland.

Referred to: Insurance.

May 22, 2012

A BILL TO BE ENTITLED

AN ACT TO AMEND THE SALARY CONTINUATION LAWS TO PROVIDE THAT ONLY OFFICERS INJURED AND INCAPACITATED AS THE RESULT OF EXTREME ACTIVITY IN THE COURSE OF PERFORMING THEIR OFFICIAL DUTIES RECEIVE A HIGHER COMPENSATION RATE FOR THE TWO-YEAR PERIOD BEFORE REVERTING TO THE RATES PROVIDED UNDER THE WORKERS' COMPENSATION LAWS, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON JUSTICE AND PUBLIC SAFETY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143-166.14 reads as rewritten:

"§ 143-166.14. Payment of salary notwithstanding incapacity; Workers' Compensation Act applicable after two years; duration of payment.

The salary of any of the above listed persons shall be paid as long as his employment in that position continues, notwithstanding his total or partial incapacity to perform any duties to which he may be lawfully assigned, if that incapacity is the result of ~~an injury by accident~~ injuries-an injury or injuries due to extreme activity which occurred in the course and scope of his official duty or duties, or an occupational disease arising out of and in the course of the performance by him of his official duties, except if that incapacity continues for more than two years from its inception, the person shall, during the further continuance of that incapacity, be subject to the provisions of Chapter 97 of the General Statutes pertaining to workers' compensation. Salary paid to a person pursuant to this Article shall cease upon the resumption of his regularly assigned duties, retirement, resignation, or death, whichever first occurs, except that temporary return to duty shall not prohibit payment of salary for a subsequent period of incapacity which can be shown to be directly related to the original injury."

SECTION 2. This act becomes effective October 1, 2012, and applies to incapacity commencing on or after that date.



GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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D

SENATE BILL 849
PROPOSED COMMITTEE SUBSTITUTE S849-CSRC-54 [v.2]

6/6/2012 8:26:57 AM

Short Title: Amend Officer Salary Continuation.

(Public)

Sponsors:

Referred to:

May 22, 2012

A BILL TO BE ENTITLED

AN ACT TO AMEND THE SALARY CONTINUATION LAWS TO PROVIDE THAT ONLY OFFICERS INJURED AND INCAPACITATED AS THE RESULT OF EXTREME ACTIVITY IN THE COURSE OF PERFORMING THEIR OFFICIAL DUTIES RECEIVE A HIGHER COMPENSATION RATE FOR THE TWO-YEAR PERIOD BEFORE REVERTING TO THE RATES PROVIDED UNDER THE WORKERS' COMPENSATION LAWS, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON JUSTICE AND PUBLIC SAFETY.

The General Assembly of North Carolina enacts:

SECTION 1. Article 12B of Chapter 143 of the General Statutes reads as rewritten:

"Article 12B.

"Salary Continuation Plan for Certain State Law-Enforcement Officers.

"§ 143-166.13. Persons entitled to benefits under Article.

(a) The following persons who are subject to the Criminal Justice Training and Standards Act are entitled to benefits under this Article:

- (1) State Government Security Officers, Department of Administration;
- (2) State Correctional Officers, Division of Adult Correction of the Department of Public Safety;
- (3) State Probation and Parole Officers, Division of Adult Correction of the Department of Public Safety;
- (4) Sworn State Law-Enforcement Officers with the power of arrest, Division of Adult Correction of the Department of Public Safety;
- (5) Alcohol Law-Enforcement Agents, Department of Public Safety;
- (6) State Highway Patrol Officers, Department of Public Safety;
- (7) General Assembly Special Police, General Assembly;
- (8) Sworn State Law-Enforcement Officers with the power of arrest, Department of Health and Human Services;
- (9) Juvenile Justice Officers, Division of Juvenile Justice of the Department of Public Safety;
- (10) Insurance Investigators, Department of Insurance;
- (11) State Bureau of Investigation Officers and Agents, Department of Justice;
- (12) Director and Assistant Director, License and Theft Enforcement Section, Division of Motor Vehicles, Department of Transportation;



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- (13) Members of License and Theft Enforcement Section, Division of Motor Vehicles, Department of Transportation, designated by the Commissioner of Motor Vehicles as either "inspectors" or uniformed weigh station personnel;
- (14) Utilities Commission Transportation Inspectors and Special Investigators;
- (15) North Carolina Ports Authority Police, Department of Transportation;
- (16) Sworn State Law-Enforcement Officers with the power of arrest, Department of Environment and Natural Resources;
- (17) Sworn State Law-Enforcement Officers with the power of arrest, Department of Public Safety.
- (18) Sworn State Law-Enforcement Officers with the power of arrest, Department of Revenue.
- (19) Sworn State Law-Enforcement Officers with the power of arrest, University System.

(b) The following persons are entitled to benefits under this Article regardless of whether they are subject to the Criminal Justice Training and Standards Act:

- (1) Driver License Examiners injured by accident arising out of and in the course of giving a road test, Division of Motor Vehicles, Department of Transportation;
- (2) Employees of the Division of Adult Correction of the Department of Public Safety injured by a direct and deliberate act of an offender supervised by the Division or while performing supervisory duties over offenders which place the employees at risk of such injury.

(c) As used in this Article, the term "eligible person" or "person" shall mean any individual listed under subsections (a) or (b) of this section.

"§ 143-166.14. Payment of salary notwithstanding incapacity; Workers' Compensation Act applicable after two years; duration of payment.

~~The salary of any of the above listed persons~~ eligible person shall be paid as long as ~~his the~~ person's employment in that position continues, notwithstanding ~~his the person's~~ total or partial incapacity to perform any duties to which ~~he the person~~ may be lawfully assigned, if that incapacity is the result of an injury ~~by accident or an occupational disease arising out of and in the course of the performance by him of his or injuries due to extreme activity which occurred in the course and scope of the eligible person's~~ official duties, except if that incapacity continues for more than two years from its inception, the person shall, during the further continuance of that incapacity, be subject to the provisions of Chapter 97 of the General Statutes pertaining to workers' compensation. Salary paid to ~~a an~~ eligible person pursuant to this Article shall cease upon the resumption of ~~his the person's~~ regularly assigned duties, retirement, resignation, or death, whichever first occurs, except that temporary return to duty shall not prohibit payment of salary for a subsequent period of incapacity which can be shown to be directly related to the original injury."

"§ 143-166.15. Application of § 97-27; how payments made.

Notwithstanding the provisions of G.S. 143-166.14 of this Article, the persons entitled to benefits shall be subject to the provisions of G.S. 97-27 during the two-year period of payment of full salary. All payments of salary shall be made at the same time and in the same manner as other salaries are paid to other persons in the same department.

" 143-166.16. Effect on workers' compensation and other benefits; application of § 97-24.

The provisions of G.S. 143-166.14 shall be in lieu of all compensation provided for the first two years of incapacity by G.S. 97-29 and 97-30, but shall be in addition to any other benefits or compensation to which such person shall be entitled under the provisions of the Workers' Compensation Act. The provisions of G.S. 97-24 will commence at the end of the two-year period for which salary is paid pursuant to G.S. 143-166.14.

"§ 143-166.17. Period of incapacity not charged against sick leave or other leave.

1 The period for which the salary of any person is paid pursuant to G.S. 143-166.14 while he
2 ~~the person~~ is incapacitated as a result of an injury by accident or an occupational disease arising
3 ~~out of and in the course of the performance by him of his or~~ injuries due to extreme activity
4 ~~which occurred in the course and scope of the eligible person's official duties,~~ shall not be
5 charged against any sick or other leave to which ~~he the person~~ shall be entitled under any other
6 provision of law.

7 **"§ 143-166.18. Report of incapacity.**

8 Any person designated in G.S. 143-166.13, who, as a result of an injury by accident arising
9 ~~out of and in the course of the performance by him of his or~~ injuries due to extreme activity
10 ~~which occurred in the course and scope of the eligible person's official duties,~~ is totally or
11 partially incapacitated to perform any duties to which ~~he the person~~ may be lawfully assigned,
12 shall report the incapacity as soon as practicable in the manner required by the secretary or
13 other head of the department to which the agency is assigned by statute.

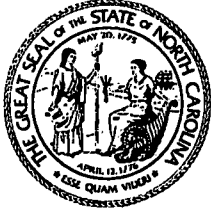
14 **"§ 143-166.19. Determination of cause and extent of incapacity; hearing before Industrial
15 Commission; appeal; effect of refusal to perform duties.**

16 Upon the filing of the report, the secretary or other head of the department or, in the case of
17 the General Assembly, the Legislative Services Officer, shall determine the cause of the
18 incapacity and to what extent the claimant may be assigned to other than ~~his the claimant's~~
19 normal duties. The finding of the secretary or other head of the department shall determine the
20 right of the claimant to benefits under this Article. Notice of the finding shall be filed with the
21 North Carolina Industrial Commission. ~~Unless the claimant, within 30 days after he receives~~
22 ~~notice, files with the North Carolina Industrial Commission, upon the form it shall require, a~~
23 ~~request for a hearing, the finding of the secretary or other department head shall be final. The~~
24 ~~finding of the secretary or other department head shall be final unless the claimant within 30~~
25 ~~days of receipt of the notice, files a request for a hearing with the North Carolina Industrial~~
26 ~~Commission using a form required by the Commission. Upon the filing of a request, the North~~
27 ~~Carolina Industrial Commission shall proceed to hear the matter in accordance with its~~
28 ~~regularly established procedure for hearing claims filed under the Worker's Compensation Act,~~
29 ~~and shall report its findings to the secretary or other head of the department. From the decision~~
30 ~~of the North Carolina Industrial Commission, an appeal shall lie as in other matters heard and~~
31 ~~determined by the Commission. Any person who refuses to perform any duties to which he the~~
32 ~~person~~ may be properly assigned as a result of the finding of the secretary, other head of the
33 department or of the North Carolina Industrial Commission shall be entitled to no benefits
34 pursuant to this Article as long as the refusal continues.

35 **"§ 143-166.20. Subrogation.**

36 The same rights and remedies set forth in G.S. 97-10.2 shall apply in all third party liability
37 cases occurring under this Article, including cases involving the right of the affected State
38 agency to recover the salary paid to an injured officer during ~~his the officer's~~ period of
39 disability."

40 **SECTION 2.** This act becomes effective October 1, 2012, and applies to incapacity
41 commencing on or after that date.



SENATE BILL 849: Amend Officer Salary Continuation

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Sen. Goolsby
Analysis of: PCS to First Edition
S849-CSRC-54

Date: June 6, 2012
Prepared by: Kory Goldsmith
Committee Counsel

SUMMARY: *Senate Bill 849 would limit the circumstances under which certain State agency law enforcement officers would be eligible to receive their full salary instead of workers' compensation for total or partial incapacity arising out of the officers carrying out their official duties.*

The PCS makes conforming changes throughout the applicable Article.

CURRENT LAW: Article 12B of Chapter 143 of the General Statutes grants to certain State agency law enforcement officers the right to receive full salary for up to 2 years instead of the reduced benefits provided under the general Workers' Compensation statutes (Chapter 97). An officer would be eligible for the increased benefit if he or she is totally or partially incapacitated as a result of either of the "injury by accident or an occupational disease" arising out of and in the course of the performance of the officer's official duties. In order to qualify for this benefit, the officer must the injury or occupational disease "as soon as practicable" to the head of the secretary or other head of the department to which the State law enforcement agency is assigned. The secretary or head of the department then determines whether the officer is entitled to benefits under the Article. The officer may appeal this decision to the North Carolina Industrial Commission.

The following State agency law enforcement officers are eligible for this benefit:

- (1) State Government Security Officers, Department of Administration;
- (2) State Correctional Officers, Division of Adult Correction of the Department of Public Safety;
- (3) State Probation and Parole Officers, Division of Adult Correction of the Department of Public Safety;
- (4) Sworn State Law-Enforcement Officers with the power of arrest, Division of Adult Correction of the Department of Public Safety;
- (5) Alcohol Law-Enforcement Agents, Department of Public Safety;
- (6) State Highway Patrol Officers, Department of Public Safety;
- (7) General Assembly Special Police, General Assembly;
- (8) Sworn State Law-Enforcement Officers with the power of arrest, Department of Health and Human Services;
- (9) Juvenile Justice Officers, Division of Juvenile Justice of the Department of Public Safety;
- (10) Insurance Investigators, Department of Insurance;
- (11) State Bureau of Investigation Officers and Agents, Department of Justice;
- (12) Director and Assistant Director, License and Theft Enforcement Section, Division of Motor Vehicles, Department of Transportation;
- (13) Members of License and Theft Enforcement Section, Division of Motor Vehicles, Department of Transportation, designated by the Commissioner of Motor Vehicles as either "inspectors" or uniformed weigh station personnel;
- (14) Utilities Commission Transportation Inspectors and Special Investigators;

Senate PCS 849

Page 2

- (15) North Carolina Ports Authority Police, Department of Transportation;
- (16) Sworn State Law-Enforcement Officers with the power of arrest, Department of Environment and Natural Resources;
- (17) Sworn State Law-Enforcement Officers with the power of arrest, Department of Public Safety.
- (18) Sworn State Law-Enforcement Officers with the power of arrest, Department of Revenue.
- (19) Sworn State Law-Enforcement Officers with the power of arrest, University System.

BILL ANALYSIS: Senate Bill 849 would restrict the circumstances under which certain State agency law enforcement officers would be eligible to receive full salary in lieu of workers' compensation if partially or totally incapacitated to injuries incurred due to extreme activity that occurred during the course and scope of their employment. This language is similar to the language used to define "killed in the line of duty" under the Death Benefits Act for law enforcement officers (Article 12A of Chapter 143 of the General Statutes). The bill would completely prohibit an officer from receiving full salary benefits if the partial or total incapacity was due to an occupational disease. An officer would still be eligible for workers' compensation benefits.

The proposed committee substitute makes conforming changes throughout Article 12B and also substitutes gender neutral terms.

EFFECTIVE DATE: The act becomes effective October 1, 2012 and applies to incapacity commencing on or after that date.

BACKGROUND: The bill was a recommendation of the Joint Legislative Oversight Committee on Justice and Public Safety.

S849-SMRC-66(CSRC-54) v1

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

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SENATE BILL 869

Short Title: Remove Restriction/Firefighter Disability. (Public)

Sponsors: Senators Daniel, Newton, Carney; Bingham, Blake, Davis, Goolsby, Meredith, Preston, Stevens, Tucker, and Westmoreland.

Referred to: Insurance.

May 23, 2012

A BILL TO BE ENTITLED

AN TO ACT REMOVE THE REQUIREMENT THAT FIREFIGHTERS AND RESCUE SQUAD WORKERS HAVE ONE YEAR OF CREDITABLE SERVICE IN ORDER TO QUALIFY FOR DISABILITY RETIREMENT BENEFITS UNDER THE LOCAL GOVERNMENTAL EMPLOYEES' RETIREMENT SYSTEM FOR INJURIES INCURRED IN THE LINE OF DUTY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 128-27(c) reads as rewritten:

"(c) Disability Retirement Benefits. – Upon the application of a member or of his employer, any member who has had five or more years of creditable service may be retired by the Board of Trustees, on the first day of any calendar month, not less than one day nor more than 120 days next following the date of filing such application, on a disability retirement allowance: Provided, that the medical board, after a medical examination of such member, shall certify that such member is mentally or physically incapacitated for the further performance of duty, that such incapacity was incurred at the time of active employment and has been continuous thereafter, that such incapacity is likely to be permanent, and that such member should be retired; Provided further the medical board shall determine if the member is able to engage in gainful employment and, if so, the member may still be retired and the disability retirement allowance as a result thereof shall be reduced as in subsection (e) below. Provided further, that the Medical Board shall not certify any member as disabled who:

- (1) Applies for disability retirement based upon a mental or physical incapacity which existed when the member first established membership in the system; or
- (2) Is in receipt of any payments on account of the same disability which existed when the member first established membership in the system.

The Board of Trustees shall require each employee upon enrolling in the retirement system to provide information on the membership application concerning any mental or physical incapacities existing at the time the member enrolls.

Notwithstanding the requirement of five or more years of creditable service to the contrary, a member who is a law enforcement officer, an eligible fireman as defined in G.S. 58-86-25, or an eligible rescue squad worker as defined in G.S. 58-86-30 and becomes incapacitated for duty as the natural and proximate result of injuries incurred while in the actual performance of his or her duties, and meets all other requirements for disability retirement benefits, may be retired by the Board of Trustees on a disability retirement allowance.



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1 Notwithstanding the requirement of five or more years of creditable service to the contrary,
2 a member who is a fireman as defined in G.S. 58-86-25 or rescue squad worker as defined in
3 G.S. 58-86-30 and who has had one year or more of creditable service and becomes
4 incapacitated for duty as the natural and proximate result of an accident occurring while in the
5 actual performance of duty, and meets all other requirements for disability retirement benefits,
6 may be retired by the Board of Trustees on a disability retirement allowance.

7 Notwithstanding the foregoing to the contrary, any beneficiary who commenced retirement
8 with an early or service retirement benefit has the right, within three years of his retirement, to
9 convert to an allowance with disability retirement benefits without modification of any election
10 of optional allowance previously made; provided, the beneficiary would have met all applicable
11 requirements for disability retirement benefits while still in service as a member. The allowance
12 on account of disability retirement benefits to the beneficiary shall be retroactive to the
13 effective date of early or service retirement.

14 Notwithstanding the foregoing, effective April 1, 1991, the surviving designated
15 beneficiary of a deceased member who met all other requirements for disability retirement
16 benefits, except whose death occurred before the first day of the calendar month in which the
17 member's disability retirement allowance was to be due and payable, may elect to receive the
18 reduced retirement allowance provided by a one hundred percent (100%) joint and survivor
19 payment option in lieu of a return of accumulated contributions, provided the following
20 conditions apply:

- 21 (1) At the time of the member's death, one and only one beneficiary is eligible to
22 receive a return of accumulated contributions, and
23 (2) The member had not instructed the Board of Trustees in writing that he did
24 not wish the provision of this subsection to apply."

25 **SECTION 2.** This act becomes effective July 1, 2012.



SENATE BILL 869: Remove Restriction/Firefighter Disability

2011-2012 General Assembly

Committee: Senate Insurance
Introduced by: Sens. Daniel, Newton, Carney
Analysis of: First Edition

Date: June 5, 2012
Prepared by: Tim Hovis
Committee Counsel

SUMMARY: *Senate Bill 869 would amend the Local Governmental Employees' Retirement System (LGERS) to allow firemen and rescue squad workers with less than one year of creditable service to qualify for disability retirement benefits.*

[As introduced, this bill was identical to H1129, as introduced by Rep. Boles, which is currently in House State Personnel.]

CURRENT LAW: G.S. 128-27(c) requires most members of the Local Governmental Employees' Retirement System (LGERS) to have five or more years of creditable service to be eligible for disability retirement benefits. Currently, G.S. 128-27(c) provides that firemen and rescue squad workers with one year or more of creditable service that become incapacitated for duty as the natural and proximate result of an accident occurring while in the actual performance of duty, and meet all other requirements for disability retirement benefits, may be retired by the Board of Trustees on a disability retirement allowance.

BILL ANALYSIS: Senate Bill 869 amends G.S. 128-27(c) pertaining to disability retirement benefits for law enforcement officers in the Local Governmental Employees' Retirement System (LGERS). The bill removes firemen and rescue squad workers from the requirement for one year of creditable service as described in the current law above. The bill adds new language to allow firemen and rescue squad workers who are members of the LGERS and who become incapacitated for duty as the natural and proximate result of an accident occurring while in the actual performance of duty, and meet all other requirements for disability retirement benefits, to be retired by the Board of Trustees on a disability retirement allowance.

This is identical to the current law for law enforcement officers.

EFFECTIVE DATE: Senate Bill 869 would become effective July 1, 2012.

S869-SMRG-52(e1) v1

VISITOR REGISTRATION SHEET

Senate Insurance

Wednesday, June 6th, 2010

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Chris Valanci	Valanci Group
David Anders	PFFPNC
Brian Urschorn	UNC General Admin
Tom Shangan	UNC
~~Andrew~~	DST
~~Joe~~	BASE
chef Norman	BML
Mark Benson	
Ben Schramberg	NCSBA
Bill Zajic	Sterling Montessori Charter School
Katherine Joyce	NCAAA
John Bode	BCS
Sam Warr	NC Dept of State Treasurer
Kenneth Muller	NC Association of Fire Chiefs
Freddy Johnson Sr	Stoney Point F.D. Cumberland County
J. Carlton Cole	Village of Pinhurst Fire Dept
Floyd Fritz	" " "

VISITOR REGISTRATION SHEET

Senate Insurance

Wednesday, June 6th, 2010

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Walter M. Gardner, Jr.	Warrenton Rural VFD
Ben Major	Fayetteville Fire Dept.
Benny Nichols	North Carolina Fire Chief
Chris Nichols	Chris A. Nichols, PLLC
Timothy Tenen	EAST Lincoln Fire Dept.
Bill Jones	NCSFA Lower Currituck VFD
TRAVIS MERCER	WINNABOW Fire Dept.
JEFF WINSTEAD	WILSON FIRE RESCUE
Jeff Thomas	Pinecroft-Sedgefield Fire Dept.
Tim Sawyer	Pinecroft Sedgefield Fire Dept.
Ryan Cole	SKYLAND FIRE RESCUE
RANDY RATTLE	WEST BUNCOMBE FD
BARRY OVERMAN	PO Box 347 Elizabeth City FD Eliz. City, 27909
Robert Lewis	Council Member CAROLINA B
Tracey V. Mosley	Wilson Fire/Rescue Services
Len McCallhan	Bahama Fire Dept
Randy Godwin	Wilson Fire/Rescue Services

VISITOR REGISTRATION SHEET

Senate Insurance

Wednesday, June 6th, 2010

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
DON DRIVER	WILSON FIRE/RESCUE SERVICES
Ran Fowler	MAINE FIRE DEPT-
PHIL WELCH	welch.phil@cityofgaston.nc.com
Michael Greene	NCPLS
Karen Drquette	Civitas
SCOTT ROGERS	Nash County Fire Services

VISITOR REGISTRATION SHEET

Senate Insurance

Wednesday, June 6th, 2010

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Michael Davenport	REALTORS
Kathleen Riech	Wilm. Realter Assn
SHEILA PIERCE	JACKSONVILLE BOARD of REALTORS
Vic Knight	NCAR
CHRIS DILLON	NLWR
David Stoller	STATE Farm.
Harry Lynd	MWC
PATRICK HANNATT	LIBRARY
Alexander Van Vliet	DST
Matthew Eisinger	Stunt L Anderson
Max Barker	GSK
Brian Cox	Guil-Rand Fire Dept
Kevin S Gordon	Waco VFD
William Hunt	Shelby Fire/Rescue
JOHN WHITE	APEX FIRE DEPT
Jerry C. Brooks	Clemmons Fire Dept
R. SCOTT ALDERMAN	LEWISVILLE FIRE DEPT.

VISITOR REGISTRATION SHEET

Senate Insurance

Wednesday, June 6th, 2010

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Paul Miller	NCSFA
Jamie Fulk	MCFD
Adam Snyder	ABFD
Randall Collic	SFD
Dean Coward	NCSFA
Jimmy Webb	Waynesville FD
Mike Sherr	NC State AFL-CIO
Garry Webb	NCSFA
Reggie Villines	NCSFA
RANDOLPH CLEMENTS	NCSFA
Wilbert Fletcher	NCSFA
Edward Brinson	NCSFA
Deb Clary	NCSFA
David Price	Bay Leaf Fire
DAVID BULLINS	STATESVILLE FIRE
Ken Briscoe	Lenoir FD
Derrick C Houston	Gastonia FD

VISITOR REGISTRATION SHEET

Senate Insurance

Wednesday, June 6th, 2010

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
HARRY W. FIELD III	UNION ROAD FD, GASTON CTY
Jamie Smith	Elizabethtown FD, Bladen
Chuck Stone	SEANC
Mich Leonard	SEANC
Chris Evans	BRASWC
HUGH TILSON	NCLTA
Sara Fender	IFNC
JOHN GRIMES	NCSFA / HERAND FIRE
David M'Anon	NCAR
Emma Hanson	DST
Steve Woodson	NC Farm Bureau
Roger Bobbitt	"
RAT EVANS	RATE BUREAU
Tim Lucas	Rate Bureau
Bill Watt	Young Moore
Karl Krupp	NCLM
Rose & Bob	NCDOT

VISITOR REGISTRATION SHEET

Senate Insurance

Wednesday, June 6th, 2010

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Robert Paschal	Young Moore
Fred Fuller	NC DOT