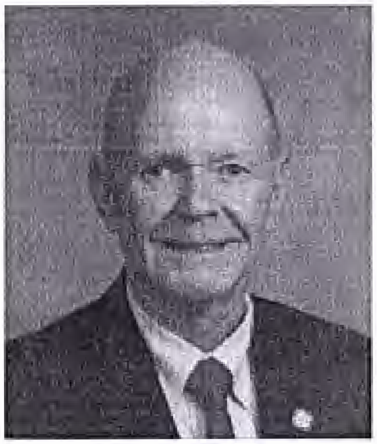
2015-2016

HOUSE INSURANCE

MINUTES

HOUSE COMMITTEE ON INSURANCE
2015-2016 SESSION

Clerks: Margaret Herring and Margie Penven
Revised 5/24/16



Rep. Dana Bumgardner, Chairman

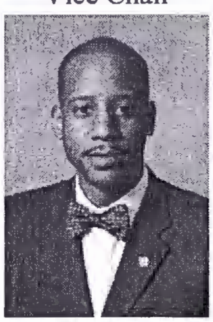
Rep. Mitchell S. Setzer, Chairman

Rep. Rosa Gill
Vice Chair

Rep. Gary Pendleton
Vice Chair

Rep. Paul Tine
Vice Chair

Rep. Dean Arp



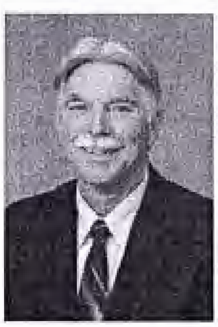
Rep. Nathan Baskerville

Rep. Jamie Boles

Rep. Bill Brawley

Rep. William Brisson

Rep. Justin Burr



Rep. Jeff Collins

Rep. Debra Conrad

Rep. Jimmy Dixon

Rep. Josh Dobson

Rep. Nelson Dollar

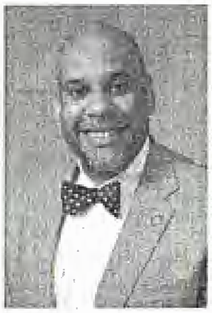
Rep. Beverly Earle

Rep. Charles Graham

Rep. Duane Hall

Rep. Kyle Hall

Rep. Susi Hamilton



Rep. Edward Hanes

Rep. Kelly Hastings

Rep. Craig Horn

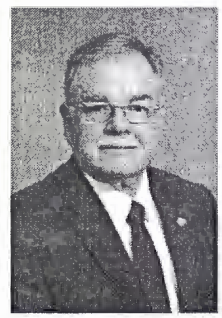
Rep. Julia Howard

Rep. Frank Iler

Rep. Verla Insko

Rep. Darren Jackson

Rep. Linda Johnson



Rep. Donny Lambeth

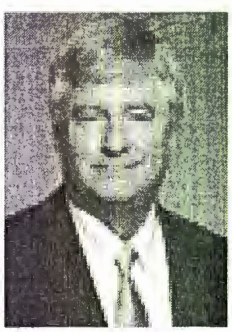
Rep. J. H. Langdon

Rep. Marvin Lucas

Rep. Pat McElraft

Rep. Greg Murphy

Rep. Garland Pierce



Rep. Billy Richardson

Rep. Phil Shepard

Rep. Harry Warren

Rep. Michael Wray

HOUSE COMMITTEE ON INSURANCE
2015-2016 SESSION

Clerks: Margaret Herring and Margie Penven

Rep. Dana Bumgardner, Chairman

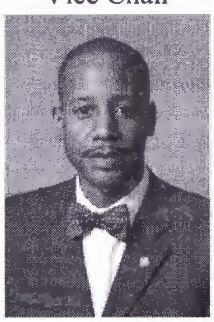
Rep. Mitchell S. Setzer, Chairman

Rep. Rosa Gill
Vice Chair

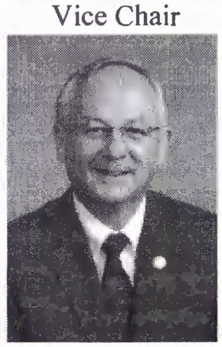
Rep. Gary Pendleton
Vice Chair

Rep. Paul Tine
Vice Chair

Rep. Dean Arp



Rep. Nathan Baskerville

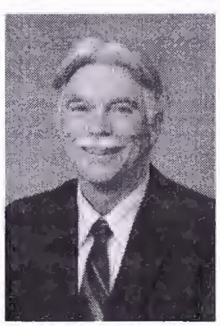


Rep. Jamie Boles

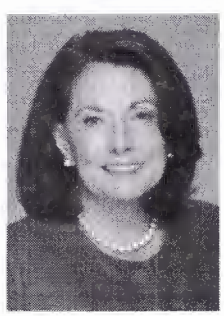
Rep. Bill Brawley

Rep. William Brisson

Rep. Justin Burr



Rep. Jeff Collins



Rep. Debra Conrad

Rep. Jimmy Dixon

Rep. Josh Dobson

Rep. Nelson Dollar

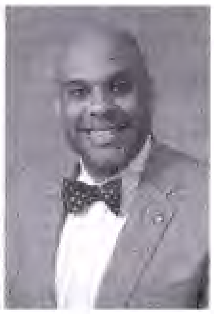
Rep. Beverly Earle

Rep. Rick Glazier

Rep. Charles Graham

Rep. Duane Hall

Rep. Susi Hamilton



Rep. Edward Hanes

Rep. Kelly Hastings

Rep. Bryan Holloway

Rep. Craig Horn

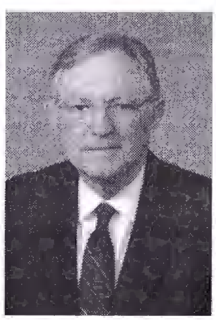
Rep. Julia Howard

Rep. Frank Iler

Rep. Vera Insko

Rep. Darren Jackson

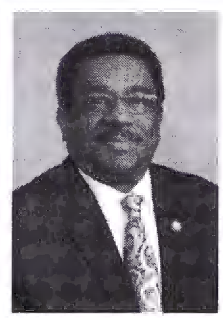
Rep. Linda Johnson



Rep. J. H. Langdon

Rep. Marvin Lucas

Rep. Pat McElraft



Rep. Garland Pierce

Rep. Phil Shepard

Rep. Harry Warren

Rep. Michael Wray

HOUSE COMMITTEE ON INSURANCE 2016

(Revised 5/24/16)

MEMBER	ASSISTANT	PHONE	OFFICE	SEAT
Bumgardner, Dana, **Chair**	Margie Penven	733-5809	2119 LB	40
Setzer, Mitchell, **Chair**	Margaret Herring	733-4948	2204 LB	7
Gill, Rosa, **Vice-Chair**	Lisa Ray	733-5880	1303LB	58
Pendleton, Gary, **Vice-Chair**	Kathy Peters	733-5860	610 LOB	97
Tine, Paul, **Vice-Chair**	Wanda Kay	733-5906	529 LOB	79
Arp, Dean	Wendy Miller	715-3007	531 LOB	66
Baskerville, Nathan	Anita Bennett	733-5824	1004 LB	105
Boles, Jamie	Kerry Guice	733-5903	528 LOB	25
Brawley, Bill	Lynn Taylor	733-5800	534 LOB	31
Brisson, William	Caroline Stirling	733-5772	405 LOB	23
Burr, Justin	Dina Long	733-5908	307A LOB	16
Collins, Jeff	Wes Householder	733-5802	1106 LB	29
Conrad, Debra	Danielle Brinton	733-5787	606 LOB	44
Dixon, Jimmy	Michael Wiggins	715-3021	416B LOB	19
Dobson, Josh	Julie Ryan	733-5862	301N LOB	114
Dollar, Nelson	Candace Slate	715-0795	307B LOB	4
Earle, Beverly	Ann Raeford	715-2530	514 LOB	60
Graham, Charles	Linda Laton	715-0875	1309 LB	84
Hall, Duane	Leigh Lawrence	733-5756	1019 LB	46
Hall, Kyle	Emma Shelby	733-5609	536 LOB	112
Hamilton, Susi	Ruth Merkle	733-5754	1313 LB	48
Hanes, Edward	Rita Harris	733-5829	1006 LB	94
Hastings, Kelly	James Jenkins	715-2002	1206 LB	20
Horn, Craig	Pattie Fleming	733-2406	305 LOB	32
Howard, Julia	Cody Honeycutt	733-5904	302 LOB	1
Iler, Frank	Carla Farmer	301-1450	639 LOB	14
Insko, Verla	Gina Insko	733-7208	502 LOB	72
Jackson, Darren	Angela McMillan	733-5974	1013 LB	34
Johnson, Linda	Joanna Hogg	733-5861	301D LOB	3
Lambeth, Donny	Pan Briles	733-5747	303 LOB	77
Langdon, J. H.	Thomas Goffe	733-5849	417B LOB	17
Lucas, Marvin	Thelma Utley	733-5775	509 LOB	22
McElraft, Pat	Nancy Fox	733-6275	634 LOB	9
Murphy, Greg	Theresa Lopez	733-5757	604 LOB	111
Pierce, Garland	Janice Fenner	733-5803	1204 LB	57
Richardson, Billy	Megan Glazier	733-5601	1021 LB	71
Shepard, Phillip	Pamela Pate	715-9644	530 LB	53
Warren, Harry	Cristy Yates	733-5784	611 LOB	62
Wray, Michael	Susan Burleson	733-5662	503 LOB	24
STAFF:				
Tim Hovis, **Coordinator**, Research Div.		733-2578	200	
Kristen Harris, Research Div.		733-2578	545	
Jason Moran-Bates, Research Div.		733-2578		
Margaret Herring, **Committee Assistant**		733-4948	2204 LB	
Margie Penven, **Committee Assistant**		733-5809	2119 LB	

HOUSE COMMITTEE ON INSURANCE

MEMBER	ASSISTANT	PHONE	OFFICE	SEAT
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Hamilton, Susi	Ruth Merkle	733-5754	1313 LB	48
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Holloway, Bryan	Emma Shelby	733-5609	305 LOB	15
Horn, Craig	Pattie Fleming	733-2406	419A LOB	32
Howard, Julia	Cody Honeycutt	733-5904	302 LOB	1
Iler, Frank	Carla Farmer	301-1450	639 LOB	14
Insko, Verla	Gina Insko	733-7208	502 LOB	72
Jackson, Darren	Angela McMillan	733-5974	1013 LB	34
Johnson, Linda	Joanna Hogg	733-5861	302D LOB	3
Lambeth, Donny	Pan Briles	733-5747	303 LOB	77
Langdon, J. H.	Thomas Goffe	733-5849	417B LOB	17
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Shepard, Phillip	Pamela Pate	733-5784	530 LB	53
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STAFF:				
Tim Hovis, **Coordinator**, Research Div.		733-2578	200	
Kristen Harris, Research Div.		733-2578	545	
my Jo Johnson. Research Div.				
Margaret Herring, **Committee Assistant**		733-4948	2204 LB	
Margie Penven, **Committee Assistant**		733-5809	2119 LB	

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ATTENDANCE

HOUSE COMMITTEE ON INSURANCE

2016 SESSION

DATES	6/22/16	6/28/16	6/29/16
BUMGARDNER, Dana **Chair**	✓	✓	✓
SETZER, Mitchell **Chair**	✓	✓	✓
GILL, Rosa **Vice Chair**		✓	
PENDLETON, Gary **Vice Chair**	✓	✓	✓
TINE, Paul **Vice Chair**	✓	✓	✓
ARP, Dean		✓	✓
BASKERVILLE, Nathan		✓	
BOLES, Jamie	✓	✓	✓
BRAWLEY, Bill	✓		
BRISSON, William		✓	
BURR, Justin	✓	✓	✓
COLLINS, Jeff	✓	✓	✓
CONRAD, Debra	✓	✓	
DIXON, Jimmy	✓		✓
DOBSON, Josh	✓	✓	✓
DOLLAR, Nelson	✓		
EARLE, Beverly	✓	✓	
GRAHAM, Charles		✓	✓
HALL, Duane		✓	
HALL, Kyle	✓	✓	✓
HAMILTON, Susi	✓	✓	
HANES, Edward	✓	✓	✓
HASTINGS, Kelly	✓	✓	✓
HORN, Craig	✓	✓	
HOWARD, Julia		✓	✓
ILER, Frank	✓	✓	✓

INSKO, Verla		✓													
JACKSON, Darren	✓	✓													
JOHNSON, Linda		✓													
LAMBETH, Donny		✓													
LANGDON, J. H.	✓	✓													
LUCAS, Marvin		✓	✓												
MCELRAFT, Pat		✓	✓												
MURPHY, Greg	✓	✓	✓												
PIERCE, Garland		✓													
RICHARDSON, Billy	✓	✓													
SHEPARD, Phil	✓	✓													
WARREN, Harry	✓	✓	✓												
WRAY, Michael		✓	✓												
HOVIS, Tim **Lead Staff Attorney**	✓														
HARRIS, Kristen **Attorney**	✓	✓	✓												
MORAN-BATES, Jason **Attorney**		✓	✓												
HERRING, Margaret **Com. Asst**	✓	✓	✓												
PENVEN, Margie **Com. Asst**	✓	✓													

[Type text]

ATTENDANCE

HOUSE COMMITTEE ON INSURANCE

2015 SESSION

DATES	3/24/15	4/14/15	4/21/15	4/28/15	6/30/15
BUMGARDNER, Dana **Chair**	✓	✓	✓	✓	✓
SETZER, Mitchell **Chair**	✓	✓	✓	✓	✓
GILL, Rosa **Vice Chair**	✓	✓	✓	✓	✓
PENDLETON, Gary **Vice Chair**	✓	✓	✓	✓	
TINE, Paul **Vice Chair**	✓	✓	✓	✓	✓
ARP, Dean	✓	✓	✓	✓	✓
BASKERVILLE, Nathan	✓		✓	✓	
BOLES, Jamie			✓	✓	✓
BRAWLEY, Bill		✓	✓	✓	
BRISSON, William	✓	✓		✓	
BURR, Justin	✓		✓	✓	✓
COLLINS, Jeff	✓	✓	✓	✓	✓
CONRAD, Debra	✓				
DIXON, Jimmy	✓	✓			
DOBSON, Josh	✓		✓	✓	
DOLLAR, Nelson		✓	✓	✓	✓
EARLE, Beverly	✓	✓	✓	✓	✓
GLAZIER, Rick					
GRAHAM, Charles	✓		✓	✓	
HALL, Duane	✓	✓	✓	✓	
HAMILTON, Susi	✓	✓	✓		
HANES, Edward	✓	✓	✓	✓	✓
HASTINGS, Kelly	✓	✓	✓	✓	
HOLLOWAY, Bryan				✓	✓
HORN, Craig	✓	✓	✓	✓	✓
HOWARD, Julia	✓	✓	✓	✓	✓

[Type text]

ILER, Frank	✓	✓	✓	✓	✓										
INSKO, Verla	✓		✓	✓	✓										
JACKSON, Darren	✓	✓	✓	✓											
JOHNSON, Linda	✓	✓													
LAMBETH, Donny		✓	✓	✓	✓										
LANGDON, J. H.	✓	✓	✓	✓	✓										
LUCAS, Marvin	✓	✓	✓	✓	✓										
MCELRAFT, Pat	✓	✓	✓	✓											
PIERCE, Garland			✓	✓	✓										
SHEPARD, Phil	✓	✓	✓	✓	✓										
WARREN, Harry	✓	✓	✓	✓	✓										
WRAY, Michael			✓	✓											
HERRING, Margaret **Com. Asst.**		✓	✓	✓	✓										
PENVEN, Margie **Com. Asst.**	✓	✓	✓	✓											
HOVIS, Tim **Lead Staff Attorney**	✓	✓	✓	✓	✓										
Johnson, Amy Jo **Staff Attorney**	✓	✓	✓	✓	X										
Kristen Harris	✓	✓	✓	✓	✓										

Corrected #2: Remove HB 288 and add HB 16

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Tuesday, March 24, 2015
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 151	Property Insurance Ratemaking Reform.	Representative Tine Representative Setzer Representative J. Bell Representative Jackson
HB 16	Repeal outdated reports.-AB	Representative Pendleton

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 4:39 PM on Monday, March 23, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margie Penven (Committee Assistant)

Margie Penven (Rep. Dana Bumgardner)

Subject:	FW: <NCGA> House Insurance Committee Meeting Notice for Tuesday, March 24, 2015 at 1:00 PM - CORRECTED #1
Attachments:	Add Meeting to Calendar_LINC_.ics

From: Dianne Russell (House Legislative Assistant Director)
Sent: Thursday, March 19, 2015 4:00 PM
To: Rep. Mitchell Setzer; Rep. Darren Jackson; Rep. Paul Tine; Rep. John Bell; Rep. Dana Bumgardner
Cc: Margaret Herring (Rep. Mitchell Setzer); Angela McMillan (Rep. Darren Jackson); Katy Kingsbury (Rep. Paul Tine); Susan West Horne (Rep. John Bell); Margie Penven (Rep. Dana Bumgardner)
Subject: <NCGA> House Insurance Committee Meeting Notice for Tuesday, March 24, 2015 at 1:00 PM - CORRECTED #1

Corrected #1: Remove HB 287 and add HB 288

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Tuesday, March 24, 2015
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 151	Property Insurance Ratemaking Reform.	Representative Tine Representative Setzer Representative J. Bell Representative Jackson
HB 288	Insurance Technical Changes.-AB	Representative Setzer Representative Bumgardner

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 3:59 PM on Thursday, March 19, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Dianne Russell (Committee Assistant)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Tuesday, March 24, 2015
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 151	Property Insurance Ratemaking Reform.	Representative Tine Representative Setzer Representative J. Bell Representative Jackson
HB 287	Amend Insurance Laws.-AB	Representative Setzer Representative Bumgardner

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 3:29 PM on Thursday, March 19, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margie Penven (Committee Assistant)

House Committee on Insurance
Tuesday, March 24, 2015, 1:00 PM
1228/1327 Legislative Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 151	Property Insurance Rate-Making Reform.	Representative Tine Representative Setzer Representative J. Bell Representative Jackson
HB 16	Repeal Outdated Reports.-AB	Representative Pendleton

Presentations

Other Business

Adjournment

House Committee on Insurance
Tuesday, March 24, 2015, at 1:00 p.m.
Room 1228/1327

MINUTES

The House Committee on Insurance met at 1:00 p.m. on Tuesday, March 24, 2014, in Room 1228/1327 of the Legislative Building, Raleigh, North Carolina. Representatives Arp, Baskerville, Brisson, Bumgardner, Burr, Collins, Conrad, Dixon, Dobson, Earle, Gill, Graham, Hall, Hamilton, Hanes, Hastings, Horn, Howard, Iler, Insko, Jackson, Johnson, Langdon, Lucas, McElraft, Pendleton, Setzer, Shepard, Tine, and Warren attended. Representatives Setzer and Bumgardner presided. The visitor registration sheets are attached as Exhibit 1. A list of Assistant Sergeants-at-Arms serving the committee is attached as Exhibit 2. A list of Pages serving the committee is attached as Exhibit 3.

House Bills 151 and 16 were heard. A copy of the agenda for the meeting is attached as Exhibit 4.

Representative Tine explained HB 151, A BILL TO BE ENTITLED AN ACT TO INCREASE THE FAIRNESS AND EQUITY OF THE PROPERTY INSURANCE RATE-MAKING PROCESS BY PROVIDING FOR GREATER PROPERTY INSURANCE RATE FILINGS, BY PROVIDING THAT MODELED LOSSES IN A PROPERTY RATE FILING BE PROPERLY ALLOCABLE TO NORTH CAROLINA, AND BY REQUIRING THE RATE BUREAU TO DESIGNATE IN A FILING THAT PORTION OF THE RATE IN EACH TERRITORY ALLOCABLE TO WIND AND HAIL. A copy of the bill is attached as Exhibit 5. A copy of the bill summary, which was prepared by Committee Counsel, Tim Hovis, is attached as Exhibit 6.

Chairman Setzer recognized Representative Collins to send forth an amendment, which is attached as Exhibit 7. Representative Tine said he opposed the amendment. During committee discussion, Mr. William M. Trott, representing the Rate Bureau, was called upon to answer questions. Upon a motion by Representative Collins, the amendment was adopted on a voice vote.

Representative Shepard moved that the amendment be rolled into a committee substitute bill and the committee substitute bill be given a favorable report, unfavorable as to the original bill. The motion carried on a voice vote.

Chairman Bumgardner recognized Representative Pendleton to explain House Bill 16, A BILL TO BE ENTITLED AN ACT TO REPEAL OUTDATED AND UNNECESSARY INSURANCE REPORTING REQUIREMENTS AS RECOMMENDED BY THE DEPARTMENT OF INSURANCE. A copy of the bill is attached as Exhibit 8. A copy of the bill summary, which was prepared by Kristen Harris, Committee Counsel, is attached as Exhibit 9.

Representative Pendleton sent forth an amendment that was requested by the Department of Insurance. A copy of the amendment is attached as Exhibit 10. Mr. Ben Popkin from the

Department of Insurance explained the amendment, and Representative Setzer moved for its adoption. On a voice vote the amendment was adopted.

Representative Setzer moved the amendment be rolled into a committee substitute bill and that the committee substitute bill be given a favorable report, unfavorable as to the original bill. The motion carried unanimously.

There being no further business, the meeting adjourned at 1:34 p.m.

A copy of the committee report is attached as Exhibit 11.

Mitchell S. Setzer
Chairman Mitchell Setzer
Presiding

Chairman Dana Bumgardner
Presiding

Margie Penven
Margie Penven
Committee Clerk

Exhibits:

1. Visitor Registration
2. Assistant Sergeants-at-Arms Serving Committee
3. Pages Serving Committee
4. Agenda
5. House Bill 151
6. Bill Summary for House Bill 151
7. Amendment to House Bill 151
8. House Bill 16
9. Bill Summary for House Bill 16
10. Amendment for House Bill 16
11. Committee Report

EXHIBIT 1

VISITOR REGISTRATION SHEET

House Committee on Insurance — March 24, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tonya Hoaim	TSS
Tom Fetzer	Nationwide
Susan Valauri	~~[illegible]~~ Nationwide
Art Lyon	NATIONAL GENERAL
Glenn Jernigan	National General
Ben Popken	NCDOI
BILL HALE	"
Bob MACK	NCDOI

VISITOR REGISTRATION SHEET

House Committee on Insurance — March 24, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Daniel Bailey	Troutman Sanders
Sonny Watts	TWL Group
Ly-Ann [illegible]	CSS
R W Kayler	Kayler Law Firm
J Peters	CSS
Hayden Bauguess	FSP
Tony McEwen	City Wilmington
A. Lane Brown	NC Captive Ins Assn
Dave Horne	Smith Anderson
Jonathan Brubaker	Brubaker & Assoc.
JAKE PARKER	NCFB

VISITOR REGISTRATION SHEET

House Committee on Insurance — **Name of Committee**

March 24, 2015 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robert Eate	CSA
John Brown	
Bill Scoggin	TB
Liz Reynolds	NAMIC
Ed Gallagher	[illegible]
Tyler Newman	BASE
Heather Jarman	BASE
Cady Thomas	FOCUS Carolina
Isabel Villa-Garcia	NCAR
Mark Zimmerman	NCAR
John Hardin	MF & S

VISITOR REGISTRATION SHEET

House Committee on Insurance — March 24, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chuck Stone	SEANC
Bill Thatt	Young Moore Henderson PA
RAY EVANS	NORTH CAROLINA RATE BUREAU
Robert PAschal	Young Moore
Tim LUCAS	NC Rate Bureau
John T. Bode	BDH
Sarah Wolfe	MWC
Connie Wilson	TISPC

VISITOR REGISTRATION SHEET

House Committee on Insurance — March 24, 2015

Name of Committee — **Date**

<u>VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK</u>

NAME	FIRM OR AGENCY AND ADDRESS
John McMillan	MFBS

EXHIBIT 2

Committee Sergeants at Arms

NAME OF COMMITTEE INSURANCE

DATE: 3-24-2015 Room: 1228/1327

House Sgt-At Arms:

1. Name: BILL BASS
2. Name: MARK CONE
3. Name: JOE CROOK
4. Name: BARRY MOORE
5. Name: ______

Senate Sgt-At Arms:

1. Name: ______
2. Name: ______
3. Name: ______
4. Name: ______
5. Name: ______

EXHIBIT 3

Tuesday, March 24
INSURANCE

Room
1228/1327

Time
1:00 pm

Name	County	Sponsor
Sean Cone	Nash	Jeff Collins
Dion Hodge	Wake	Yvonne Lewis Holley
Christian Judkins	Wake	Yvonne Lewis Holley
Nia Judkins	Wake	Yvonne Lewis Holley

EXHIBIT 4

House Committee on Insurance
Tuesday, March 24, 2015, 1:00 PM
1228/1327 Legislative Building

AGENDA

Chairman Bumgardner, presiding

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 151	Property Insurance Ratemaking Reform.	Representative Tine Representative Setzer Representative J. Bell Representative Jackson
HB 16	Repeal outdated reports.-AB	Representative Pendleton

Presentations

Other Business

Adjournment

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 1

HOUSE BILL 151

Short Title:	Property Insurance Ratemaking Reform.	(Public)
Sponsors:	Representatives Tine, Setzer, J. Bell, and Jackson (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Insurance.	

March 5, 2015

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE FAIRNESS AND EQUITY OF THE PROPERTY INSURANCE RATE-MAKING PROCESS BY PROVIDING FOR GREATER TRANSPARENCY REGARDING THE ROLE OF CATASTROPHE MODELING IN PROPERTY INSURANCE RATE FILINGS, BY PROVIDING THAT MODELED LOSSES IN A PROPERTY RATE FILING BE PROPERLY ALLOCABLE TO NORTH CAROLINA, AND BY REQUIRING THE RATE BUREAU TO DESIGNATE IN A FILING THAT PORTION OF THE RATE IN EACH TERRITORY ALLOCABLE TO WIND AND HAIL.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-36-10 reads as rewritten:

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

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

…

(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 hurricane losses based upon a commercial hurricane simulation computer model with a property insurance rate filing, the Bureau shall present data from more than one such model. The Commissioner may consider modeled hurricane losses presented by the Rate Bureau.

…."

SECTION 2. G.S. 58-36-15 reads as rewritten:

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

…

(d2) The following supporting data, at a minimum, shall be included in any property insurance rate filing where a catastrophe model is used:

(1) Any simulated loss from a catastrophe model should include the following:

a. An event identifier.

b. The simulation year.

c. The State and county of first landfall, and the wind speed, based upon the Saffir-Simpson scale, at landfall.

d. The gross amount of North Carolina damages before application of any deductible or other applicable policy provisions that impact the coverage, calculated with and without any applicable demand surge adjustments.

e. The net amount of North Carolina insured loss after application of any deductible or other applicable policy provisions that impact the coverage, calculated with and without any applicable demand surge adjustments.

f. Any other information required by rules promulgated by the Commissioner.

(2) Annual historical exposure and hurricane loss data by territory for 2003 and each subsequent year. The Bureau shall also provide annual historical exposure and hurricane loss data by territory for 1987 through 2002 to the extent this data is reasonably available.

(3) If requested by the Department, a statistical analysis comparing the historic loss data required by subdivision (2) of this subsection with any simulated losses used to support the rate filing.

(4) Trade secret information provided under this subsection is confidential and shall be handled in accordance with the provisions of G.S. 66-152 and G.S. 132-1.2.

(d3) In all residential property insurance rate filings, the Bureau shall set forth for each territory in the State (i) that portion of the rate based on all risks with the exception of wind and hail and (ii) that portion of the rate based on consideration of risks and the costs of reinsurance for wind and hail. The Department shall post both the filed rate and the final rate for each territory on its Web site, including that portion of the filed rate and the final rate for each territory based on all risks with the exception of wind and hail and that portion based on wind and hail.

…."

SECTION 3. This act becomes effective August 1, 2015, and applies to filings by the Rate Bureau on or after that date.

EXHIBIT 6

HOUSE BILL 151: Property Insurance Ratemaking Reform

2015-2016 General Assembly

Committee:	House Insurance	**Date:**	March 24, 2015
Introduced by:	Reps. Tine, Setzer, J. Bell, Jackson	**Prepared by:**	Tim Hovis
Analysis of:	First Edition		Committee Counsel

SUMMARY: House Bill 151 makes the following changes to the law governing property insurance rate filings: (1) requires the Rate Bureau to submit data from more than one model if modeled losses are used; and (2) requires supporting data specific to North Carolina be included in a rate filing when a catastrophe model is used. Each filing must also include annual historical loss data by territory for 2003 and each subsequent year and for 1987 to 2002 to the extent the data is reasonably available.

The bill also adds a new subsection to require the Rate Bureau to set forth in all residential property rate filings that portion of the rate in each territory based on risks other than wind and hail and that portion based on wind and hail. The Department is required to post the respective filed rate and the final rate for each territory on its Web site.

BACKGROUND: Article 36 of Chapter 58 requires the N.C. Rate Bureau to file with the Commissioner for approval the proposed rates and rating plans for insurance against loss to residential real property. The burden of proving that a proposed 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 requires the Rate Bureau to submit data from more than one catastrophe model in a rate filing, if modeled losses are used, and provides that the Commissioner may consider modeled losses presented by the Bureau.

Section 2 adds two new subsections to G.S. 58-36-15 governing rate filings. The first subsection requires any simulated loss from a catastrophe model to include specific information such as the amount of N.C. damages before and after the application of any deductible, specific information concerning first N.C. landfall or entry, wind speed, and other information. If requested by the Department, a statistical analysis comparing the historic data with any simulated losses from the catastrophe model must also be provided.

Section 2 also adds a new subsection to require the Rate Bureau to set forth in all residential property rate filings that portion of the rate in each territory based on risks other than wind and hail and that portion based on wind and hail. The Department is required to post the respective filed rate and the final rate for each territory on its Web site.

EFFECTIVE DATE: The act becomes effective August 1, 2015 and applies to filings made by the Rate Bureau on or after that date.

EXHIBIT 7

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 151

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

H151-ARG-3 [v.1]

Page 1 of 1

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

Date ________________________,2015

Representative Collins

moves to amend the bill on page 1, line 34, by rewriting the line to read:

"from more than one such model. The Commissioner shall consider modeled"

SIGNED Jeff L Collins
Amendment Sponsor

SIGNED ______________________________
Committee Chair if Senate Committee Amendment

ADOPTED ______________ FAILED ______________ TABLED ______________

H151-ARG-3-V-1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 1

HOUSE BILL 16

Short Title:	Repeal outdated reports.-AB	(Public)
Sponsors:	Representative Pendleton (Primary Sponsor). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Insurance.	

January 29, 2015

A BILL TO BE ENTITLED

AN ACT TO REPEAL OUTDATED AND UNNECESSARY INSURANCE REPORTING REQUIREMENTS, AS RECOMMENDED BY THE DEPARTMENT OF INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-2-165(b) reads as rewritten:

"(b) The Commissioner may require statements under this ~~section, G.S. 58-2-170,~~section and G.S. 58-2-190 to be filed in a format that can be read by electronic data processing equipment, provided that this subsection does not apply to an audited financial statement prepared by a certified public accountant that is submitted by a town or county mutual pursuant to subsection (a1) of this section."

SECTION 2. G.S. 58-2-170 is repealed.

SECTION 3. G.S. 58-3-191(a) and (b1) are repealed.

SECTION 4. G.S. 58-67-140(a)(7) is repealed.

SECTION 5. G.S. 58-36-3(c) is repealed.

SECTION 6. G.S. 58-40-130(e) is repealed.

SECTION 7. G.S. 58-50-95 is repealed.

SECTION 8. This act is effective when it becomes law and applies to reports otherwise required to be filed on or after July 1, 2015.

* H 1 6 - V - 1 *

EXHIBIT 9

2015-2016 General Assembly

HOUSE BILL 16:
Repeal outdated reports.-AB

Committee:	House Insurance	**Date:**	March 24, 2015
Introduced by:	Rep. Pendleton	**Prepared by:**	Kristen Harris
Analysis of:	First Edition		Committee Counsel

SUMMARY: House Bill 16 would repeal insurance reporting requirements as recommended by the Department of Insurance.

BILL ANALYSIS:

Section 1 makes a technical change to G.S. 58-2-165(b) to remove language referencing a reporting requirement that is being repealed in Section 2 below.

Section 2 repeals G.S. 58-2-170, which requires professional liability insurers to file annual statements or medical malpractice claims reports with the Commissioner and self-insurers to provide written notice of self-insurance annually.

Section 3 repeals G.S. 58-3-191(a) and (b) which deals with managed care reporting and disclosure requirements.

Section 4 repeals G.S. 58-67-140(a)(7), which authorizes the Commissioner to suspend or revoke an HMO license.

Section 5 repeals G.S. 58-36-3(c), which requires the Department of Insurance to report annually to the General Assembly on the effectiveness of Session Law 2001-389. S.L. 2001-389 addresses the provision of motorcycle insurance at fair and economical rates.

Section 6 repeals G.S. 58-40-130(e), which requires the Commissioner to report annually to the General Assembly the effects of any changes in North Carolina civil law statutes on the experience of insurers subject to G.S. 58-40-130.

Section 7 repeals G.S. 58-50-95, which requires the Commissioner to report annually to the Joint Legislative Oversight Committee on Health and Human Services regarding the nature and appropriateness of health benefit plan external reviews.

EFFECTIVE DATE: This act is effective when it becomes law and applies to reports otherwise required to be filed on or after July 1, 2015.

EXHIBIT 10

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 16

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

H16-ATU-4 [v.2]

Page 1 of 1

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

Date ______________________,2015

Representative Pendleton

moves to amend the bill on page 1, lines 12-13 by deleting the lines;

and moves to amend the bill on page 1, lines 17-18, by rewriting the lines to read:
"**SECTION 7.** This act is effective when it becomes law.";

and to renumber the sections accordingly.

SIGNED ______________________________
Amendment Sponsor

SIGNED ______________________________
Committee Chair if Senate Committee Amendment

ADOPTED ____________ FAILED ____________ TABLED ____________

* H 1 6 - A T U - 4 - V - 2 *

EXHIBIT 11

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

INSURANCE COMMITTEE REPORT
Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL

HB **16** Repeal outdated reports.-AB

Draft Number:	H16-PCS40170-TU-2
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Pendleton

HB **151** Property Insurance Ratemaking Reform.

Draft Number:	H151-PCS40169-RG-1
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Tine

TOTAL REPORTED: 2

CMR75-V-1

Margie Penven (Rep. Dana Bumgardner)

From:	Margaret Herring (Rep. Mitchell Setzer)
Sent:	Wednesday, April 01, 2015 04:45 PM
To:	Rep. Linda Johnson; Rep. Jeff Collins; Rep. Paul Tine; Rep. Mitchell Setzer; Rep. Dana Bumgardner
Cc:	Joanna Hogg (Rep. Linda Johnson); Wes Householder (Rep. Jeff Collins); Katy Kingsbury (Rep. Paul Tine); Margaret Herring (Rep. Mitchell Setzer); Margie Penven (Rep. Dana Bumgardner)
Subject:	<NCGA> House Insurance Committee Meeting Notice for Tuesday, April 14, 2015 at 1:00 PM
Attachments:	Add Meeting to Calendar_LINC_.ics

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Tuesday, April 14, 2015
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 163	Captive Insurance Amendments.	Representative L. Johnson Representative Collins Representative Tine
HB 287	Amend Insurance Laws.-AB	Representative Setzer Representative Bumgardner
HB 288	Insurance Technical Changes.-AB	Representative Setzer Representative Bumgardner

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 4:42 PM on Wednesday, April 01, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margaret Herring (Committee Assistant)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Tuesday, April 14, 2015
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**

The following bills will be considered:

BILL NO.	**SHORT TITLE**	**SPONSOR**
HB 163	Captive Insurance Amendments.	Representative L. Johnson Representative Collins Representative Tine
HB 287	Amend Insurance Laws.-AB	Representative Setzer Representative Bumgardner
HB 288	Insurance Technical Changes.-AB	Representative Setzer Representative Bumgardner

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 3:27 PM on Wednesday, October 07, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margie Penven (Committee Assistant)

House Committee on Insurance
Tuesday, April 14, 2015, 1:00 PM
1228/1327 Legislative Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 163	Captive Insurance Amendments.	Representative L. Johnson Representative Collins Representative Tine
HB 287	Amend Insurance Laws.-AB	Representative Setzer Representative Bumgardner
HB 288	Insurance Technical Changes.-AB	Representative Setzer Representative Bumgardner

Presentations

Other Business

Adjournment

House Committee on Insurance
Tuesday, April 14, 2015 at 1:00 PM
Room 1228/1327 of the Legislative Building

MINUTES

The House Committee on Insurance met at 1:00 PM on April 14, 2015, in Room 1228/1327 of the Legislative Building. Representatives Arp, Brawley, Brisson, Bumgardner, Collins, Dixon, Dollar, Earle, Gill, D. Hall, Hamilton, Hanes, Hastings, Horn, Howard, Iler, Jackson, L. Johnson, Lambeth, Langdon, Lucas, McElraft, Pendleton, Setzer, Shepard, Tine, and Warren attended.

Representative Dana Bumgardner, Co-Chair, presided. Visitor Registration is attached as Exhibit 1. A list of Assistant Sergeants-at-Arms serving the committee is attached as Exhibit 2, and a list of Pages serving the committee is attached as Exhibit 3.

The following bills were on the agenda: HB 163, Captive Insurance Amendments (Representatives L. Johnson, Collins, Tine); HB 287, Amend Insurance Laws,-AB (Representatives Setzer, Bumgardner); and HB 288, Insurance Technical Changes-AB (Representatives Setzer, Bumgardner). A copy of the Agenda is attached as Exhibit 4.

Representative Setzer moved that a proposed committee substitute (PCS) for House Bill 163 be brought before the Committee for consideration, seconded by Representative Warren. The motion carried, and Representative Tine explained the PCS for 163, A BILL TO BE ENTITLED AN ACT TO MAKE VARIOUS CLARIFYING AND TECHNICAL CHANGES TO THE NORTH CAROLINA CAPTIVE INSURANCE ACT. A copy of the PCS is attached as Exhibit 5, and the Bill Summary prepared by Kristen Harris, Committee Counsel, is attached as Exhibit 6.

After committee discussion, Representative Warren moved to give a favorable report to the PCS for House Bill 163, unfavorable as to the original bill. The motion carried unanimously.

Representative Warren moved that a proposed committee substitute for House Bill 287 be brought before the Committee for consideration, and the motion was seconded by Representative Gill. The motion carried. Mr. Ben Popkin from the Department of Insurance explained the PCS for House Bill 287, A BILL TO BE ENTITLED AN ACT TO MAKE CONFORMING AND CLARIFYING CHANGES TO THE LAWS GOVERNING PROFESSIONAL EMPLOYER ORGANIZATIONS, INSURANCE COMPANY DEPOSITS, CONTINUING CARE, RETIREMENT COMMUNITIES, HEALTH INSURANCE EXTERNAL REVIEW, HEALTH INSURANCE FIDUCIARIES, MOTOR VEHICLE FINANCIAL RESPONSIBILITY, INSURANCE COMPANY NAMES, AND AUTO AND HOMEOWNERS' INSURANCE OPTIONAL PROGRAM ENHANCEMENTS; AND TO PROVIDE FOR A STUDY OF THE HEALTH INSURANCE PREMIUM RATE REVIEW PROCESS AND MONEYS FROM THE INSURANCE REGULATORY FUND TO IMPLEMENT THAT STUDY, AS RECOMMENDED BY THE DEPARTMENT OF INSURANCE. A copy of the PCS is attached as Exhibit 7, and the Bill Summary prepared by Tim Hovis, Committee Counsel, is attached as Exhibit 8.

Representative Langdon moved that the PCS for House Bill 287 be given a favorable report, unfavorable as to the original bill, and bill be re-referred to the Committee on Appropriations. The motion was seconded by Representative Brawley, and it passed unanimously.

Representative Langdon moved that a PCS for House Bill 288, A BILL TO BE ENTITLED AN ACT TO MAINTAIN NAIC ACCREDITATION OF THE DEPARTMENT OF INSURANCE BY MAKING REVISIONS TO THE LAWS GOVERNING INSURANCE COMPANY HOLDING SYSTEMS, be brought before the Committee for consideration. Representative Horn seconded, and the motion carried. A copy of the PCS is attached as Exhibit 9, and the Bill Summary, prepared by Kristen Harris, Committee Counsel, is attached as Exhibit 10.

Representative Setzer sent forth an amendment to the PCS for House Bill 288 and moved for its adoption. The motion carried unanimously. A copy of the amendment is attached as Exhibit 11.

Representative Tine moved that the amendment be rolled into a new committee substitute bill and be given a favorable report as to the new committee substitute, unfavorable as to the original bill. The motion carried. A copy of the new committee substitute bill with the amendment rolled in is attached as Exhibit 12.

There being no further business, the meeting adjourned at 1:15 p.m.

A copy of the committee reports are attached as Exhibit 13 and 14.

Chairman Dana Bumgardner, Presiding

Margie Penven, Committee Assistant

Exhibits:

1. Visitor Registration
2. Assistant-Sergeants-at-Arms Serving Committee
3. Pages Serving Committee
4. Agenda
5. PCS for HB 163
6. Bill Summary for PCS for HB 163
7. PCS for HB 287
8. Bill Summary for PCS for HB 287
9. PCS for HB 288
10. Bill Summary for PCS for HB 288
11. Amendment to PCS for HB 288
12. New PCS for HB 288 with Amendment Rolled In
13. Committee report #1
14. Committee report #2

EXHIBIT 1

VISITOR REGISTRATION SHEET

House Comm. on Insurance 04/14/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Liz Reynolds	NAMIC
Jake Cashion	NCCC
Sonny Watts	TWL GRP
Andy Chase	KMA
James S. Walker	Attorney at Law - Charlotte, NC
Erica Nelson	
J Peters	CSS
Bob Mack	NCDOI
Ray Evans	NCRB
Robert Paschal	Young Moore
[illegible]	MWC

VISITOR REGISTRATION SHEET

House Comm. on Insurance 04/14/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
BILL HALE	NC DOI
[illegible]	NHRS
P. Lane Brown III	NCCIA
Jonathan Reich	Womble Carlyle / NCCIA
J Bode	BVH
Ray McLean	Womble / Carlyle
[illegible]	MF}s
Susan Valenri	NW
Art Lyon	National General
[illegible]	[illegible]
Paul Sherman	NC FB

VISITOR REGISTRATION SHEET

House Comm. on Insurance 04/14/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	[illegible]
TJ Bigbee	NP
Jackie O[illegible]	NCDOI
Jan Andrews	NCDOI
Jeffrey Trendel	NCDOI
Hayden Bauguess	FSP
Jonathan Brubaker	Brubaker + Assoc.
Joyce Peters	[illegible]

VISITOR REGISTRATION SHEET

House Comm. on Insurance — 04/14/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Judy Jenkins	Otsuka
Brian Meuwald	WM

EXHIBIT 2

Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Insurance

DATE: 04/14/15 Room: 1228

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name:
5. Name:

Senate Sgt-At Arms:

1. Name:
2. Name:
3. Name:
4. Name:
5. Name:

EXHIBIT 3

Tuesday, April 14 Insurance	Room 1228/1327	Time 1:00 p.m.

Name	County	Sponsor
Ben Smith	Johnston	Rep. Leo Daughtry
Roam Bilan	Pitt	Rep. Brian Brown
Jillian Lewis	Surry	Rep. Sarah Stevens

EXHIBIT 4

House Committee on Insurance
Tuesday, April 14, 2015, 1:00 PM
1228/1327 Legislative Building

AGENDA

Representative Bumgardner presiding

Welcome and Opening Remarks

Introduction of Pages and Sergeant-at-Arms Staff

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 163	Captive Insurance Amendments.	Representative L. Johnson Representative Collins Representative Tine
HB 287	Amend Insurance Laws.-AB	Representative Setzer Representative Bumgardner
HB 288	Insurance Technical Changes.-AB	Representative Setzer Representative Bumgardner

Presentations

Other Business

Adjournment

EXHIBIT5

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H **D**

HOUSE BILL 163
PROPOSED COMMITTEE SUBSTITUTE H163-CSTU-6 [v.5]
4/10/2015 4:38:29 PM

Short Title: Captive Insurance Amendments. (Public)

Sponsors:

Referred to:

March 9, 2015

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS CLARIFYING AND TECHNICAL CHANGES TO THE NORTH CAROLINA CAPTIVE INSURANCE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. Part 9 of Article 10 of Chapter 58 of the General Statutes reads as rewritten:

"Part 9. Captive Insurance Companies.

"Subpart 1. General Provisions.

…

"**§ 58-10-340. Definitions.**

The following definitions apply in this Part:

(1) ~~Affiliated~~ Affiliate or affiliated company. – Any ~~company~~ person in the same corporate system as a parent, an industrial insured, ~~or~~ a member ~~organization~~ organization, or a participant by virtue of common ownership, control, operation, or management.

…

(9) Captive insurance company. – Any pure captive insurance company, association captive insurance company, industrial insured captive insurance company, risk retention group, protected cell captive insurance company, ~~incorporated cell captive insurance company,~~ special purpose captive insurance company, or special purpose financial captive insurance company formed or licensed under this Part.

…

(12) Controlled unaffiliated business. – A person meeting all of the following:

a. The person is ~~not in the corporate system of a parent and its affiliated companies in the case of a pure captive insurance company or is not in the corporate system of an industrial insured and its affiliated companies in the case of an industrial insured captive insurance company.~~ not an affiliate.

b. The person has an existing contractual relationship with ~~a parent or one of its affiliated companies in the case of a pure captive insurance company or with an industrial insured or one of its affiliated companies in the case of an industrial insured captive insurance company.~~ an affiliate.

c. The person's risks are managed by a ~~pure~~ captive insurance ~~company or an industrial insured captive insurance company, as~~

H163-CSTU-6-V-5

~~applicable,~~company, an affiliate of a captive insurance company, a participant, or an affiliate of a participant in accordance with G.S. 58-10-470.

(12a) Core. – A protected cell captive insurance company, excluding its protected cells.

…

(17) Incorporated protected cell. – A protected cell ~~of an incorporated cell captive insurance company~~ that is organized as a corporation or other legal entity separate from the ~~incorporated~~ protected cell captive insurance ~~company.~~ company of which it is a part.

~~(18) Incorporated cell captive insurance company. – A protected cell captive insurance company that is established as a corporation or other legal entity separate from its incorporated cells that are also organized as separate legal entities.~~

(17a) Impairment. – When the assets of a captive insurance company or protected cell are less than the sum of its liabilities and required minimum capital and surplus.

…

(25) Mutual insurer. – A company owned by its policyholders where no stock is available for ~~purchase on the stock exchanges.~~purchase.

(26) NAIC. – Defined in G.S. 58-1-5.

(27) Organizational documents. – The documents that must be submitted pursuant to North Carolina law in order to legally form a business in this State or to obtain a ~~certificate of authority~~ license to transact business in this State.

(28) Parent. – An individual, corporation, limited liability company, partnership, association, or other entity, or individual that directly or indirectly ~~owns, controls, or holds with power to vote more than fifty percent (50%) of the outstanding voting of any of the following interests:~~controls a captive insurance company.

~~a. Securities of a pure captive insurance company organized as a stock corporation.~~

~~b. Membership interests of a pure captive insurance company organized as a nonprofit corporation.~~

~~c. Membership interests of a pure captive insurance company organized as a limited liability company.~~

~~d. Securities of an SPFC.~~

(29) Participant. – ~~A~~ Any person ~~or an entity authorized to be a participant by G.S. 58-10-515,~~ and any affiliate or any controlled unaffiliated business of ~~a participant,~~ such person that is insured by a protected cell captive insurance company, ~~if~~ where the losses of the participant are limited through a participant contract.

…

(32) Protected cell. – Either of the following:

a. A separate account established by a protected cell captive insurance company ~~formed or~~ licensed under this Part, in which ~~an identified pool of~~ assets and liabilities ~~is~~ are segregated and insulated by means of this Part from the remainder of the protected cell captive insurance company's assets and liabilities, in accordance with the terms of one or more participant contracts to fund the liability of the protected cell captive insurance company, with respect to the participants as set forth in the participant contracts.

b. A separate account established and maintained by an SPFC for one SPFC contract and the accompanying insurance securitization with a counterparty.

(33) Protected cell assets. – All assets, contract rights, and general intangibles identified with and attributable to a specific protected cell of a protected cell captive insurance company.

(34) Protected cell captive insurance company. – Any captive insurance company meeting all of the following:

a. The minimum capital and surplus required by this Part are provided by one or more sponsors.

b. The company is ~~formed or~~ licensed under this Part.

c. The company insures the risks of separate participants through participant contracts.

d. The company funds its liability to each participant through one or more protected cells and segregates the assets of each protected cell from the assets of other protected cells and from the assets of the protected cell captive insurance company's general account.

(35) Protected cell liabilities. – All liabilities and other obligations identified with and attributed to a specific protected cell of a protected cell captive insurance company.

(36) Pure captive insurance company. – Any company that insures risks of its ~~parent and~~parent, affiliated ~~companies or a~~ companies, controlled unaffiliated ~~business or businesses.~~businesses, or any combination of these entities.

…

(39) SPFC or Special Purpose Financial Captive. – A captive insurance company that has received a ~~certificate of authority~~ license from the Commissioner for the limited purposes provided for in this Part.

…

(42) Sponsor. – Any person ~~or entity~~ that is approved by the Commissioner to provide all or part of the capital and surplus required by this Part and to organize and operate a protected cell captive insurance company.

…

"§ 58-10-345. Licensing; authority; confidentiality.

(a) Any business entity, when permitted by its organizational documents, may apply to the Commissioner for a license to do any insurance comprised in G.S. 58-7-15; provided, however, that:

…

(5) No captive insurance company shall provide personal motor vehicle or homeowner's insurance coverage or any component ~~thereof.~~of those coverages on a direct basis.

(6) No captive insurance company shall accept or cede reinsurance except as provided in G.S. 58-10-445 and G.S. 58-10-605.

(7) No captive insurance company shall provide accident and health insurance on a direct basis.

(8) No captive insurance company shall provide workers' compensation and employer's liability insurance on a direct basis.

(9) No captive insurance company shall provide life insurance or annuities on a direct basis.

(10) A special purpose captive insurance company may provide insurance or reinsurance or both for risks as approved by the Commissioner.

…

(h) If the Commissioner is satisfied that the documents and statements filed by an applicant ~~captive insurance company~~ business entity comply with this section, then the Commissioner shall grant a license authorizing it to do insurance business in this State.

…

"§ 58-10-355. Organizational examination.

In addition to the processing of the application, an organizational investigation or examination may be performed before an ~~applicant~~ applicant business entity is licensed. Such investigation or examination shall consist of a general survey of the ~~applicant's~~ applicant business entity's corporate records, including charters, bylaws, and minute books; verification of capital and surplus; verification of principal place of business; determination of assets and liabilities; and a review of such other factors as the Commissioner deems necessary.

"§ 58-10-360. Designation of captive manager.

Before licensing, the applicant business entity shall report in writing to the Commissioner the name and address of ~~the~~ any captive manager designated to manage the captive insurance company. The Commissioner shall approve the captive manager and may require the submission of additional information regarding the proposed captive manager in a form and manner as the Commissioner may designate.

…

"§ 58-10-370. Capital and surplus requirements.

(a) No applicant business entity shall be issued a license unless it possesses and maintains unimpaired paid-in capital and surplus of:

…

(6) In the case of a special purpose captive insurance company, not less than two hundred fifty thousand dollars ~~($250,000).~~($250,000) or such other amount determined by the Commissioner.

…

"§ 58-10-380. Formation of captive insurance companies.

…

(b1) A special purpose captive insurance company may be organized and operated in any form of business organization authorized by the Commissioner.

~~(c) A captive insurance company incorporated or organized in this State shall have not less than three incorporators or three organizers of whom not less than one shall be a resident of this State.~~

…

(m) With the Commissioner's prior written approval, a captive insurance company may establish one or more separate accounts and may allocate to them amounts to provide for the insurance of risks of certain of its parents, affiliates, controlled unaffiliated businesses, or members, as the case may be, subject to the following:

(1) The income, gains, and losses, realized or unrealized, from assets allocated to a separate account shall be credited to or charged against the account, without regard to other income, gains, or losses of the captive insurance company.

(2) Amounts allocated to a separate account in the exercise of the power granted by this subsection are owned by the captive insurance company, and the captive insurance company may not be nor hold itself out to be a trustee with respect to such amounts.

(3) Unless otherwise approved by the Commissioner, assets allocated to a separate account shall be valued in accordance with the laws or rules otherwise applicable to the captive insurance company's assets.

(4) If and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the captive insurance company may conduct.

(5) No sale, exchange, or other transfer of assets may be made by a captive insurance company between any of its separate accounts or between any other investment account and one or more of its separate accounts unless (i) in the case of a transfer into a separate account, the transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made; and (ii) such transfer, whether into or from a separate account, is made by a transfer of cash or by a transfer of securities having a readily determinable market value, provided that such transfer of securities is approved by the Commissioner. The Commissioner may approve other transfers among such accounts, if, in the Commissioner's opinion, such transfers would be equitable.

(6) To the extent deemed necessary by a captive insurance company in order to comply with any applicable federal or state laws, the captive insurance company, with respect to any separate account, including any separate account which is a management investment company or a unit investment trust, may provide for persons having an interest in the separate account appropriate voting and other rights and special procedures for the conduct of the business of such account, including special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and the selection of a committee, the members of which need not be otherwise affiliated with such company, to manage the business of such account.

"§ 58-10-385. Directors.

…

(b) No director, officer, or employee of a captive insurance company shall, except on behalf of the captive insurance company, accept or be the beneficiary of, any fee, brokerage, gift, or other compensation because of any investment, loan, deposit, purchase, sale, payment, or exchange made by or for the captive insurance ~~company,~~company unless otherwise approved in advance by the Commissioner, but such person may receive reasonable compensation for necessary services rendered to the captive insurance company in his or her usual private, professional, or business capacity.

…

"§ 58-10-390. Conflict of interest.

…

(b) Each officer, director, and key employee shall file such disclosure with the ~~Board of Directors yearly.~~board of directors or other governing body of the captive insurance company annually.

…

"§ 58-10-405. Annual reports.

…

(b) Prior to ~~March 1 of each year, and prior to~~ March 15 of each ~~year in the case of pure captive insurance companies or industrial insured captive insurance companies,~~ year, each captive insurance company shall submit to the Commissioner a report of its financial

~~condition,~~condition on the preceding December 31, verified by oath of two of its executive officers. Each captive insurance company shall report using generally accepted accounting principles, unless the Commissioner requires, approves, or accepts the use of statutory accounting principles or other comprehensive basis of accounting. The Commissioner may require, approve, or accept any appropriate or necessary modifications of the statutory accounting principles or other comprehensive basis of accounting for the type of insurance and kinds of insurers to be reported upon. The Commissioner may require additional information to supplement such report. Except as otherwise provided, each risk retention group and association captive insurance company shall file its report in the form required by G.S. 58-2-165, and each risk retention group shall comply with the requirements set forth in G.S. 58-4-5. All other captive insurance companies shall report on forms adopted by the Commissioner. G.S. 58-10-345(f) shall apply to each report filed pursuant to this section. Branch captive insurance companies shall file the report required by this section unless otherwise required by G.S. 58-10-545. Special Purpose Financial Captive insurance companies shall report in accordance with G.S. 58-10-625.

…

(d) The Commissioner may require any captive insurance company to file a report on its financial condition semiannually, quarterly, monthly, or any other frequency determined by the Commissioner.

(e) The Commissioner may waive the filing of the annual report required by this section subject to the filing of the annual audit required by G.S. 58-10-415. A captive insurance company must make a written request for exemption from the annual report at least 30 days prior to the annual report due date. The Commissioner may not simultaneously exempt a captive insurance company from both the annual report and the annual audit requirements.

"§ 58-10-415. Annual audit and statement of actuarial ~~certification.~~opinion.

…

(d) The annual audit shall consist of the following:

(1) Annual audited financial report. –The annual audited financial report shall include the following:

a. Financial statements. – Financial statements shall be prepared in accordance with generally accepted accounting principles, unless the Commissioner requires, approves, or accepts the use of statutory accounting principles or other comprehensive basis of accounting, with useful or necessary modifications or adaptations required, ~~approved~~ approved, or accepted by the Commissioner, and shall be audited by an independent certified public accountant in accordance with generally accepted auditing standards as determined by the American Institute of Certified Public Accountants. The Commissioner may require that the financial ~~statement~~ statements be supplemented by additional information.

b. Notes to financial statements. – The notes to financial statements shall be those required by generally accepted accounting principles, or as otherwise approved by the Commissioner, and shall also include a reconciliation of differences, if any, between the audited financial report and the report of the captive insurance company's financial condition filed with the Commissioner in accordance with G.S. 58-10-405(b).

c. Related required auditor communications. – Copies of related required auditor communications in accordance with generally accepted auditing standards.

(2) Certified public accountant's affirmation. – The certified public accountant shall furnish a written statement in the engagement letter or other document submitted to the captive insurance company that the certified public accountant is aware ~~of~~ of, and will comply ~~with~~ with, the responsibilities imposed by G.S. 58-10-420(b) and G.S. 58-10-420(c).

~~(5) Certification of loss reserves and loss expense reserves. – The annual audited financial report shall be filed with a Statement of Actuarial Opinion evaluating the captive insurance company's loss reserves and loss expense reserves. The individual who prepares the Statement of Actuarial Opinion shall be a Fellow of the Casualty Actuarial Society, a member in good standing of the American Academy of Actuaries, or an individual who has demonstrated competence in loss reserve evaluation to the Commissioner. Certification shall be in such form as the Commissioner deems appropriate.~~

(e) Every captive insurance company, unless otherwise exempted by the Commissioner, shall annually submit with the annual audited financial report the opinion of an appointed actuary entitled, "Statement of Actuarial Opinion," evaluating the captive insurance company's loss reserves and loss expense reserves. The individual who prepares the Statement of Actuarial Opinion shall be a Fellow of the Casualty Actuarial Society, a member in good standing of the American Academy of Actuaries, or an individual who has demonstrated to the Commissioner competence in loss reserve evaluation.

"§ 58-10-420. Independent certified public accountants.

(a) A captive insurance company, after becoming subject to this Part, shall within 60 ~~days~~ days, if not already disclosed at the time of application, report to the Commissioner in writing, the name and address of the independent certified public accountant retained to conduct the annual audit set forth in G.S. 58-10-415.

(b) A captive insurance company shall require its independent certified public accountant to immediately notify in writing an officer and all members of the board of directors or other governing body of the captive insurance company of any determination by the independent certified public accountant that the captive insurance company has materially misstated its financial condition in its report to the Commissioner as required in G.S. 58-10-405. A captive insurance company receiving a notification pursuant to this subsection shall forward a copy of the notification to the Commissioner within five business days after receipt of the notification and shall provide the independent certified public accountant with proof that the notification was forwarded to the Commissioner. If the independent certified public accountant fails to receive the proof within the five-day period required by this subsection, the independent certified public accountant shall within the next five business days submit a copy of the notification to the Commissioner.

…

(d) The lead audit partner may not act in that capacity for more than five consecutive years. For purposes of this subsection, lead audit partner means the partner having primary responsibility for the audit. The person shall be disqualified from acting in that or similar capacity for the captive insurance company for a period of five consecutive years. A captive insurance company may make application to the Commissioner for relief from the above rotation requirement on the basis of unusual circumstances. This application should be made at least 30 days before the end of the ~~calendar~~ fiscal year. The Commissioner may consider the following factors in determining if the relief should be granted:

(1) Number of partners, expertise of the partners, or the number of insurance clients in the firm;

(2) Premium volume of the captive insurance company; or

(3) Number of jurisdictions in which the insurer transacts business.

(e) Risk retention groups shall comply with Part 7 of Article 10 of this Chapter instead of this section.

…

"§ 58-10-430. Examinations.

(a) Whenever the Commissioner determines it to be prudent, the Commissioner shall ~~visit a captive insurance company and inspect and~~ examine ~~its~~ a captive insurance company's affairs to ascertain its financial condition, its ability to fulfill its obligations, and whether it has complied with this Part. The expenses and charges of the examination shall be paid by the captive insurance company.

…

"§ 58-10-440. Investment requirements.

…

(b) No pure captive insurance company, industrial insured captive insurance company, protected cell captive insurance company, ~~incorporated cell captive insurance company,~~ special purpose captive insurance company, or special purpose financial captive insurance company shall be subject to any restrictions on allowable investments, provided that the Commissioner may prohibit or limit any investment that threatens the solvency or liquidity of any such company.

(c) No ~~pure~~ captive insurance company or protected cell shall make a loan to or an investment in its parent ~~company or affiliates~~ company, an affiliated company, a controlled unaffiliated business, or a participant without prior written approval of the Commissioner, and any such loan or investment shall be evidenced by documentation approved by the Commissioner. Loans of minimum capital and surplus funds required by G.S. 58-10-370 are prohibited.

…

"§ 58-10-465. Applicable provisions.

…

(b) The Commissioner may ~~exempt, by rule, regulation, or order,~~exempt special purpose captive insurance companies, on a ~~case by case~~case-by-case basis, from provisions of this Chapter and any rules established under this Chapter that the Commissioner determines to be inappropriate given the nature of the risks to be insured.

"§ 58-10-470. Establishment of standards regarding risk management.

The Commissioner may adopt rules establishing standards ~~to ensure~~so that a ~~parent or its~~captive insurance company, a participant, or an affiliated ~~company, or an industrial insured or its affiliated company,~~company is able to exercise control of the risk management function of any controlled unaffiliated business to be insured by a ~~pure~~ captive insurance ~~company or an industrial insured captive insurance company, respectively;~~company; provided, however, that until such time as rules under this section are adopted, the Commissioner may approve the coverage of such risks by a ~~pure~~ captive insurance ~~company or an industrial insured captive insurance company.~~company on a case-by-case basis.

"§ 58-10-475. Supervision; rehabilitation; liquidation.

Except as otherwise provided in this Part, the terms and conditions set forth in Article 30 of this Chapter shall apply in full to captive insurance companies ~~formed or~~ licensed under this Part.

…

"§ 58-10-485. Violations and penalties.

(a) If, after providing the opportunity for a contested case hearing held in accordance with the provisions of Article 3A of Chapter 150B of the General Statutes, the Commissioner finds that any insurer, person, or entity required to be ~~licensed, permitted,~~licensed or authorized to transact the business of insurance under this Part has violated any provision of this Part or any rule or regulation authorized by this Part, the Commissioner may order:

(1) The insurer, person, or entity to cease and desist from engaging in the act or practice giving rise to the violation.

(2) Payment of a monetary penalty pursuant to G.S. 58-2-70.

(3) The suspension or revocation of the insurer's, person's, or entity's license.

…

"§ 58-10-490. Inactive captive insurance companies.

(a) As used in this section, unless the context requires otherwise, "inactive captive insurance company" means a captive insurance company which meets both of the following criteria:

(1) The company has ceased transacting the business of insurance.

(2) There are no remaining liabilities associated with policies written or assumed by the company.

(b) The Commissioner may declare a captive insurance company, other than a risk retention group, an inactive captive insurance company, if such captive insurance company meets the criteria of subsection (a) of this section.

(c) An inactive captive insurance company shall possess and maintain unimpaired capital and surplus in an amount determined by the Commissioner.

(d) An inactive captive insurance company shall not be subject to or liable for the payment of any tax under Article 8B of Chapter 105 of the General Statutes.

(e) The Commissioner may exempt an inactive captive insurance company from any of the filing and reporting requirements of this Part.

…

"Subpart 2. Protected Cell Captive Insurance Companies.

…

"§ 58-10-505. Additional filing requirements for applicant protected cell captive insurance companies.

In addition to the information required by G.S. 58-10-345(c), each applicant protected cell captive insurance company shall file with the Commissioner all of the following:

…

(3) All contracts or sample contracts between the applicant and any participants.

(4) ~~Evidence that~~A statement describing how expenses shall be allocated to each protected cell in a fair and equitable manner.

"§ 58-10-510. Establishment of protected cells.

(a) A protected cell captive insurance company ~~formed or~~ licensed under this Part may establish and maintain one or more incorporated or unincorporated protected cells, to insure risks of one or more participants, subject to the following conditions:

…

~~(5)~~ ~~An incorporated protected cell may be organized and operated in any form of business organization authorized by the Commissioner. Each incorporated protected cell of a protected cell captive insurer shall be treated as a captive insurer for purposes of this Part. Unless otherwise permitted by the organizational documents of a protected cell captive insurer, each incorporated protected cell of the protected cell captive insurer must have the same directors, secretary, and registered office as the protected cell captive insurer.~~

(6) All attributions of assets and liabilities between a protected cell and the general account shall be in accordance with the ~~plan~~ plans of operation and participant contracts approved by the Commissioner. ~~No other attribution of assets or liabilities shall be made by a protected cell captive insurance company between the protected cell captive insurance company's general account and its protected cells.~~ Any attribution of assets ~~and liabilities~~

between the general account and a protected cell shall be in cash or in readily marketable securities with established market values.

…

(j) ~~All attributions of assets and liabilities to the protected cells and the general account shall be in accordance with the plan of operation approved by the Commissioner. No other attribution of assets or liabilities shall be made by a protected cell captive insurance company between its general account and any protected cell, or between any protected cells.~~ The protected cell captive insurance company shall attribute all insurance obligations, assets, and liabilities relating to a reinsurance contract entered into with respect to a protected cell to such protected cell. The performance under such reinsurance contract and any tax benefits, losses, refunds, or credits allocated pursuant to a tax allocation agreement to which the protected cell captive insurance company is a party, including any payments made by or due to be made to the protected cell captive insurance company pursuant to the terms of such agreement, shall reflect the insurance obligations, assets, and liabilities relating to the reinsurance contract that are attributed to such protected cell.

(k) In connection with the ~~conservation, rehabilitation,~~rehabilitation or liquidation of a protected cell or a protected cell captive insurance company, the assets and liabilities of a protected cell shall, to the extent the Commissioner determines they are separable, at all times be kept separate from and shall not be commingled with those of other protected cells and the protected cell captive insurance ~~company.~~company's general account.

(l) Each protected cell captive insurance company shall annually file with the Commissioner such financial reports as required by the Commissioner. Any such financial report shall include without limitation ~~accounting statements~~a consolidating schedule detailing the financial experience of each protected cell.

(m) Each protected cell captive insurance company shall notify the Commissioner in writing within 10 business days of any protected cell that is impaired, ~~insolvent~~insolvent, or otherwise unable to meet its claim or expense obligations.

(n) No participant contract shall take effect without the Commissioner's prior written approval. The addition of each new protected cell, the withdrawal of any participant, or the termination of any existing protected cell shall constitute a change in the plan of operation requiring the Commissioner's prior written approval.

(o) ~~The~~ If required by the Commissioner, the business written by a protected cell captive insurance company, with respect to each protected ~~cell, must be secured by one of the following methods:~~cell shall be:

(1) Fronted by an insurance company ~~licensed under the laws of any state.~~approved by the Commissioner.

(2) Reinsured by a reinsurer ~~authorized or~~ approved by ~~this State.~~the Commissioner.

(3) Secured by a trust fund in the United States for the benefit of policyholders and claimants, funded by an irrevocable letter of credit, or other arrangement that is acceptable to the Commissioner. ~~The amount of security provided shall be no less than the reserves associated with those liabilities which are neither fronted nor reinsured, including reserves for losses, allocated loss adjustment expenses, incurred but not reported losses, and unearned premiums for business written through the participant's protected cell.~~ The Commissioner may require the protected cell captive insurance company to increase the funding of any security arrangement established under this subdivision. If the form of security is a letter of credit, the letter of credit shall be issued by a bank approved by the Commissioner. A trust maintained pursuant to this subdivision shall be established in a form and upon such terms approved by the Commissioner.

(p) Notwithstanding this Chapter or other laws of this State, and in addition to G.S. 58-10-525, in the event of an insolvency of a protected cell captive insurance company where the Commissioner determines that one or more protected cells remain solvent, the Commissioner may separate such cells from the protected cell captive insurance company and may allow, on application of the protected cell captive insurance ~~company,~~company or a protected cell's participant, for the conversion or transfer of such protected cells into one or more new or existing protected cell captive insurance companies, or one or more other captive insurance companies, pursuant to such plan or plans of operation as the Commissioner deems acceptable.

(q) A protected cell of a protected cell captive insurance company may be transferred to another protected cell captive insurance company or may be converted into another captive insurance company upon the approval of a transfer agreement or conversion plan by the Commissioner. All assets and liabilities of the protected cell immediately before the transfer or conversion shall remain the assets and liabilities after the transfer or conversion. All actions and other legal proceedings which were pending by or against the protected cell immediately prior to the transfer or conversion may be continued by or against the protected cell or the captive into which the protected cell converts.

(r) A protected cell of a protected cell captive insurance company may enter into a contract with its protected cell captive insurance company or with another protected cell of the protected cell captive insurance company that shall be enforceable as if each protected cell of the protected cell captive insurance company were a separate legal entity, even if the protected cell is not organized as an incorporated protected cell.

"**§ 58-10-512. Incorporated protected cells.**

(a) A protected cell of a protected cell captive insurance company may be formed as an incorporated protected cell.

(b) The articles of incorporation or articles of organization of an incorporated protected cell shall refer to the protected cell captive insurance company for which it is a protected cell and shall state that the protected cell is incorporated or organized for the limited purposes authorized by the protected cell captive insurance company's license.

(c) An incorporated protected cell may be organized and operated in any form of business organization authorized by the Commissioner. Unless otherwise permitted by the organizational documents of a protected cell captive insurance company, each incorporated protected cell of the protected cell captive insurance company must have the same directors, secretary, and registered office as the protected cell captive insurance company.

(d) In addition to the information required to be filed pursuant to G.S. 58-10-510(a)(1), a protected cell captive insurance company shall meet the requirements of G.S. 58-10-345(c)(1) for each incorporated protected cell. Other documents related to the incorporated protected cell shall be filed with the Commissioner as required before issuing policies of insurance.

(e) It is the intent of the General Assembly under this section to provide protected cell captive insurance companies with the option to establish one or more protected cells as a separate corporation or other legal entity. This section shall not be construed to limit any rights or protections applicable to protected cells that are not incorporated protected cells.

(f) Subject to the prior written approval of the protected cell captive insurance company and of the Commissioner, an incorporated protected cell shall be entitled to enter into contracts and undertake obligations in its own name and for its own account. In the case of a contract or obligation to which the protected cell captive insurance company is not a party, either in its own name and for its own account or on behalf of a protected cell, the counterparty to the contract or obligation shall have no right or recourse against the protected cell captive insurance company and its assets other than against assets properly attributable to the incorporated protected cell that is a party to the contract or obligation.

"**§ 58-10-513. Cell shares and cell dividends.**

(a) A protected cell captive insurance company may create and issue shares from any of its protected cells, the proceeds of which shall be included in the assets attributable to the cell from which the cell shares were issued.

(b) The proceeds of the issue of shares other than cell shares created and issued by a protected cell captive insurance company shall be included in the protected cell captive insurance company's general account.

(c) A protected cell captive insurance company may pay dividends to cell shareholders from assets attributable to such cell in accordance with the provisions of G.S. 58-10-375.

"§ 58-10-515. ~~Participation~~ Participants in a protected cell captive insurance company.

(a) ~~Associations, corporations, limited liability companies, partnerships, trusts, and other business entities~~Any person may be ~~participants~~ a participant in ~~any~~ a protected cell captive insurance company formed or licensed under this Part.

…

(d) ~~A~~ Except as otherwise approved by the Commissioner, a participant shall insure only its own risks and the risks of its affiliates and controlled unaffiliated businesses through a protected cell captive insurance company.

"§ 58-10-517. Company to inform persons they are dealing with protected cell captive insurance company.

A protected cell captive insurance company shall inform any person with whom it transacts business that it is a protected cell captive insurance company, and for the purposes of that transaction, identify or specify the protected cell with which that person is transacting, unless that transaction is not a transaction with a particular protected cell, in which case it shall specify that the transaction is with the protected cell captive insurance company's core.

…

"§ 58-10-525. Application of supervision, rehabilitation, and liquidation provisions to protected cell captive insurance companies.

(a) Except as otherwise provided in this Part, Article 30 of this Chapter shall apply to a protected cell captive insurance ~~company.~~company and to each protected cell of a protected cell captive insurance company.

(b) Upon any order of supervision, rehabilitation, or liquidation of a protected cell or a protected cell captive insurance company, the Commissioner or receiver shall manage the assets and liabilities of the protected cell captive insurance ~~company~~ company, including assets and liabilities attributed to protected cells, pursuant to this Part.

…

"Subpart 3. Branch Captive Insurance Companies.

…

"§ 58-10-535. Security for payment of branch captive insurance company liabilities.

…

(b) Subject to the prior approval of the Commissioner, the amounts required in subsection (a) of this section may be held in the form of:

(1) A trust formed under a trust agreement and funded by assets acceptable to the Commissioner.

(2) An irrevocable letter of credit issued ~~or confirmed~~ by a bank approved by the Commissioner.

…

"~~**§ 58-10-540. Petition for certificate of authority.**~~

~~In the case of an alien captive insurance company seeking to become licensed as a branch captive insurance company, the alien captive insurance company shall petition the Commissioner to issue a certificate setting forth the Commissioner's finding that, after considering the character, reputation, financial responsibility, insurance experience, and business qualifications of the officers and directors of the alien captive insurance company, the~~

~~licensing and maintenance of the branch operations will promote the general good of the State. After the Commissioner issues a certificate of authorization, the alien captive insurance company shall comply with all other applicable State statutes or common law.~~

…

"Subpart 4. Special Purpose Financial Captives.

…

"§ 58-10-560. Controlling provisions when conflict exists; exemptions.

…

(b) The ~~Commissioner, by rule, regulation, or order,~~ <u>Commissioner</u> may exempt an SPFC or its protected cells, on a case-by-case basis, from this Part if the Commissioner determines regulation under this Part to be inappropriate given the nature of the risks to be insured.

"§ 58-10-565. Application requirements.

…

(l) To ~~ensure~~ <u>minimize the likelihood that</u> the proposed plan of operation is ~~not~~ hazardous to any counterparty, the Commissioner may require reasonable safeguards in the SPFC's plan of operation where applicable and appropriate in the circumstance, including, without limitation, that certain assets of the SPFC be held in a trust to secure the obligations of the SPFC to a counterparty under an SPFC contract.

…

"§ 58-10-600. Asset management agreements.

An SPFC may enter into swap agreements, or other forms of asset management agreements, including guaranteed investment contracts, or other transactions that have the objective of leveling timing differences in funding of up-front or ongoing transaction expenses, or managing asset, credit, or interest rate risk of the investments to ~~ensure~~ <u>minimize the likelihood</u> that the investments are <u>not</u> sufficient to assure payment or repayment of the securities, and related interest or principal payments, issued pursuant to an SPFC insurance securitization transaction, or the obligations of the SPFC under the SPFC contract.

…

"§ 58-10-635. Supervision, rehabilitation, or liquidation of SPFC.

…

(e) Notwithstanding another provision in this Chapter, rules adopted under this Chapter, or another applicable law or regulation, upon any order of rehabilitation or liquidation of a SPFC, or one or more of the SPFC's protected cells, the receiver shall manage the assets and liabilities of the SPFC pursuant to the provisions of this Part. The receiver shall ~~ensure~~ <u>ascertain</u> that the assets linked to one protected cell are not applied to the liabilities linked to another protected cell or to the SPFC generally, unless an asset or liability is linked to more than one protected cell, in which case the receiver shall deal with the asset or liability in accordance with the terms of any relevant governing instrument or contract.

….

"Subpart 5. Other Provisions.

…

<u>**"§ 58-10-655. Commissioner to share information with Department of Revenue.**</u>

<u>Notwithstanding any other provisions of Chapter 58, the Commissioner may share confidential and privileged documents, materials, or information with the Department of Revenue. The documents, materials, or information shared shall be considered tax information and subject to the provisions of G.S. 105-259.</u>"

SECTION 2. G.S. 105-259(b) is amended by adding the following new subdivision to read:

(49) To exchange information concerning a tax imposed by Article 8B of this Chapter with the North Carolina Department of Insurance when the information is needed to fulfill a duty imposed on the Department."

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

EXHIBIT6

HOUSE BILL 163: Captive Insurance Amendments

2015-2016 General Assembly

Committee:	House Insurance	**Date:**	April 14, 2015
Introduced by:	Reps. L. Johnson, Collins, Tine	**Prepared by:**	Kristen Harris
Analysis of:	PCS to First Edition H163-CSTU-6		Committee Counsel

SUMMARY: The Proposed Committee Substitute to House Bill 163 would make various changes to the North Carolina Captive Insurance Act as recommended by the Department of Insurance.

CURRENT LAW AND BACKGROUND: Captive insurance companies form and operate in North Carolina under the North Carolina Captive Insurance Act which became effective July 1, 2013.

BILL ANALYSIS:

Section 1 contains various technical and clarifying changes. Enhancements and substantive changes are outlined below by individual statute.

G.S. 58-10-340 Definitions.

- Removes an incorporated cell captive insurance company from the definition of "captive insurance company" because a protected cell captive insurance company can contain incorporated protected cells.
- Adds definitions for "core" and "impairment".

G.S. 58-10-370 Capital and surplus requirements.

Amends the capital and surplus requirement for a special purpose captive insurance company so the Commissioner has discretion to set an amount less than $250,000.

G.S. 58-10-380 Formation of captive insurance companies.

- Adds a provision that says a special purpose captive insurance company may be organized in any form of business organization authorized by the Commissioner.
- Removes the requirements that a captive insurance company be incorporated or organized by no less than three individuals, including one being a resident of North Carolina.
- Adds a provision to allow a captive to establish one or more separate accounts within the captive in order to segregate risks for certain insureds of the captive thus negating the need to reorganize as a protected cell captive insurance company.

G.S. 58-10-385 Directors.

Amends the statute to give the Commissioner discretion to decide whether it is appropriate for a director, officer, or employee to be the beneficiary of any fee, brokerage, gift, or other compensation because of any investment, loan, deposit, purchase, sale, payment, or exchange made by or for the captive insurance company.

G.S. 58-10-405 Annual reports.

- Makes March 15th the due date for all annual reports, other than risk retention groups and association captive insurance companies.
- Adds a provision to allow the Commissioner to require a report on the financial condition of a captive insurance company on any frequency that the Commissioner determines.
- Adds a provision to allow the Commissioner to exempt a captive insurance company from the annual report requirement subject to the filing of an annual audit.

G.S. 58-10-415 Annual audit and actuarial certification.

- Separates the statement of actuarial opinion from being a part of the annual audit requirement.
- Adds a provision to allow the Commissioner to exempt a captive insurance company from the statue of actuarial opinion requirement.

G.S. 58-10-430 Examinations.

Removes the requirement that the Department physically visit a captive insurance company when conducting an examination.

G.S. 58-10-440 Investment requirements.

Amends the section to allow a captive insurance company or protected cell to make a loan to its parent company, an affiliated company, a controlled unaffiliated business, or a participant provided the transaction is approved by the Commissioner.

G.S. 58-10-465 Applicable provisions.

Removes the requirement that the Commissioner adopt a rule or regulation or issue an order to exempt a special purpose captive insurance company from a law in Chapter 58 or a regulation established under Chapter 58.

G.S. 58-10-490 Inactive captive insurance companies.

Adds a new section which allows captives to become inactive during periods when the owners decide not to utilize them. During this period, they do not have to pay premium tax and they may be exempted from the filing and reporting requirements in the captive law.

G.S. 58-10-510 Establishment of protected cells.

- Amends section to make it, at the Commissioner's discretion, whether to require a protected cell to have the business it writes fronted, reinsured, or secured by a trust fund.
- Adds language regarding the transfer or conversion of a protected cell.
- Adds language stating that a protected cell may enter into a contract with its protected cell captive insurance company or with another protected cell within the protected cell captive insurance company.

G.S. 58-10-512 Incorporated protected cells.

Adds a new section on incorporated cells detailing what is required to form an incorporated protected cell and giving it authority to enter into contracts and undertake its obligations in its own name.

G.S. 58-10-513 Cell shares and cell dividends.

Adds a new section detailing the issuance of cell shares and the payment of cell dividends.

G.S. 58-10-515 Participation in a protected cell captive insurance company.

Adds a provision to allow the Commissioner the discretion to allow a participant to insure risks other than its own, its affiliates, or controlled unaffiliated businesses.

G.S.58-10-517 Company to inform persons they are dealing with protected cell captive insurance company.

Adds a new section requiring all protected cell captive insurance companies to inform any person with whom it transacts business that it is a protected cell captive insurance company and the name of any cell, if any, with which the person is transacting.

G.S. 58-10-525 Application of supervision, rehabilitation, and liquidation provisions to protected cell captive insurance companies.

Adds language applying Article 30 not only to a protected cell captive insurance company as a whole, but also to protected cells individually.

G.S. 58-10-540 Petition for certificate of authority.

Deletes the statute from Chapter 58 to remove the requirement that an alien captive insurance company obtain a certificate of general good from the Commissioner.

G.S. 58-10-560 Controlling provisions when conflict exists; exemptions.

Removes the requirement that the Commissioner adopt a rule or regulation or issue an order to exempt a special purpose financial captive insurance company or its protected cells from the captive insurance act or a regulation established under the act.

G.S. 58-10-655 Commissioner to share information with Department of Revenue.

Adds new section requested by the Department of Revenue to provide for the sharing of information relating to captive's financials between the Department of Revenue and the Department of Insurance.

Section 2 adds new conforming language to G.S. 105-259(b) to regulate the disclosure of the information being shared by the Departments of Insurance and Revenue.

EFFECTIVE DATE: This act is effective when it becomes law.

The Department of Insurance substantially contributed to this summary.

EXHIBIT 7

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H **D**

HOUSE BILL 287
PROPOSED COMMITTEE SUBSTITUTE H287-CSRG-2 [v.1]
4/13/2015 3:20:31 PM

Short Title: Amend Insurance Laws.-AB (Public)

Sponsors:

Referred to:

March 19, 2015

A BILL TO BE ENTITLED

AN ACT TO MAKE CONFORMING AND CLARIFYING CHANGES TO THE LAWS GOVERNING PROFESSIONAL EMPLOYER ORGANIZATIONS, INSURANCE COMPANY DEPOSITS, CONTINUING CARE RETIREMENT COMMUNITIES, HEALTH INSURANCE EXTERNAL REVIEW, HEALTH INSURANCE FIDUCIARIES, MOTOR VEHICLE FINANCIAL RESPONSIBILITY, INSURANCE COMPANY NAMES, AND AUTO AND HOMEOWNERS' INSURANCE OPTIONAL PROGRAM ENHANCEMENTS; AND TO PROVIDE FOR A STUDY OF THE HEALTH INSURANCE PREMIUM RATE REVIEW PROCESS AND MONEYS FROM THE INSURANCE REGULATORY FUND TO IMPLEMENT THAT STUDY, AS RECOMMENDED BY THE DEPARTMENT OF INSURANCE.

The General Assembly of North Carolina enacts:

CONFORMING AND CLARIFYING CHANGES

SECTION 1. G.S. 58-89A-60(d) reads as rewritten:

"(d) Every applicant shall furnish the Commissioner a complete set of fingerprints ~~and a recent photograph~~ of each officer, director, and controlling person in a form prescribed by the ~~Commissioner of each officer, director, and controlling person.~~Commissioner. Each set of fingerprints shall be certified by an authorized law enforcement officer.

Upon request by the Department, the Department of Public Safety shall provide to the Department from the State and National Repositories of Criminal Histories the criminal history of any applicant and the officer, director, and controlling person of any applicant. Along with the request, the Department shall provide to the Department of Public Safety the fingerprints of the person that is the subject of the request, a form signed by the person that is the subject of the request consenting to the criminal record check and use of fingerprints and other identifying information required by the State and National Repositories, and any additional information required by the Department of Public Safety. The person's fingerprints shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation may forward a set of fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The Department shall keep all information obtained pursuant to this subsection confidential. The Department of Public Safety may charge a fee to offset the cost incurred by it to conduct a criminal record check under this section. The fee shall not exceed the actual cost of locating, editing, researching, and retrieving the information.

In the event that an applicant has secured a professional employer organization license in another state in which the professional employer organization's controlling persons have completed a criminal background investigation within 12 months of this application, a certified copy of the report from the appropriate authority of that state may satisfy the requirement of this subsection. This subsection also applies to a change in a controlling party of a professional employer organization. For purposes of investigation under this subsection, the Commissioner shall have all the power conferred by G.S. 58-2-50 and other applicable provisions of this Chapter."

SECTION 2. G.S. 58-5-55(a) reads as rewritten:

"(a) In addition to other requirements of Articles 1 through 64 of this Chapter, all domestic stock insurance companies shall deposit their required statutory capital with the ~~Commissioner.~~Commissioner, and all domestic non-stock insurance companies shall deposit their required statutory surplus with the Commissioner. Such deposits shall be under the exclusive control of the Commissioner for the protection of policyholders."

SECTION 3. G.S. 58-64-80 reads as rewritten:

"**§ 58-64-80. Advisory Committee.**

There shall be a nine member Continuing Care Advisory Committee appointed by the Commissioner. The Committee shall consist of at least two residents of facilities, two representatives of ~~the North Carolina Association of Nonprofit Homes for the Aging,~~LeadingAge North Carolina, one individual who is a certified public accountant and is licensed to practice in this State, one individual skilled in the field of architecture or engineering, and one individual who is a health care professional."

SECTION 4. G.S. 58-50-82(b)(1) reads as rewritten:

"**§ 58-50-82. Expedited external review.**

"(1) Notify the insurer that made the noncertification, noncertification appeal decision, or second-level grievance review decision which is the subject of the request that the request has been received and provide a copy of the request. The Commissioner shall also request any information from the insurer necessary to make the preliminary review set forth in G.S. 58-50-80(b)(2) and require the insurer to deliver the information not later than one ~~business~~ day after the request was made."

SECTION 5. G.S. 58-50-40(c) reads as rewritten:

"(c) Any insurance fiduciary who violates subsection (b) of this section shall be guilty of ~~a Class H felony.~~the following felony offense:

(1) If the total value of losses suffered as a result of an insurance fiduciary's violation of subsection (b) of this section is one hundred thousand dollars ($100,000) or more, the violation is a Class C felony.

(2) If the total value of losses suffered as a result of an insurance fiduciary's violation of subsection (b) of this section is less than one hundred thousand dollars ($100,000), the violation is a Class H felony."

SECTION 6. G.S. 20-309(a) is amended by adding a new subsection to read:

"(c1) The proof of insurance required to demonstrate financial responsibility under subsection (c) of this section may be satisfied by producing records of insurance in either physical or electronic format. Acceptable electronic formats include display of electronic images on a mobile phone or other portable electronic device produced through an application or Web site of the insurer."

SECTION 7. G.S. 58-3-50 reads as rewritten:

"**§ 58-3-50. Companies must do business in own name; emblems, insignias, etc.**

Every insurance company or group of companies must conduct its business in the State in, and the policies and contracts of insurance issued by it shall be headed or entitled only by, its proper or corporate name or names. There shall not appear on the policy anything that would indicate that it is the obligation of any other than the company or companies responsible for the payment of losses under the policy, though it will be permissible to stamp or print on the policy, the name or names of the department or general agency issuing the same, and the group of companies with which the company is financially affiliated. The use of any emblem, insignia, or anything other than the true and proper corporate name of the company or group of companies shall be permitted only with the approval of the ~~Commissioner.~~Commissioner, provided that, with the exception of policies subject to the provisions of Article 36 of this Chapter, a coverage within a policy may be issued by more than one company, so long as the policy clearly identifies the company responsible for each coverage."

SECTION 8. Article 36 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-36-43. Optional program enhancements authorized not altering coverage under Rate Bureau jurisdiction.**

(a) Member companies writing private passenger automobile or homeowners' insurance under this Article may incorporate optional enhancements to their automobile and homeowners' programs as an endorsement to an automobile or homeowners' policy issued under this Article if the insurer has filed the proposed enhancement with the Commissioner and if the proposed enhancement is approved by the Commissioner. Any approved optional enhancements shall be considered outside the authority of the Rate Bureau. If the proposed enhancement will include an additional premium charge, the proposed premium charge shall be included with the proposed program enhancements filed with the Commissioner. The Commissioner shall review the proposed premium charges and approve them if the Commissioner finds that they are based on sound actuarial principles. Amendments to private passenger automobile or homeowners' program enhancements are subject to the same requirements as initial filings. Neither the acceptance, renewal of a policy, nor any underwriting rating criteria shall be conditioned by a company upon the acceptance by the policyholder of any optional automobile or homeowners' enhancements. A rate amendment authorized by this section is not a rate deviation and is not subject to the requirements for rate deviations set forth in G.S. 58-36-30(a).

(b) Insurers shall utilize statistical codes outlined by their statistical organization in reporting premiums and losses resulting from program enhancements filed under this section. Those statistical codes shall be substantially different than the codes utilized for data collected for rate-making purposes in order to avoid commingling of the data."

HEALTH INSURANCE PREMIUM RATE REVIEW MODERNIZATION STUDY

SECTION 9.(a) Authorization. – The Department of Insurance shall study and evaluate the need for and the expected impact of modernization in the Department's regulatory processes and requirements related to health insurance premium rate review.

SECTION 9.(b) Elements of Study. – As part of the study and evaluation, the Department shall at a minimum include the following:

(1) Consideration and evaluation of other states' health insurance rate review laws, requirements and processes.

(2) Consideration and evaluation of the expected impact of modernization on the costs of health insurance for businesses and consumers.

(3) Consideration and evaluation of the expected impact of modernization on insurers' and the State's operations and costs.

(4) Consideration and evaluation of federal provisions relating to rate review of health insurance premium rates and the expected impact of modernization in light of the federal requirements.

SECTION 9.(c) Report. – The Department of Insurance shall submit a report with its findings and recommendations to the 2015 General Assembly when it reconvenes in 2016.

The report may include proposed legislation and any other recommendations requiring legislative action.

SECTION 9.(d) Consultants. – The Commissioner of Insurance may hire consultants to assist the Department in completing its duties under this section.

SECTION 9.(e) Funding. – There is appropriated from the Insurance Regulatory Fund created under G.S. 58-6-25 to the Department of Insurance the sum of one hundred fifty thousand dollars ($150,000) for the 2015-2016 fiscal year for the purposes of conducting the study described by this section. Unspent and unencumbered funds remaining on June 30, 2017, shall revert to the Fund.

EFFECTIVE DATE

SECTION 10. Section 4 of this act becomes effective January 1, 2016. Section 8 of this act becomes effective July 1, 2015, and applies to optional enhancements, as described in that section, filed and approved on or after that date. The remainder of this act is effective when it becomes law.

EXHIBIT 8

HOUSE BILL 287: Amend Insurance Laws.-AB

2015-2016 General Assembly

Committee:	House Insurance	**Date:**	April 13, 2015
Introduced by:	Reps. Setzer, Bumgardner	**Prepared by:**	Tim Hovis Committee Counsel
Analysis of:	PCS to First Edition H287-CSRG-2		

SUMMARY: House Bill 287 makes various statutory changes recommended by the Department of Insurance.

The PCS changes the title.

BILL ANALYSIS: G.S. 58-7-37(a) was changed during the legislative session to remove the requirement for control individuals to submit, along with fingerprints, "a recent photograph." This was due to the fact that the SBI no longer requires a photograph. **Section 1** will make the Professional Employer Organizations (PEO) statute consistent with the General Domestic Companies statute.

Section 2 updates the law pertaining to domestic security deposits (G.S. 58-5-55) to include a deposit requirement for domestic "non-stock insurance companies" organized pursuant to G.S. 58-7-75(1a). G.S. 58-5-55 addresses the deposit requirements for stock and mutual companies, but it does not address the requirement for non-stock companies.

Section 3 updates language in G.S. 58-64-80 referencing the "North Carolina Association of Non-Profit Homes for the Aging". (NCANPHA). NCANPHA is now called the "LeadingAge North Carolina."

Section 4 requires insurers in an expedited external review process to provide information to the Commissioner within one day as opposed to one "business" day.

Section 5 would increase the penalties from a Class H to a Class C felony for an insurance fiduciary who causes the cancellation of a group health or life insurance policy by failing to pay premiums if the resulting losses are $100,000 or more.

Section 6 would allow proof of financial responsibility (auto liability insurance) for registration to be demonstrated in a physical or electronic format.

Section 7 would allow insurers to write coverage within a policy jointly as long as the policy identifies the company responsible for each coverage.

Section 8 would create a new section allowing automobile insurers to file individually with the Commissioner for approval optional enhancements to their automobile policies. These enhancements could then be offered as an endorsement to an automobile policy. Any additional premium resulting from the enhancement must be included with the proposed enhancement filed with the Commissioner and must be reviewed by the Commissioner to ensure that the additional premium is based on sound actuarial principles. The acceptance or renewal of a policy may not be conditioned upon the acceptance by a policyholder of an optional enhancement.

This section specifically provides that any rate amendment based on the enhancement is not a rate deviation under current law. Under current law, G.S. 58-36-30(a), proposed rate deviations must be filed with the Commissioner and the Rate Bureau and approved by the Commissioner.

Under the bill, optional enhancements would be outside the jurisdiction of the Rate Bureau.

Section 9 would require the Department of Insurance to study an evaluate the need for and impact of modernization of regulatory processes related to health insurance premium rates. The bill would appropriate from the Insurance Regulatory Fund $150,000 for the 2015-2016 fiscal year to conduct the study.

EFFECTIVE DATE: Section 4 of the act would become effective January 1, 2016. Section 8 of the act would become effective July 1, 2015 and applies to enhancements filed on or after that date. The remaining sections would become effective upon becoming law.

EXHIBIT 9

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H **D**

HOUSE BILL 288
PROPOSED COMMITTEE SUBSTITUTE H288-CSTU-5 [v.3]
4/9/2015 3:41:58 PM

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

Sponsors:

Referred to:

March 19, 2015

A BILL TO BE ENTITLED

AN ACT TO MAINTAIN NAIC ACCREDITATION OF THE DEPARTMENT OF INSURANCE BY MAKING REVISIONS TO THE LAWS GOVERNING INSURANCE COMPANY HOLDING SYSTEMS, RISK-BASED CAPITAL REQUIREMENTS FOR LIFE INSURERS, AND CORPORATE GOVERNANCE REQUIREMENTS FOR RISK RETENTION GROUPS, AS RECOMMENDED BY THE DEPARTMENT OF INSURANCE.

The General Assembly of North Carolina enacts:

PART I. INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT REVISIONS

SECTION 1.1. G.S. 58-19-1 reads as rewritten:

"**§ 58-19-1. Findings; purpose; legislative intent.**

(a) The General Assembly finds that the public interest and the interests of policyholders are or may be adversely affected when any of the following occur:

(1) Control of an insurer is sought by persons who would utilize such control adversely to the interests of policyholders.

(2) Acquisition of control of an insurer would substantially lessen competition or create a monopoly in the insurance business in this State.

(3) An insurer that is part of ~~a~~ an insurance holding company system is caused to enter into transactions or relationships with affiliated companies on terms that are not fair and reasonable.

(4) An insurer pays dividends to shareholders that jeopardize the financial condition of such insurer.

…."

SECTION 1.2.(a) Subdivisions (3) through (7) of G.S. 58-19-5 are recodified as subdivisions (11) through (15) of that section. Subdivision (8) of G.S. 58-19-5 is recodified as subdivision (17) of that section.

SECTION 1.2.(b) G.S. 58-19-5, as amended by subsection (a) of this section, reads as rewritten:

"**§ 58-19-5. Definitions.**

As used in this Article, unless the context requires otherwise, the following terms have the following meanings:

(1) An "affiliate" of or person "affiliated" with a specific ~~person is a~~person. – A person that indirectly through one or more intermediaries or directly

H288-CSTU-5-V-3

controls, is controlled by, or is under common control with the person specified.

(2) "Control", including the terms "controlling", "controlled by", and ~~"under common control with",~~ "under common control with". – ~~means the~~The direct or indirect possession of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise. Control is presumed to exist if any person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by G.S. 58-19-25(j) that control does not exist in fact. The Commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(3) Enterprise risk. – Any activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurer's risk-based capital to fall into company action level as set forth in Article 12 of this Chapter or would cause the insurer to be in a hazardous financial condition as set forth in G.S. 58-30-60.

(4) Executive officer. – A chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.

(5) Form A. – The statement regarding the acquisition of control of or merger with a domestic insurer that is required to be filed with the Commissioner pursuant to G.S. 58-19-15.

(6) Form B. – The insurance holding company system annual registration statement that is required to be filed with the Commissioner pursuant to G.S. 58-19-25.

(7) Form C. – The summary of changes to the insurance company system annual registration statement that is required to be filed with the Commissioner pursuant to G.S. 58-19-25.

(8) Form D. – The prior notice of a transaction that is required to be filed with the Commissioner pursuant to G.S. 58-19-30(b).

(9) Form E. – The pre-acquisition notification that is required to be filed with the Commissioner pursuant to G.S. 58-19-15(f).

(10) Form F. – The annual enterprise risk report required to be filed with the Commissioner pursuant to G.S. 58-19-25(l).

(11) ~~"Insurance holding company system" means an~~Insurance holding company system. – An entity comprising two or more affiliated persons, one or more of which is an insurer.

(12) ~~"Insurer" includes~~Insurer. – As defined in G.S. 58-1-5(3), and includes a person subject to Articles 65 and 66 or 67 of this Chapter. "Insurer" does not include (1) an agency, authority, or instrumentality of the United States; any of its possessions and territories; the Commonwealth of Puerto Rico; the

District of Columbia; nor a state or political subdivision of a state; nor (2) fraternal benefit societies or fraternal orders.

(13) ~~"Person" means an~~Person. – An individual, corporation, partnership, limited liability company, association, joint stock company, trust, unincorporated organization, or any similar entity or any combination of the foregoing acting in concert.

(14) A "security holder" of a specified ~~person is one~~person. – One who owns any security of such person, including common stock, preferred stock, debt obligations, or any other security convertible into or evidencing the right to acquire any of the foregoing.

(15) A "subsidiary" of a specified ~~person is an~~person. – An affiliate controlled by such person indirectly through one or more intermediaries or directly.

(16) Ultimate controlling person. – A person not controlled by any other person.

(17) ~~"Voting security" includes~~Voting security. – Includes any security convertible into or evidencing a right to acquire a voting security."

SECTION 1.3.(a) Subsections (b) through (j) of G.S. 58-19-5 are recodified as subsections (g) through (o) of that section, subsections (a1) through (a3) of G.S. 58-19-15 are recodified as subsections (b) through (d) of that section, and subdivision (g)(12) of G.S. 58-19-5 is recodified as subdivision (g)(14) of that section.

SECTION 1.3.(b) G.S. 58-19-15, as amended by subsection (a) of this section, reads as rewritten:

"**§ 58-19-15. Acquisition of control of or merger with domestic insurer.**

(a) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities, or seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer, if, after the consummation thereof, the person would, directly or indirectly (or by conversion or by exercise of any right to acquire), be in control of the insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless the offer, request, invitation, ~~agreement,~~ agreement entered into, or acquisition is conditioned upon the approval of the ~~Commissioner~~ Commissioner, and furnished on a Form A as prescribed by the Commissioner under this section. No such merger or other acquisition of control is effective until a statement containing the information required by this section has been filed with the Commissioner and all other provisions of this section have been complied with and the merger or acquisition of control has been approved by the Commissioner under this section. The statement containing the information required by this section shall also be filed with the domestic insurer when it is filed with the Commissioner.

(b) For the purposes of this section a "domestic insurer" includes any person controlling a domestic ~~insurer.~~insurer, unless the person, as determined by the Commissioner, is either directly or through its affiliates primarily engaged in business other than insurance. Further, for the purposes of this section, "person" does not include any securities broker holding, in the usual and customary broker's function, less than twenty percent (20%) of the voting securities of an insurance company or of any person that controls an insurance company.

(c) Any acquisition of control of a domestic insurer must be completed not later than 90 days after the date of the Commissioner's order approving the acquisition under this section, unless the Commissioner grants an extension in writing on a showing of good cause for the delay. Any increase in a company's capital and surplus required under this Article as a result of the change of control of a domestic insurer must be completed not later than 90 days after the date of the Commissioner's order approving the change of control and before the company writes any new insurance business.

(d) If the deadlines for completion in subsection ~~(a2)~~(c) of this section are not met, the person seeking to acquire control of the domestic insurer must resubmit the statement required by subsection ~~(b)~~(g) of this section, and the Commissioner may reconsider approval of acquisition of control under this section.

(e) For purposes of this section, any controlling person of the domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, shall file with the Commissioner, with a copy to the insurer, confidential notice of its proposed divesture at least 30 days prior to the cessation of control. The Commissioner shall determine those instances in which the party or parties seeking to divest or to acquire a controlling interest in an insurer, will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the Commissioner, in his discretion determines that confidential treatment will interfere with enforcement of this section. If the statement referred to in subsection (a) of this section is otherwise filed, this subsection shall not apply.

(f) With respect to a transaction subject to this section, the acquiring person must also file a pre-acquisition notification with the Commissioner on a Form E as prescribed by the Commissioner. In addition to the information required by the Form E, the Commissioner may require an expert opinion as to the competitive impact of the proposed acquisition at the acquiring person's expense. A failure to file the pre-acquisition notification may subject the insurer or other person who fails to make the filing and who also fails to demonstrate a good-faith effort to comply with this requirement to a fine of not more than fifty thousand dollars ($50,000).

(g) The statement to be filed with the Commissioner under subsection (a) of this section shall be furnished on a Form A as prescribed by the Commissioner, made under oath or ~~affirmation~~ affirmation, and shall contain the following information:

…

(11) The term of any agreement, contract, or understanding made with or proposed to be made with any third party in connection with any acquisition of control of or merger with a domestic insurer, and the amount of any fees, commissions, or other compensation to be paid to the third party with regard thereto.

(12) An agreement by the person required to file the statement referred to in subsection (a) of this section that it will provide the annual report, specified in G.S. 58-19-25, for so long as control exists.

(13) An acknowledgement by the person required to file the statement referred to in subsection (a) of this section that the person and all subsidiaries within its control in the insurance holding company system will provide information to the Commissioner upon request as necessary to evaluate enterprise risk to the insurer.

(14) Such additional information as the Commissioner may by rule prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

If the person required to file the statement referred to in subsection (a) of this section is a partnership, limited partnership, syndicate, or other group, the Commissioner shall require that the information called for by subdivisions (1) through ~~(12)~~(14) of this subsection be given with respect to each partner of such partnership or limited partnership, each member of such syndicate or group, and each person who controls such partner or member. If any such partner, member, or person is a corporation or the person required to file the statement referred to in subsection (a) of this section is a corporation, the Commissioner shall require that the information called for by subdivisions (1) through ~~(12)~~(14) of this subsection be given with respect to such corporation, each officer and director of such corporation, and each person who is, directly or indirectly, the beneficial owner of more than ten percent (10%) of the outstanding voting securities of such corporation.

If any material change occurs in the facts set forth in the statement filed with the Commissioner and sent to such insurer pursuant to this section, an amendment setting forth such change, together with copies of all documents and other material relevant to such change, shall be filed with the Commissioner and sent to such insurer by the filer within two business days after the person learns of such change.

…

(j) The public hearing referred to in subsection ~~(d)~~(i) of this section shall be held within 120 days after the statement required by subsection (a) of this section is filed, and the Commissioner shall give at least 30 days notice of the hearing to the person filing the statement, to the insurer, and to such other persons as may be designated by the Commissioner. The Commissioner shall make a determination as expeditiously as is reasonably practicable after the conclusion of the hearing. At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected by the hearing shall have the right to present evidence, examine and cross-examine witnesses, and offer oral or written arguments; and in connection therewith shall be entitled to conduct discovery proceedings at any time after the statement is filed with the Commissioner under this section and in the same manner as is presently allowed in the superior courts of this State. In connection with discovery proceedings authorized by this section, the Commissioner may issue such protective orders and other orders governing the timing and scheduling of discovery proceedings as might otherwise have been issued by a superior court of this State in connection with a civil proceeding. If any party fails to make reasonable and adequate response to discovery on a timely basis or fails to comply with any order of the Commissioner with respect to discovery, the Commissioner on the Commissioner's own motion or on motion of any other party or person may order that the hearing be postponed, recessed, convened, or reconvened, as the case may be, following proper completion of discovery and reasonable notice to the person filing the statement, to the insurer, and to such other persons as may be designated by the Commissioner.

If the proposed acquisition of control will require the approval of the insurance commissioners of more than one state, the public hearing referred to in this subsection may be held on a consolidated basis upon request of the person filing the statement referred to in subsection (a) of this section. Such person shall file the statement referred to in subsection (a) of this section with the NAIC within five days of making the request for a public hearing. A commissioner may opt out of a consolidated hearing and shall provide notice to the applicant of the opt out within 10 days of the receipt of the statement referred to in subsection (a) of this section. A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the commissioners of the states in which the insurers are domiciled. Such commissioners shall hear and receive evidence. A commissioner may attend such hearing, in person or by telecommunication.

…

(n) ~~The~~ Each of the following are violations of this section:

(1) The failure to file any statement, amendment, or other material required to be filed pursuant to subsection (a) or ~~(b)~~(g) of this ~~section; or~~section.

(2) The effectuation or any attempt to effectuate an acquisition of control ~~of~~ of, divestiture of, or merger with a domestic insurer, unless the Commissioner has given his approval ~~thereto.~~of the acquisition, divestiture, or merger.

(o) The courts of this State are vested with jurisdiction over every person not resident, domiciled, or authorized to do business in this State who files a statement with the Commissioner under this section; and the overall actions involving such person arising out of violations of this section and each such person is deemed to have performed acts equivalent to and constituting an appointment by such person of the Commissioner to be his true and lawful attorney upon whom may be served all legal process in any action, suit, or proceeding arising out of violations of this section. Copies of all such process shall be handled in accordance with the provisions of G.S. 58-16-30, 58-16-35, and 58-16-45."

SECTION 1.4. G.S. 58-19-25 reads as rewritten:

"§ 58-19-25. Registration of insurers.

(a) Every insurer that is ~~licensed~~ authorized to do business in this State and that is a member of an insurance holding company system shall register with the ~~Commissioner,~~Commissioner pursuant to G.S. 58-19-25(b), except a foreign insurer subject to the registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to those contained in:

(1) This section.

(2) G.S. 58-19-30(a), G.S. 58-19-30(c), and G.S. 58-19-30(d).

(3) G.S. 58-19-30(b) or a statutory or regulatory provision such as the following: Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within 15 days after the end of the month in which it learns of each change or addition. The insurer shall also file a copy of its registration statement and any amendments to the statement in each state in which that insurer is authorized to do business, if requested by the insurance regulator of that state.

Any insurer that is subject to registration under this section shall register within 30 days after it becomes subject to registration, and an amendment to the registration statement shall be filed by April 1 of each year for the previous calendar year; unless the Commissioner for good cause shown extends the time for registration or filing, and then within the extended time. All registration statements shall contain a summary, on a ~~form~~ Form C as prescribed by the Commissioner, outlining all items in the current registration statement representing changes from the prior registration statement. The Commissioner may require any insurer that is ~~a~~ an insurance member of a holding company system that is not subject to registration under this section to furnish a copy of the registration statement or other information filed by the insurance company with the insurance regulator of its domiciliary jurisdiction.

(b) Every insurer subject to registration shall file the registration statement on a ~~form~~ Form B prescribed by the Commissioner, which shall contain the following current information:

…

(6) If requested by the Commissioner, the insurer shall include financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include, but are not limited to, annual audited financial statements filed with the United States Securities and Exchange Commission pursuant to the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended. An insurer required to file financial statements pursuant to this subdivision may satisfy the request by providing the Commissioner with the most recently filed parent corporation financial statements that have been filed with the United States Securities and Exchange Commission.

(7) Statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures.

(8) Any other information required by the Commissioner by rule or regulation.

(c) No information need be disclosed on the registration statement filed pursuant to subsection (b) of this section if such information is not material for the purposes of this section. Unless the Commissioner by rule or order provides otherwise, all sales, purchases, exchanges, loans or extensions of credit, investments, or guarantees involving one-half of one percent (1/2%) or less of an insurer's admitted assets as of the preceding December 31 are not material for the purposes of this section.

(d) Subject to G.S. 58-7-130(b) and G.S. 58-19-30(c), each domestic insurer shall report to the Commissioner all dividends and other distributions to shareholders within five business days following the declaration thereof and at least 30 days before the payment ~~thereof. The Commissioner may adopt rules to further the requirements of this section.~~of the dividend or distribution by providing the information set forth in G.S. 58-19-30(e). A prior notification of an ordinary dividend or any other ordinary distribution required under this subsection shall be deemed to be incomplete unless all of the information required by G.S. 58-19-30(e) has been included. The Commissioner shall consider the factors set forth in G.S. 58-19-30(d) in his review of dividends or other distributions to shareholders pursuant to this subsection. The Commissioner may adopt rules to further the requirements of this section.

(e) Any person within an insurance holding company system subject to registration shall provide complete and accurate information to an insurer, where such information is reasonably necessary to enable the insurer to comply with the provisions of this Article.

(f) The Commissioner shall terminate the registration of any insurer that demonstrates that it no longer is a member of an insurance holding company system. A termination of registration shall include the information set forth in subdivision (j)(1) of this section and shall be deemed to have been granted unless the Commissioner, within 30 days after receipt of the request, notifies the registrant otherwise.

(g) The Commissioner may require or allow two or more affiliated insurers subject to registration under this section to file a consolidated ~~registration statement.~~or alternative registration statement as provided in subsection (h) of this section. The Commissioner, however, reserves the right to require individual filings if he deems such filings necessary in the interest of clarity, ease of administration, or the public good.

(h) ~~The Commissioner~~Any authorized insurer may ~~allow an insurer that is authorized to do business in this State and that is part of an insurance holding company system to register~~file a registration statement on behalf of any affiliated insurer ~~that is~~or insurers that are required to register under subsection ~~(a) of this section and to file all information and material required to be filed under this section.~~(a) of this section. A registration statement may include information not required by Article 19 of this Chapter regarding any insurer in the insurance holding company system even if the insurer is not authorized to do business in this State. In lieu of filing a registration statement on a Form B, the authorized insurer may file a copy of the registration statement or similar report that it is required to file in its state of domicile, provided all of the following apply:

(1) The statement or report contains substantially similar information required to be furnished on Form B.

(2) The filing insurer is the principal insurance company in the insurance holding company system.

The question of whether the filing insurer is the principal insurance company in the insurance holding company system is a question of fact, and an insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer shall set forth a brief statement of facts which will substantiate the filing insurer's claim that it, in fact, is the principal insurer in the insurance holding company system.

(i) The provisions of this section do not apply to any insurer, information, or transaction if and to the extent that the Commissioner by rule or order exempts the same from the provisions of this section.

(j) Any person may file with the Commissioner a disclaimer of ~~affiliation~~ affiliation, which includes the information outlined in G.S. 58-19-25(j)(1), with any authorized insurer, or such a disclaimer of affiliation may be filed by such insurer or any member of an insurance holding company ~~system.~~system as set forth in this subsection.

(1) ~~The~~A disclaimer ~~shall fully disclose all material relationships and bases for affiliation between such person and such insurer as well as the basis for disclaiming such affiliation. After a disclaimer has been filed, the insurer shall be relieved of any duty to register or report under this section that may arise out of the insurer's relationship with such person unless the Commissioner disallows such a disclaimer. The Commissioner shall disallow such a disclaimer only after furnishing all parties in interest with notice and opportunity to be heard and after making specific findings of fact to support such disallowance.~~ of affiliation shall be deemed to have been granted unless the Commissioner, within 30 days following the receipt of a complete disclaimer of affiliation, notifies the filing party that the disclaimer of affiliation is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer of affiliation has been granted by the Commissioner, or if the disclaimer of affiliation is deemed to have been approved.

(2) A disclaimer of affiliation pursuant to this subsection or a request for termination of registration pursuant to G.S. 58-19-25(f) claiming that a person does not, or will not upon the taking of some proposed action, control another person (hereinafter the "subject") shall contain the following information:

a. The number of authorized, issued, and outstanding voting securities of the subject.

b. With respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject's voting securities, which are held of record or known to be beneficially owned, and the number of shares concerning which there is a right to acquire, directly or indirectly.

c. All material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person.

d. A statement explaining why the person should not be considered to control the subject.

(k) The failure to file a registration statement or any summary of the registration statement or enterprise risk filing thereto required by this section within the time specified for such filing is a violation of this section.

(l) Effective January 1, 2016, the ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report on Form F as prescribed by the Commissioner. The report shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the NAIC."

SECTION 1.5.(a) G.S. 58-19-30(b)(5) is recodified as G.S. 58-19-30(b)(6).

SECTION 1.5.(b) G.S. 58-19-30, as amended by subsection (a) of this section, reads as rewritten:

"§ 58-19-30. Standards and management of an insurer within ~~a~~ an insurance holding company system.

(a) Transactions within ~~a~~ an insurance holding company system to which an insurer subject to registration is a party are subject to all of the following standards:

(1) The terms shall be fair and reasonable.

(2) Charges or fees for services performed shall be reasonable.

(3) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied.

(4) The books, accounts, and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.

(5) The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(6) Agreements for cost-sharing services and management services shall include such provisions as required by this Article or rule and regulation issued by the Commissioner.

(b) The following transactions involving a domestic insurer and any person in its holding company ~~system~~ system, including amendments or modifications of affiliated agreements that were previously filed pursuant to this section and that are subject to any materiality standards contained in subdivision (1) through (7) of this section, may not be entered into unless the insurer has notified the Commissioner in writing of its intention to enter into the transaction at least 30 days before the transaction, or such shorter period as the Commissioner permits, and the Commissioner has not disapproved it within that ~~period:~~ period. The notice for amendments or modifications shall include the reason for the change and the financial impact on the domestic insurer. Informal notice shall be given to the Commissioner, within 30 days after termination of a previously filed agreement, so that the Commissioner may determine the type of filing required, if any. An insurer required to give notice of a proposed transaction pursuant to this subsection shall furnish the required information on a Form D, as prescribed by the Commissioner.

(1) Sales, purchases, exchanges, loans or extensions of credit, or investments, provided the transactions equal or exceed: (i) with respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders; (ii) with respect to life insurers, three percent (3%) of the insurer's admitted assets; each as of the preceding December 31.

(2) Loans or extensions of credit to any person who is not affiliated, where the insurer makes the loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit provided the transactions equal or exceed: (i) with respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders; (ii) with respect to life insurers, three percent (3%) of the insurer's admitted assets; each as of the preceding December 31.

(3) Reinsurance agreements or modifications to the ~~agreements~~ agreements, including the following:

a. Reinsurance pooling agreements.

b. Agreements in which either (i) the reinsurance premium or a change in the insurer's ~~liabilities~~ liabilities or (ii) the projected reinsurance premium or a change in the insurer's liabilities in any of the next three years equals or exceeds five percent (5%) of the insurer's surplus as regards policyholders, as of the preceding ~~December 31, including those agreements~~December 31.

c. Agreements that may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of the assets will be transferred to one or more affiliates of the insurer.

(4) All management agreements, service contracts, ~~guarantees,~~tax allocation agreements, or cost-sharing arrangements. Management agreements, service contracts, and cost-sharing arrangements shall at a minimum and as applicable:

a. Identify the person providing services and the nature of such services.

b. Set forth the methods to allocate costs.

c. Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the NAIC Accounting Practices and Procedures Manual.

d. Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement.

e. State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance.

f. Define books and records of the insurer to include all books and records developed or maintained under or related to the agreement.

g. Specify that all books and records of the insurer are and remain the property of the insurer and are subject to the control of the insurer.

h. State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer.

i. Include standards for termination of the agreement with and without cause.

j. Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services.

k. Specify that, if the insurer is placed in receivership or seized by the Commissioner under Article 30 of this Chapter:

1. All of the rights of the insurer under the agreement extend to the receiver or Commissioner.

2. All books and records will immediately be made available to the receiver or the Commissioner and shall be turned over to the receiver or Commissioner immediately upon the receiver's or the Commissioner's request.

l. Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed in receivership pursuant to Article 30 of this Chapter.

m. Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding a seizure by the Commissioner under Article 30 of this Chapter, and will make them available to the receiver, for so long as the affiliate continues to receive timely payment for services rendered.

(5) Guarantees when made by a domestic insurer; provided, however, that a guarantee which is quantifiable as to amount is not subject to the notice requirements of this subdivision unless it exceeds the lesser of one-half percent (0.5%) of the insurer's admitted assets or ten percent (10%) of surplus as regards policyholders as of the preceding December 31. Further, all guarantees which are not quantifiable as to amount are subject to the notice requirements of this subdivision.

(6) Any material transactions, specified by rule, that the Commissioner determines may adversely affect the interests of the insurer's policyholders.

Nothing in this section authorizes or permits any transactions that, in the case of an insurer, not a member of the same insurance holding company system, would be otherwise contrary to law. A domestic insurer may not enter into transactions that are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would otherwise occur. If the Commissioner determines that such separate transactions were entered into over any 12-month period for that purpose, the Commissioner may exercise the Commissioner's authority under G.S. 58-19-50. The Commissioner, in reviewing transactions pursuant to this subsection, shall consider whether the transactions comply with the standards set forth in subsection (a) of this section and whether they may adversely affect the interests of policyholders. The Commissioner shall be notified within 30 days after any investment of a domestic insurer in any one corporation if, as a result of the investment, the total investment in the corporation by the insurance holding company system exceeds ten percent (10%) of the corporation's voting securities.

(c) No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until (i) 30 days after the Commissioner has received notice of the declaration thereof and has not within that period disapproved the payment or (ii) the Commissioner has approved the payment within the 30-day period.

For the purposes of this section, an "extraordinary dividend" or "extraordinary distribution" includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding 12 months exceeds the greater of (i) ten percent (10%) of the insurer's surplus as regards policyholders as of the preceding December 31, or (ii) the net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the 12-month period ending the preceding December 31; but does not include pro rata distributions of any class of the insurer's own securities.

Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution that is conditional upon the Commissioner's approval, and the declaration shall confer no rights upon shareholders until (i) the Commissioner has approved the payment of the dividend or distribution or (ii) the Commissioner has not disapproved the payment within the 30-day period referred to above.

(d) For the purposes of this Article, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, ~~all of the following factors, among others, shall be considered:~~the factors set forth in subdivisions (1) through (11) of this subsection, among others, shall be considered. In determining the adequacy of an insurer's surplus, no single factor is controlling. The Commissioner will consider the net effect of all of the factors in subdivisions (1) through (11) of this subsection, plus other factors bearing on the financial condition of the insurer.

(1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria.

(2) The extent to which the insurer's business is diversified among the several kinds of insurance.

(3) The number and size of risks insured in each kind of insurance.

(4) The extent of the geographic dispersion of the insurer's insured risks.

(5) The nature and extent of the insurer's reinsurance program.

(6) The quality, diversification, and liquidity of the insurer's investment portfolio. In determining the quality and liquidity of investments in subsidiaries, the Commissioner will consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant.

(7) The recent past and projected future trend in the size of the insurer's surplus as regards policyholders.

(8) The surplus as regards policyholders maintained by other comparable insurers. In comparing the surplus maintained by other insurers, the Commissioner will consider the extent to which each of these factors varies from company to company.

(9) The adequacy of the insurer's reserves.

(10) The quality and liquidity of investments in affiliates. The Commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in his judgment such investment so warrants.

(11) The quality of the insurer's earnings and the extent to which the reported earnings of the insurer include extraordinary items.

(e) Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders made pursuant to subsection (c) of this section and prior notice of an ordinary dividend or any other ordinary distribution to shareholders under G.S. 58-19-25(d) shall include the following:

(1) The amount of the proposed dividend or distribution.

(2) The date established for payment of the dividend or distribution.

(3) A statement as to whether the dividend or distribution is to be in cash or other property and, if in property, a description thereof, its cost, and its fair market value together with an explanation of the basis for valuation.

(4) A statement identifying the dividend or distribution as an ordinary dividend or other ordinary distribution subject to G.S. 58-19-25(d) or as an extraordinary dividend or other extraordinary distribution as defined in subsection (c) of this section.

(5) A copy of the calculations determining whether the proposed dividend or distribution is an ordinary dividend or other ordinary distribution subject to G.S. 58-19-25(d), or an extraordinary dividend or other extraordinary distribution as defined in subsection (c) of this section. The work paper shall include the following information:

a. The amounts, dates, and form of payment of all dividends or distributions (including regular dividends but excluding distributions of the insurer's own securities) paid within the period of 12 consecutive months ending on the date fixed for payment of the proposed dividend for which notification is being given or approval is sought and commencing on the day after the same day of the same month in the last preceding year.

b. Surplus as regards policyholders as of the preceding December 31.

c. If the insurer is a life insurer, the net gain from operations for the 12-month period ending the preceding December 31.

d. If the insurer is not a life insurer, the net income less realized capital gains for the 12-month period ending the preceding December 31.

(6) A balance sheet and statement of income for the period between the last annual statement filed with the Commissioner and the end of the month preceding the month in which the request for approval or the prior notification of a dividend or distribution is submitted. The insurer shall indicate the amount of all unrealized capital gains included in unassigned funds.

(7) A brief statement as to the effect of the proposed dividend or distribution upon the insurer's surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs.

(8) A brief statement as to the intended use or uses of the proposed dividend or distribution by the parent, and if applicable, any upstream parent of the insurer.

A request for approval of an extraordinary dividend or any other extraordinary distribution shall be deemed to be incomplete unless all of the information required by this subsection has been included."

SECTION 1.6. G.S. 58-19-35 reads as rewritten:

"**§ 58-19-35. Examination.**

(a) Subject to the limitation contained in this section and in addition to the powers that the Commissioner has under other provisions of Articles 1 through 64 of this Chapter relating to the examination of insurers, the Commissioner also has the power to ~~order~~ examine any insurer registered under ~~G.S. 58-19-25~~G.S. 58-19-25, its affiliates, or any acquiring party ~~to produce such records, books, or other information in the possession of the insurer or its affiliates or the acquiring party as are reasonably necessary~~ to ascertain the financial condition of such ~~insurer~~ insurer, its affiliates, or acquiring ~~party or to determine compliance with Articles 1 through 64 of this Chapter.~~party, including the enterprise risk to the insurer by the ultimate controlling person, by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis. ~~In the event such insurer or acquiring party fails to comply with such order, the Commissioner shall have the power to examine such insurer or its affiliates or such acquiring party to obtain such information.~~

(b) The Commissioner may retain, at the expense of the registered insurer or acquiring party that is being examined, such attorneys, actuaries, economists, accountants, and other experts not otherwise a part of the Commissioner's staff as are reasonably necessary to assist in the conduct of the examination under subsection (a) of this section. Any persons so retained shall be under the direction and control of the Commissioner and shall act in a purely advisory capacity.

(c) Repealed by Session Laws 1995, c. 360, s. 2(h).

~~(d) The Commissioner shall exercise his power under subsection (a) of this section only if the examination of the insurer or acquiring party under other provisions of Articles 1 through 64 of this Chapter is inadequate or the interests of the policyholders of such insurer may be adversely affected.~~

(e) The Commissioner may order any insurer registered under G.S. 58-19-25 or any acquiring party to produce such records, books, or other information in the possession of the insurer, its affiliates, or acquiring party as reasonably necessary to determine compliance with this Chapter.

(f) To determine compliance with this Chapter, the Commissioner may order any insurer registered under G.S. 58-19-25 to produce information not in the possession of the insurer if the insurer can obtain access to such information pursuant to contractual relationships, statutory obligations, or other method. In the event the insurer cannot obtain the information requested by the Commissioner, the insurer shall provide the Commissioner a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of that information. Whenever it appears to the Commissioner that the detailed explanation is without merit, the Commissioner may require, after notice and hearing, the insurer to pay a penalty of one thousand dollars ($1,000) for each day's delay or may suspend or revoke the insurer's license.

(g) In the event the insurer fails to comply with an order, the Commissioner shall have the power to examine the affiliates to obtain the information. The Commissioner shall also have the power to issue subpoenas, to administer oaths, and to examine under oath any person for purposes of determining compliance with this section. Upon the failure or refusal of any person to obey a subpoena, the Commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. Every person shall be obligated to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. He or she shall be entitled to the same fees and mileage, if claimed, as a witness in the courts of the county specified in the subpoena as the site of the examination. Any fees, mileage, and actual expense necessarily incurred in securing the attendance of witnesses, and their testimony, shall be itemized and charged against, and be paid by, the company being examined."

SECTION 1.7. Article 19 of Chapter 58 of the General Statutes is amended by adding a new Section to read:

"**§ 58-19-37. Supervisory colleges.**

(a) With respect to any insurer registered under G.S. 58-19-25, and in accordance with subsection (c) of this section, the Commissioner shall also have the power to participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with this Chapter. The powers of the Commissioner with respect to supervisory colleges include, but are not limited to, the following:

(1) Initiating the establishment of a supervisory college.
(2) Clarifying the membership and participation of other supervisors in the supervisory college.
(3) Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor.
(4) Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing.
(5) Establishing a crisis management plan.

(b) Each registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the Commissioner's participation in a supervisory college in accordance with subsection (c) of this section, including reasonable travel expenses. For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates, and the Commissioner may establish a regular assessment to the insurer for the payment of these expenses.

(c) In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management, and governance processes, and as part of the examination of individual insurers in accordance with G.S. 58-19-35, the Commissioner may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal, and international regulatory agencies. The Commissioner may enter into agreements in accordance with G.S. 58-19-40 providing the basis for cooperation between the Commissioner and the other regulatory agencies and the activities of the supervisory college. Nothing in this section shall delegate to the supervisory college the authority of the Commissioner to regulate or supervise the insurer or its affiliates within its jurisdiction."

SECTION 1.8. G.S. 58-19-40 reads as rewritten:

"**§ 58-19-40. Confidential treatment.**

(a) Documents, materials, or other information in the possession or control of the Department that are ~~All information, documents, and copies thereof~~ obtained by or disclosed to the Commissioner or any other person in the course of an examination or investigation made pursuant to G.S. 58-19-35, and all information reported pursuant to subdivisions (12) and (13) of G.S. 58-19-15(g), ~~G.S. 58-19-25~~G.S. 58-19-25, and G.S. 58-19-30, shall be ~~given~~ confidential ~~treatment; shall not be subject to subpoena; and shall not be made~~by law and privileged, shall not be considered a public record under either G.S. 58-2-100 or Chapter 132 of the General Statutes, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties. The Commissioner shall not otherwise make the documents, materials, or other information public ~~by the Commissioner, the NAIC, or any other person, except to insurance regulators of other states,~~ without the prior written consent of the insurer ~~or acquiring party~~ to which it pertains unless the Commissioner, after giving the insurer and its affiliates ~~or the acquiring party that~~who would be affected thereby notice and opportunity to be heard, determines that the interest of ~~the insurer's policyholders~~policyholders, shareholders, or the public will be served by the publication thereof, in which event ~~he~~ the Commissioner may publish all or any part ~~thereof~~of the information in such manner as ~~he considers~~may be deemed appropriate.

(b) Neither the Commissioner nor any person who received documents, materials, or other information while acting under the authority of the Commissioner or with whom such documents, materials, or other information are shared pursuant to this Article shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (a) of this section.

(c) In order to assist in the performance of the duties imposed by this Article, the Commissioner:

(1) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (a) of this section, with other state, federal, and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, including members of any supervisory college described in G.S. 58-19-37, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information and has verified in writing the legal authority to maintain confidentiality.

(2) Notwithstanding subdivision (1) of this subsection, may only share confidential and privileged documents, material, or information reported pursuant to G.S. 58-19-25 with Commissioners of states having statutes or regulations substantially similar to subsection (a) of this section and who have agreed in writing not to disclose such information.

(3) May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information from the

NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(4) Shall enter into written agreements with the NAIC governing sharing and use of information provided pursuant to this Article consistent with this subsection that shall:

a. Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC and its affiliates and subsidiaries pursuant to this Article, including procedures and protocols for sharing by the NAIC with other state, federal, or international regulators;

b. Specify that ownership of information shared with the NAIC and its affiliates and subsidiaries pursuant to this Article remains with the Commissioner, and the NAIC's use of the information is subject to the direction of the Commissioner;

c. Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC pursuant to this Article is subject to a request or subpoena to the NAIC for disclosure or production; and

d. Require the NAIC and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the NAIC and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the NAIC and its affiliates and subsidiaries pursuant to Article 19 of this Chapter.

(d) The sharing of information by the Commissioner pursuant to this Article shall not constitute a delegation of regulatory authority or rule making, and the Commissioner is solely responsible for the administration, execution, and enforcement of the provisions of Article 19 of this Chapter.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (c) of this section.

(f) Documents, materials, or other information in the possession or control of the NAIC pursuant to a requirement of this Article shall be confidential by law and privileged, shall not be considered a public record under G.S. 58-2-100 or Chapter 132 of the General Statutes, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action."

SECTION 1.9. G.S. 58-19-50 is amended by adding a new subsection to read:

"(f) Whenever it appears to the Commissioner that any person has committed a violation of G.S. 58-19-15, and which prevents the full understanding of the enterprise risk to the insurer by the affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with Article 30 of this Chapter."

SECTION 1.10. G.S. 58-19-60 reads as rewritten:

"§ 58-19-60. Recovery.

(a) If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under such order has a right to recover on behalf of the insurer, (i) from any parent corporation or insurance holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions (other than distributions of shares of the same class of stock) paid by the insurer on its capital stock, or (ii) any payment in the form of a bonus, termination settlement, or extraordinary lump sum salary adjustment made by the insurer or its subsidiary or subsidiaries to a director, officer, or employee, where the distribution or payment pursuant to (i) or (ii) above is made at any time during the one year preceding the petition for liquidation or rehabilitation, as the case may be, subject to the limitations of subsections (b), (c), and (d) of this section.

(b) No such distribution is recoverable if the parent or affiliate shows that when paid such distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that such distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(c) Any person that was a parent corporation or insurance holding company or a person that otherwise controlled the insurer or affiliate at the time such distributions were paid is liable up to the amount of distributions or payments under subsection (a) of this section such person received. Any person who otherwise controlled the insurer at the time such distributions were declared is liable up to the amount of distributions he would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

(d) The maximum amount recoverable under this section is the amount needed in excess of all other available assets of the insurer to pay its contractual obligations and to reimburse any guaranty funds.

(e) To the extent that any person liable under subsection (c) of this section is insolvent or otherwise fails to pay claims due from it pursuant to that subsection, its parent corporation, insurance holding company, or person who otherwise controlled it at the time that the distribution was paid, are jointly and severally liable for any resulting deficiency in the amount recovered from such parent corporation or insurance holding company or person who otherwise controlled it."

SECTION 1.11. Article 19 of Chapter 58 of the General Statutes is amended by adding four new sections to read:

"**§ 58-19-75. Forms – general requirements.**

(a) Forms A, B, C, D, E, and F are intended to be guides in the preparation of the statements required by G.S. 58-19-15, 58-19-25, and 58-19-30. They are not intended to be fill-in-the-blank forms. The statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted, provided the answers are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer to the item is in the negative, an appropriate statement to that effect shall be made.

(b) A complete copy of each statement, including exhibits and all other papers and documents filed as a part of the statement, shall be filed with the Commissioner by personal delivery or mail addressed to the Commissioner and shall be signed in the manner prescribed on the form. Unsigned copies shall be conformed. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of the power of attorney or other authority shall also be filed with the statement.

(c) If an applicant requests a hearing on a consolidated basis under G.S. 58-19-15, in addition to filing the Form A with the Commissioner, the applicant shall file a copy of the Form A with the NAIC in electronic form.

(d) Statements should be prepared electronically. Statements shall be easily readable and suitable for review and reproduction. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United

States dollars. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency normally shall be converted into United States dollars.

"**§ 58-19-80. Forms – incorporation by reference, summaries and omissions.**

(a) Information required by any item of Form A, Form B, Form D, Form E, or Form F may be incorporated by reference in answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference in answer or partial answer to any item of Form A, Form B, Form D, Form E, or Form F provided the document is filed as an exhibit to the statement. Excerpts of documents may be filed as exhibits if the documents are extensive. Documents currently on file with the Commissioner which were filed within three years need not be attached as exhibits. References to information contained in exhibits or in documents already on file shall clearly identify the material and shall specifically indicate that such material is to be incorporated by reference in answer to the item. Such materials shall not be incorporated by reference in any case where the incorporation would render the statement incomplete, unclear, or confusing.

(b) Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the pertinent provisions of the document. In addition to the statement, the summary or outline must incorporate by reference particular parts of any exhibit or document currently on file with the Commissioner which was filed within three years and may be qualified in its entirety by such reference. In any case where two or more documents required to be filed as exhibits are substantially identical in all material respects except as to the parties thereto, the dates of execution, or other details, a copy of only one of the documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which those documents differ from the documents, a copy of which is filed.

"**§ 58-19-85. Forms – information unknown or unavailable and extension of time to furnish.**

If it is impractical to furnish any required information, document, or report at the time it is required to be filed, there shall be filed with the Commissioner a separate document:

(1) Identifying the information, document, or report in question.
(2) Stating why the filing thereof at the time required is impractical.
(3) Requesting an extension of time for filing the information, document, or report to a specified date. The request for extension shall be deemed granted unless the Commissioner after receipt of the request denies the request prior to the time the information, document, or report is required.

"**§ 58-19-90. Forms – additional information and exhibits.**

In addition to the information expressly required to be included in Form A, Form B, Form C, Form D, Form E, and Form F, the Commissioner may request such further material information, if any, as may be necessary to make the information contained therein not misleading. The person filing may also file such exhibits as it may desire in addition to those expressly required by the statement. The exhibits shall be so marked as to indicate clearly the subject matters to which they refer. Changes to Form A, B, C, D, or F shall include on the top of the cover page the phrase: "Change No. [insert number] to" and shall indicate the date of the change and not the date of the original filing."

SECTION 1.12. G.S. 58-10-12(e) reads as rewritten:

"(e) Except as specifically provided in a plan of conversion, for five years following the effective date of the conversion, no person or persons acting in concert (other than the former mutual, any parent company, or any employee benefit plans or trusts sponsored by the former mutual or a parent company) shall directly or indirectly acquire, or agree or offer to acquire, in any manner the beneficial ownership of five percent (5%) or more of the outstanding shares of any class of a voting security of the former mutual or any parent company without the prior approval of the Commissioner of a statement filed by that person with the Commissioner. The statement shall contain the information required by ~~G.S. 58-19-15(b)~~G.S. 58-19-15(g) and any other information required by the Commissioner. The Commissioner shall not approve an acquisition under this subsection unless the Commissioner finds that:

(1) ~~The requirements of G.S. 58-19-15(c) will be satisfied.~~None of the conditions set forth in G.S. 58-19-15(i) will exist.

(2) The acquisition will not ~~frustrate~~ impede the plan of conversion or the amendment to the articles of incorporation as approved by the members and the Commissioner.

(3) The boards of directors of the former mutual and any parent company have approved the acquisition.

(4) The acquisition would be in the best interest of the present and future policyholders of the former mutual without regard to any interest of policyholders as shareholders of the former mutual or any parent company."

PART II. REVISIONS TO RISK-BASED CAPITAL REQUIREMENTS FOR LIFE INSURERS

SECTION 2. G.S. 58-12-11(a) reads as rewritten:

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

(1) The filing of a risk-based capital report by an insurer that indicates ~~that:~~any of the following:

a. The insurer's total adjusted capital is greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based ~~capital; or~~capital.

b. In the case of a life or health insurer, the insurer has total adjusted capital that (i) is greater than or equal to its company action level risk-based capital but less than ~~the product of~~three times its authorized control level risk-based ~~capital and 2.5~~capital and (ii) has a negative ~~trend; or~~trend.

c. In the case of a property or casualty insurer or a health organization, the insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty or health organization risk-based capital instructions.

…."

PART III. UPDATE CORPORATE GOVERNANCE REQUIREMENTS FOR RISK RETENTION GROUPS

SECTION 3. G.S. 58-22-15 reads as rewritten:

"**§ 58-22-15. Risk retention groups chartered in this State.**

(a) General Requirements. – A risk retention group shall, pursuant to the provisions of Part 9 of Article 10 of this Chapter, be chartered and licensed to write only liability insurance pursuant to this Article and, except as provided elsewhere in this Article, must comply with all of the laws and rules applicable to such insurers chartered and licensed in this State and with G.S. 58-22-20 to the extent such requirements are not a limitation on laws, administrative rules, or requirements of this State.

(b) Plan of Operation. – Before it may offer insurance in any state, each risk retention group shall also submit for approval to the Commissioner of this State a plan of operation or feasibility study. The Commissioner may limit the net amount of risk retained by a risk retention group for any individual risk. The risk retention group shall submit an appropriate revision in the event of any subsequent material change in any item of the plan of operation or feasibility study, within 10 days after any such change. The group shall not offer any additional kinds of liability insurance, in this State or in any other state, until a revision of such plan or study is approved by the Commissioner.

(c) Required Information. – At the time of filing its application for a charter, the risk retention group shall provide to the Commissioner in summary form the following information: the identity of the initial members of the group, the identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group, the amount and nature of initial capitalization, the coverages to be afforded, and the states in which the group intends to operate. Upon receipt of this information, the Commissioner shall forward such information to the NAIC. Providing notification to the NAIC is in addition to and shall not be sufficient to satisfy the requirements of G.S. 58-22-20 or any other sections of this Article.

(d) Governance Standards. – Risk retention groups shall comply with the following governance standards:

(1) Board of directors. – The following standards apply to the board of directors of the risk retention group:

a. Definitions. – The following definitions apply in this subdivision:

1. Board of directors or board. – The governing body of the risk retention group elected by the shareholders or members to establish policy, elect or appoint officers and committees, and make other governing decisions.

2. Director. – A natural person designated in the articles of the risk retention group, or designated, elected, or appointed by any other manner, name, or title to act as a director.

b. Independent directors. – The board of directors of the risk retention group shall have a majority of independent directors. If the risk retention group is a reciprocal, then the attorney-in-fact would be required to adhere to the same standards regarding independence of operation and governance as imposed on the risk retention group's board of directors or subscribers advisory committee under these standards; and, to the extent permissible under State law, service providers of a reciprocal risk retention group should contract with the risk retention group and not the attorney-in-fact.

c. Determination of independence. – No director qualifies as independent unless the board of directors affirmatively determines that the director has no material relationship, as partially specified in sub-subdivision d. of this subdivision, with the risk retention group. Each risk retention group shall disclose these determinations to the Commissioner at least annually. For the purpose of this subdivision, any person that is a direct or indirect owner of or subscriber in the risk retention group (or is an officer, director, or employee of such an owner and insured, unless some other position of such officer, director, or employee constitutes a material relationship), as contemplated by Section 3901(a)(4)(E)(ii) of the federal Liability Risk Retention Act, is considered to be "independent."

d. Material relationship. – "Material relationship" of a person with the risk retention group includes, but is not limited to, the following:

1. The receipt in any one 12-month period of compensation or payment of any other item of value by such person, a member of such person's immediate family, or any business with which such person is affiliated from the risk retention group or a consultant or service provider to the risk retention group is greater than or equal to five percent (5%) of the risk retention group's gross written premium for such 12-month period or two percent (2%) of its surplus, whichever is greater, as measured at the end of any fiscal quarter falling in such a 12-month period. Such person or immediate family member of such person is not independent until one year after his/her compensation from the risk retention group falls below the threshold.
2. A relationship with an auditor as follows: a director or an immediate family member of a director who is affiliated with or employed in a professional capacity by a present or former internal or external auditor of the risk retention group is not independent until one year after the end of the affiliation, employment, or auditing relationship.
3. A relationship with a related entity as follows: a director or immediate family member of a director who is employed as an executive officer of another company where any of the risk retention group's present executives serve on that other company's board of directors is not independent until one year after the end of such service or the employment relationship.

(2) Service provider contracts. – The term of any material service provider contract with the risk retention group shall not exceed five years. Any such contract, or its renewal, shall require the approval of the majority of the risk retention group's independent directors. The risk retention group's board of directors shall have the right to terminate any service provider, audit, or actuarial contracts at any time for cause after providing adequate notice as defined in the contract. The service provider contract is deemed material if the amount to be paid for such contract is more than or equal to the greater of five percent (5%) of the risk retention group's annual gross written premium or two percent (2%) of its surplus.

a. For purposes of this standard, "service providers" shall include captive managers, auditors, accountants, actuaries, investment advisors, lawyers, managing general underwriters, or other party responsible for underwriting, determination of rates, collection of premium, adjusting and settling claims, or the preparation of financial statements. Any reference to "lawyers" in the prior sentence of this sub-subdivision does not include defense counsel retained by the risk retention group to defend claims, unless the amount of fees paid to such lawyers are "material" under the standard set forth in this subdivision for a service provider contract.

b. No service provider contract shall be entered into with a person meeting the definition of "material relationship" contained in sub-subdivision (1)d. of this subsection unless the risk retention group has notified the Commissioner in writing of its intention to enter into such transaction at least 30 days prior thereto and the Commissioner has not disapproved it within such period.

(3) Written policy. – The risk retention group's board of directors shall adopt a written policy in the plan of operation as approved by the board that requires the board to do all of the following:

a. Assure that all owner/insureds of the risk retention group receive evidence of ownership interest.

b. Develop a set of governance standards applicable to the risk retention group.

c. Oversee the evaluation of the risk retention group's management including, but not limited to, the performance of the captive manager, managing general underwriter, or other party or parties responsible for underwriting, determination of rates, collection of premium, adjusting or settling claims, or the preparation of financial statements.

d. Review and approve the amount to be paid for all material service providers.

e. Review and approve, at least annually, all of the following:

1. Risk retention group's goals and objectives relevant to the compensation of officers and service providers.

2. The officers' and service providers' performance in light of those goals and objectives.

3. The continued engagement of the officers and material service providers.

(4) Governance standards. – The board of directors shall adopt and disclose governance standards. For purposes of this subdivision, "disclose" means making such information available through electronic or other means, such as posting on the risk retention group's Web site, and providing such information to members or insureds upon request. The standards to be disclosed shall include all of the following:

a. A process by which the directors are elected by the owner/insureds.

b. Director qualification standards.

c. Director responsibilities.

d. Director access to management and, as necessary and appropriate, independent advisors.

e. Director compensation.

f. Director orientation and continuing education.

g. The policies and procedures that are followed for management succession.

h. The policies and procedures that are followed for annual performance evaluation of the board.

(5) Business conduct and ethics. – The board of directors shall adopt and disclose a code of business conduct and ethics for directors, officers, and employees and promptly disclose to the board of directors any waivers of the code for directors or executive officers. The code of business conduct and ethics shall include the following topics:

a. Conflicts of interest.

b. Matters covered under the corporate opportunities doctrine as that doctrine has been interpreted by the courts of this State.

c. Confidentiality.

d. Fair dealing.

e. Protection and proper use of risk retention group assets.

f. Duty of compliance with all applicable laws, rules, and regulations.

g. A requirement to report any illegal or unethical behavior which affects the operation of the risk retention group.

(6) Reporting noncompliance. – The captive manager or the president or chief executive officer of the risk retention group shall promptly notify the Commissioner in writing if either becomes aware of any material noncompliance with the governance standards set forth in this subsection."

PART IV. EFFECTIVE DATE

SECTION 4. Section 2 of this act becomes effective January 1, 2017. The remainder of this act becomes effective July 1, 2015.

HOUSE BILL 288: Insurance Technical Changes.-AB

2015-2016 General Assembly

Committee:	House Insurance	**Date:**	April 14, 2015
Introduced by:	Reps. Setzer, Bumgardner	**Prepared by:**	Kristen Harris Committee Counsel
Analysis of:	PCS to First Edition H288-CSTU-5		

***SUMMARY:** The Proposed Committee Substitute to House Bill 288 enacts legislative changes to North Carolina's insurance laws to comply with requirements of the National Association of Insurance Commissioners (NAIC) and allow the North Carolina Department of Insurance to maintain its accreditation with the NAIC.*

BACKGROUND: The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and the five U.S. territories. The formal certification program began in June 1990. North Carolina has been accredited since 1991. All fifty states, the District of Columbia and Puerto Rico are currently accredited.

CURRENT LAW:

Chapter 58 of the General Statutes governs North Carolina's insurance laws. Currently, the provisions in Chapter 58 meet NAIC requirements.

BILL ANALYSIS:

House Bill 288 amends existing statutes in Chapter 58 by incorporating model act provisions from the NAIC that are required to be enacted by 2017. In addition, sections from the North Carolina Administrative Code are incorporated into Chapter 58 as outlined below.

PART I

Section 1.1:

G.S. 58-19-1 Findings; purpose; legislative intent.

- Subsection (3) contains a clarifying change.

Section 1.2(a):

Contains recodifications.

Section 1.2(b):

G.S. 58-19-5 Definitions.

- Subsections (3) through (10) add various definitions. The definitions "enterprise risk" and Forms E and F are required for NAIC accreditation. The definitions "executive officer" and Forms A, B, C, and D are being incorporated from the North Carolina Administrative Code (NCAC.)
- Subsection (16) adds a definition for "ultimate controlling person" which is being incorporated from the NCAC.

Section 1.3(a):

Contains recodifications.

Section 1.3(b):

G.S. 58-19-15 Acquisition of control of or merger with domestic insurer.

- Subsection (a) contains a technical change and incorporates language from the NCAC.
- Subsection (b) amends the definition of "domestic insurer" as required for NAIC accreditation.
- Subsections (e) and (f) adopt provisions required for NAIC accreditation. Subsection (e) requires notification to the Commissioner when a holding company divests of a domestic insurer. Subsection (f) requires a pre-acquisition notification (Form E), which will include information about the impact of the acquisition on competition.
- Subsection (g) amends the form of the statement to be filed with the Commissioner which is being incorporated from the NCAC. It also sets forth additional information to be provided with the acquisition of control of a domestic insurer as required for NAIC accreditation.
- Subsection (j) adopts provisions required for NAIC accreditation concerning public hearing and statement filing requirements.
- Subsections (n) and (o) contains changes required for NAIC accreditation.

Section 1.4:

G.S. 58-19-25 Registration of insurers.

- Subsection (a) changes "licensed" to "authorized," incorporates language from the NCAC, and contains clarifying changes.
- Subsection (b) incorporates language from the NCAC and adopts provisions required for NAIC accreditation that set forth information that an insurer must provide to the Commissioner when filing a registration statement.
- Subsections (d) and (f) through (h) incorporate language from the NCAC.
- Subsection (j) contains technical changes and incorporates language from the NCAC. The language added in Subsection (j)(1) would no longer require a hearing for the denial of a disclaimer of affiliation but would still provide for a hearing upon request. This language agrees with the NAIC model law but is not required for NAIC accreditation.
- Subsection (k) adds language required for NAIC accreditation establishing that the failure to file the enterprise risk filing (Form F) is a violation of Article 19.
- Subsection (l) adopts provisions required for NAIC accreditation establishing the requirement for the ultimate controlling person of an insurer to file the enterprise risk report annually.

Section 1.5(a):

Contains recodifications.

Section 1.5(b):

G.S. 58-19-30 Standards and management of an insurer within a holding company system.

- Subsection (a) contains a clarifying change and adds language required for NAIC accreditation establishing that management and cost sharing arrangements between the insurers and its affiliates must include specified minimum provisions.
- Subsection (b) contains technical and clarifying changes and incorporates language from the NCAC.

  It also adds language required for NAIC accreditation requiring insurers to obtain prior approval for modifications to affiliated agreements, which are already subject to the Commissioner's approval, further specifies the reinsurance agreements which are subject to the Commissioner's approval, adds tax allocation agreements amongst affiliates to the types of agreements that require the Commissioner's prior approval, and sets forth minimum standards for management agreements and cost sharing agreements between an insurer and its affiliates.

  It also creates a new subsection for the guarantee agreement filing requirement. The language agrees with the NAIC model law but is not required for accreditation.
- Subsections (d) and (e) incorporate language from the NCAC.

Section 1.6:

G.S. 58-19-35 Examination.

- Subsections (a), (e), (f), and (g) add language required for NAIC accreditation that authorizes the Commissioner to examine enterprise risk and provides that the Commissioner may order the insurer to provide information generated from contractual arrangements with affiliates that may not be in the insurer's possession.
- Subsection (d) removes language to conform to changes made to subsection (a) required for NAIC accreditation.

Section 1.7:

G.S. 58-19-37 Supervisory Colleges.

- Subsections (a) through (c) add language required for NAIC accreditation that establishes the Commissioner's authority to participate in supervisory colleges in order to facilitate the sharing of information with regulators from other jurisdictions that regulate entities that are affiliated with the domestic insurer.

Section 1.8:

G.S. 58-19-40 Confidential Treatment.

- Subsections (a) through (f) add language required for NAIC accreditation that revises the confidentiality language regarding holding company filings to be substantially the same as the NAIC model law.

Section 1.9:

Subsection (f) adds language required for NAIC accreditation that establishes sanctions for violations, which prevent the Commissioner's full understanding of the enterprise risk.

Section 1.10:

Contains clarifying changes.

Section 1.11:

Incorporates language from the NCAC and the NAIC model law.

Section 1.12:

Contains technical and clarifying changes.

PART II

Section 2:

Adds language required for NAIC accreditation that changes the definition of a life and health insurer's risk based capital company action level.

PART III

Section 3:

G.S. 58-22-15 Risk retention groups chartered in this State.

- Subsection (d) adds language required for NAIC accreditation relating to risk retention groups. Specifically, guidelines are established for a risk retention group's board of directors, attorney-in-fact, and captive manager, president, or CEO.

EFFECTIVE DATE: Section 2 of this act becomes effective January 1, 2017. The remainder of this act becomes effective July 1, 2015.

The Department of Insurance substantially contributed to this summary.

EXHIBIT 11

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 288

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

H288-ARG-4 [v.1]

Page 1 of 1

Comm. Sub. [YES]
Amends Title [NO]
H288-CSTU-5

Date ______________________,2015

Representative Setzer

moves to amend the bill on page 8, lines 5 through 13, by rewriting the lines to read:

"(1) ~~The disclaimer of affiliation shall fully disclose all material relationships and bases for affiliation between such person and such insurer as well as the basis for disclaiming such affiliation. After a disclaimer has been filed, the insurer shall be relieved of any duty to register or report under this section that may arise out of the insurer's relationship with such person unless the Commissioner disallows such a disclaimer.~~ The Commissioner shall disallow such a disclaimer only after furnishing all parties in interest with notice and opportunity to be heard and after making specific findings of fact to support such disallowance. A disclaimer of affiliation shall be deemed to have been"

SIGNED ____
Amendment Sponsor

SIGNED ____
Committee Chair if Senate Committee Amendment

ADOPTED ____________ FAILED ____________ TABLED ____________

H288-ARG-4-V-1

EXHIBIT 12

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H **D**

HOUSE BILL 288
PROPOSED COMMITTEE SUBSTITUTE H288-PCS20284-TU-5

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

Sponsors:

Referred to:

March 19, 2015

A BILL TO BE ENTITLED

AN ACT TO MAINTAIN NAIC ACCREDITATION OF THE DEPARTMENT OF INSURANCE BY MAKING REVISIONS TO THE LAWS GOVERNING INSURANCE COMPANY HOLDING SYSTEMS, RISK-BASED CAPITAL REQUIREMENTS FOR LIFE INSURERS, AND CORPORATE GOVERNANCE REQUIREMENTS FOR RISK RETENTION GROUPS, AS RECOMMENDED BY THE DEPARTMENT OF INSURANCE.

The General Assembly of North Carolina enacts:

PART I. INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT REVISIONS

SECTION 1.1. G.S. 58-19-1 reads as rewritten:

"**§ 58-19-1. Findings; purpose; legislative intent.**

(a) The General Assembly finds that the public interest and the interests of policyholders are or may be adversely affected when any of the following occur:

(1) Control of an insurer is sought by persons who would utilize such control adversely to the interests of policyholders.

(2) Acquisition of control of an insurer would substantially lessen competition or create a monopoly in the insurance business in this State.

(3) An insurer that is part of ~~a~~ an insurance holding company system is caused to enter into transactions or relationships with affiliated companies on terms that are not fair and reasonable.

(4) An insurer pays dividends to shareholders that jeopardize the financial condition of such insurer.

…."

SECTION 1.2.(a) Subdivisions (3) through (7) of G.S. 58-19-5 are recodified as subdivisions (11) through (15) of that section. Subdivision (8) of G.S. 58-19-5 is recodified as subdivision (17) of that section.

SECTION 1.2.(b) G.S. 58-19-5, as amended by subsection (a) of this section, reads as rewritten:

"**§ 58-19-5. Definitions.**

As used in this Article, unless the context requires otherwise, the following terms have the following meanings:

(1) An "affiliate" of or person "affiliated" with a specific ~~person is a~~person. – A person that indirectly through one or more intermediaries or directly

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controls, is controlled by, or is under common control with the person specified.

(2) "Control", including the terms "controlling", "controlled by", and ~~"under common control with",~~ "under common control with." – ~~means the~~The direct or indirect possession of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise. Control is presumed to exist if any person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by G.S. 58-19-25(j) that control does not exist in fact. The Commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(3) Enterprise risk. – Any activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurer's risk-based capital to fall into company action level as set forth in Article 12 of this Chapter or would cause the insurer to be in a hazardous financial condition as set forth in G.S. 58-30-60.

(4) Executive officer. – A chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.

(5) Form A. – The statement regarding the acquisition of control of or merger with a domestic insurer that is required to be filed with the Commissioner pursuant to G.S. 58-19-15.

(6) Form B. – The insurance holding company system annual registration statement that is required to be filed with the Commissioner pursuant to G.S. 58-19-25.

(7) Form C. – The summary of changes to the insurance company system annual registration statement that is required to be filed with the Commissioner pursuant to G.S. 58-19-25.

(8) Form D. – The prior notice of a transaction that is required to be filed with the Commissioner pursuant to G.S. 58-19-30(b).

(9) Form E. – The pre-acquisition notification that is required to be filed with the Commissioner pursuant to G.S. 58-19-15(f).

(10) Form F. – The annual enterprise risk report required to be filed with the Commissioner pursuant to G.S. 58-19-25(l).

(11) ~~"Insurance holding company system" means an~~Insurance holding company system. – An entity comprising two or more affiliated persons, one or more of which is an insurer.

(12) ~~"Insurer" includes~~Insurer. – As defined in G.S. 58-1-5(3), and includes a person subject to Articles 65 and 66 or 67 of this Chapter. "Insurer" does not include (1) an agency, authority, or instrumentality of the United States; any of its possessions and territories; the Commonwealth of Puerto Rico; the

District of Columbia; nor a state or political subdivision of a state; nor (2) fraternal benefit societies or fraternal orders.

(13) ~~"Person" means an~~Person. – An individual, corporation, partnership, limited liability company, association, joint stock company, trust, unincorporated organization, or any similar entity or any combination of the foregoing acting in concert.

(14) A "security holder" of a specified ~~person is one~~person. – One who owns any security of such person, including common stock, preferred stock, debt obligations, or any other security convertible into or evidencing the right to acquire any of the foregoing.

(15) A "subsidiary" of a specified ~~person is an~~person. – An affiliate controlled by such person indirectly through one or more intermediaries or directly.

(16) Ultimate controlling person. – A person not controlled by any other person.

(17) ~~"Voting security" includes~~Voting security. – Includes any security convertible into or evidencing a right to acquire a voting security."

SECTION 1.3.(a) Subsections (b) through (j) of G.S. 58-19-5 are recodified as subsections (g) through (o) of that section, subsections (a1) through (a3) of G.S. 58-19-15 are recodified as subsections (b) through (d) of that section, and subdivision (g)(12) of G.S. 58-19-5 is recodified as subdivision (g)(14) of that section.

SECTION 1.3.(b) G.S. 58-19-15, as amended by subsection (a) of this section, reads as rewritten:

"§ 58-19-15. Acquisition of control of or merger with domestic insurer.

(a) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities, or seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer, if, after the consummation thereof, the person would, directly or indirectly (or by conversion or by exercise of any right to acquire), be in control of the insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless the offer, request, invitation, ~~agreement,~~ agreement entered into, or acquisition is conditioned upon the approval of the ~~Commissioner~~ Commissioner, and furnished on a Form A as prescribed by the Commissioner under this section. No such merger or other acquisition of control is effective until a statement containing the information required by this section has been filed with the Commissioner and all other provisions of this section have been complied with and the merger or acquisition of control has been approved by the Commissioner under this section. The statement containing the information required by this section shall also be filed with the domestic insurer when it is filed with the Commissioner.

(b) For the purposes of this section a "domestic insurer" includes any person controlling a domestic ~~insurer.~~insurer, unless the person, as determined by the Commissioner, is either directly or through its affiliates primarily engaged in business other than insurance. Further, for the purposes of this section, "person" does not include any securities broker holding, in the usual and customary broker's function, less than twenty percent (20%) of the voting securities of an insurance company or of any person that controls an insurance company.

(c) Any acquisition of control of a domestic insurer must be completed not later than 90 days after the date of the Commissioner's order approving the acquisition under this section, unless the Commissioner grants an extension in writing on a showing of good cause for the delay. Any increase in a company's capital and surplus required under this Article as a result of the change of control of a domestic insurer must be completed not later than 90 days after the date of the Commissioner's order approving the change of control and before the company writes any new insurance business.

(d) If the deadlines for completion in subsection ~~(a2)~~(c) of this section are not met, the person seeking to acquire control of the domestic insurer must resubmit the statement required by subsection ~~(b)~~(g) of this section, and the Commissioner may reconsider approval of acquisition of control under this section.

(e) For purposes of this section, any controlling person of the domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, shall file with the Commissioner, with a copy to the insurer, confidential notice of its proposed divesture at least 30 days prior to the cessation of control. The Commissioner shall determine those instances in which the party or parties seeking to divest or to acquire a controlling interest in an insurer, will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the Commissioner, in his discretion determines that confidential treatment will interfere with enforcement of this section. If the statement referred to in subsection (a) of this section is otherwise filed, this subsection shall not apply.

(f) With respect to a transaction subject to this section, the acquiring person must also file a pre-acquisition notification with the Commissioner on a Form E as prescribed by the Commissioner. In addition to the information required by the Form E, the Commissioner may require an expert opinion as to the competitive impact of the proposed acquisition at the acquiring person's expense. A failure to file the pre-acquisition notification may subject the insurer or other person who fails to make the filing and who also fails to demonstrate a good-faith effort to comply with this requirement to a fine of not more than fifty thousand dollars ($50,000).

(g) The statement to be filed with the Commissioner under subsection (a) of this section shall be furnished on a Form A as prescribed by the Commissioner, made under oath or ~~affirmation~~ affirmation, and shall contain the following information:

…

(11) The term of any agreement, contract, or understanding made with or proposed to be made with any third party in connection with any acquisition of control of or merger with a domestic insurer, and the amount of any fees, commissions, or other compensation to be paid to the third party with regard thereto.

(12) An agreement by the person required to file the statement referred to in subsection (a) of this section that it will provide the annual report, specified in G.S. 58-19-25, for so long as control exists.

(13) An acknowledgement by the person required to file the statement referred to in subsection (a) of this section that the person and all subsidiaries within its control in the insurance holding company system will provide information to the Commissioner upon request as necessary to evaluate enterprise risk to the insurer.

(14) Such additional information as the Commissioner may by rule prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

If the person required to file the statement referred to in subsection (a) of this section is a partnership, limited partnership, syndicate, or other group, the Commissioner shall require that the information called for by subdivisions (1) through ~~(12)~~(14) of this subsection be given with respect to each partner of such partnership or limited partnership, each member of such syndicate or group, and each person who controls such partner or member. If any such partner, member, or person is a corporation or the person required to file the statement referred to in subsection (a) of this section is a corporation, the Commissioner shall require that the information called for by subdivisions (1) through ~~(12)~~(14) of this subsection be given with respect to such corporation, each officer and director of such corporation, and each person who is, directly or indirectly, the beneficial owner of more than ten percent (10%) of the outstanding voting securities of such corporation.

If any material change occurs in the facts set forth in the statement filed with the Commissioner and sent to such insurer pursuant to this section, an amendment setting forth such change, together with copies of all documents and other material relevant to such change, shall be filed with the Commissioner and sent to such insurer by the filer within two business days after the person learns of such change.

…

(j) The public hearing referred to in subsection ~~(d)~~(i) of this section shall be held within 120 days after the statement required by subsection (a) of this section is filed, and the Commissioner shall give at least 30 days notice of the hearing to the person filing the statement, to the insurer, and to such other persons as may be designated by the Commissioner. The Commissioner shall make a determination as expeditiously as is reasonably practicable after the conclusion of the hearing. At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected by the hearing shall have the right to present evidence, examine and cross-examine witnesses, and offer oral or written arguments; and in connection therewith shall be entitled to conduct discovery proceedings at any time after the statement is filed with the Commissioner under this section and in the same manner as is presently allowed in the superior courts of this State. In connection with discovery proceedings authorized by this section, the Commissioner may issue such protective orders and other orders governing the timing and scheduling of discovery proceedings as might otherwise have been issued by a superior court of this State in connection with a civil proceeding. If any party fails to make reasonable and adequate response to discovery on a timely basis or fails to comply with any order of the Commissioner with respect to discovery, the Commissioner on the Commissioner's own motion or on motion of any other party or person may order that the hearing be postponed, recessed, convened, or reconvened, as the case may be, following proper completion of discovery and reasonable notice to the person filing the statement, to the insurer, and to such other persons as may be designated by the Commissioner.

If the proposed acquisition of control will require the approval of the insurance commissioners of more than one state, the public hearing referred to in this subsection may be held on a consolidated basis upon request of the person filing the statement referred to in subsection (a) of this section. Such person shall file the statement referred to in subsection (a) of this section with the NAIC within five days of making the request for a public hearing. A commissioner may opt out of a consolidated hearing and shall provide notice to the applicant of the opt out within 10 days of the receipt of the statement referred to in subsection (a) of this section. A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the commissioners of the states in which the insurers are domiciled. Such commissioners shall hear and receive evidence. A commissioner may attend such hearing, in person or by telecommunication.

…

(n) ~~The~~ Each of the following are violations of this section:

(1) The failure to file any statement, amendment, or other material required to be filed pursuant to subsection (a) or ~~(b)~~(g) of this ~~section; or~~section.

(2) The effectuation or any attempt to effectuate an acquisition of control ~~of~~ of, divestiture of, or merger with a domestic insurer, unless the Commissioner has given his approval ~~thereto.~~of the acquisition, divestiture, or merger.

(o) The courts of this State are vested with jurisdiction over every person not resident, domiciled, or authorized to do business in this State who files a statement with the Commissioner under this section; and the overall actions involving such person arising out of violations of this section and each such person is deemed to have performed acts equivalent to and constituting an appointment by such person of the Commissioner to be his true and lawful attorney upon whom may be served all legal process in any action, suit, or proceeding arising out of violations of this section. Copies of all such process shall be handled in accordance with the provisions of G.S. 58-16-30, 58-16-35, and 58-16-45."

SECTION 1.4. G.S. 58-19-25 reads as rewritten:

"**§ 58-19-25. Registration of insurers.**

(a) Every insurer that is ~~licensed~~ authorized to do business in this State and that is a member of an insurance holding company system shall register with the ~~Commissioner,~~Commissioner pursuant to G.S. 58-19-25(b), except a foreign insurer subject to the registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to those contained in:

(1) This section.

(2) G.S. 58-19-30(a), G.S. 58-19-30(c), and G.S. 58-19-30(d).

(3) G.S. 58-19-30(b) or a statutory or regulatory provision such as the following: Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within 15 days after the end of the month in which it learns of each change or addition. The insurer shall also file a copy of its registration statement and any amendments to the statement in each state in which that insurer is authorized to do business, if requested by the insurance regulator of that state.

Any insurer that is subject to registration under this section shall register within 30 days after it becomes subject to registration, and an amendment to the registration statement shall be filed by April 1 of each year for the previous calendar year; unless the Commissioner for good cause shown extends the time for registration or filing, and then within the extended time. All registration statements shall contain a summary, on a ~~form~~ Form C as prescribed by the Commissioner, outlining all items in the current registration statement representing changes from the prior registration statement. The Commissioner may require any insurer that is ~~a~~ an insurance member of a holding company system that is not subject to registration under this section to furnish a copy of the registration statement or other information filed by the insurance company with the insurance regulator of its domiciliary jurisdiction.

(b) Every insurer subject to registration shall file the registration statement on a ~~form~~ Form B prescribed by the Commissioner, which shall contain the following current information:

…

(6) If requested by the Commissioner, the insurer shall include financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include, but are not limited to, annual audited financial statements filed with the United States Securities and Exchange Commission pursuant to the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended. An insurer required to file financial statements pursuant to this subdivision may satisfy the request by providing the Commissioner with the most recently filed parent corporation financial statements that have been filed with the United States Securities and Exchange Commission.

(7) Statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures.

(8) Any other information required by the Commissioner by rule or regulation.

(c) No information need be disclosed on the registration statement filed pursuant to subsection (b) of this section if such information is not material for the purposes of this section. Unless the Commissioner by rule or order provides otherwise, all sales, purchases, exchanges, loans or extensions of credit, investments, or guarantees involving one-half of one percent (1/2%) or less of an insurer's admitted assets as of the preceding December 31 are not material for the purposes of this section.

(d) Subject to G.S. 58-7-130(b) and G.S. 58-19-30(c), each domestic insurer shall report to the Commissioner all dividends and other distributions to shareholders within five business days following the declaration thereof and at least 30 days before the payment ~~thereof. The Commissioner may adopt rules to further the requirements of this section.~~of the dividend or distribution by providing the information set forth in G.S. 58-19-30(e). A prior notification of an ordinary dividend or any other ordinary distribution required under this subsection shall be deemed to be incomplete unless all of the information required by G.S. 58-19-30(e) has been included. The Commissioner shall consider the factors set forth in G.S. 58-19-30(d) in his review of dividends or other distributions to shareholders pursuant to this subsection. The Commissioner may adopt rules to further the requirements of this section.

(e) Any person within an insurance holding company system subject to registration shall provide complete and accurate information to an insurer, where such information is reasonably necessary to enable the insurer to comply with the provisions of this Article.

(f) The Commissioner shall terminate the registration of any insurer that demonstrates that it no longer is a member of an insurance holding company system. A termination of registration shall include the information set forth in subdivision (j)(1) of this section and shall be deemed to have been granted unless the Commissioner, within 30 days after receipt of the request, notifies the registrant otherwise.

(g) The Commissioner may require or allow two or more affiliated insurers subject to registration under this section to file a consolidated ~~registration statement.~~or alternative registration statement as provided in subsection (h) of this section. The Commissioner, however, reserves the right to require individual filings if he deems such filings necessary in the interest of clarity, ease of administration, or the public good.

(h) ~~The Commissioner~~Any authorized insurer may ~~allow an insurer that is authorized to do business in this State and that is part of an insurance holding company system to register~~file a registration statement on behalf of any affiliated insurer ~~that is~~or insurers that are required to register under subsection ~~(a) of this section and to file all information and material required to be filed under this section.~~(a) of this section. A registration statement may include information not required by Article 19 of this Chapter regarding any insurer in the insurance holding company system even if the insurer is not authorized to do business in this State. In lieu of filing a registration statement on a Form B, the authorized insurer may file a copy of the registration statement or similar report that it is required to file in its state of domicile, provided all of the following apply:

(1) The statement or report contains substantially similar information required to be furnished on Form B.

(2) The filing insurer is the principal insurance company in the insurance holding company system.

The question of whether the filing insurer is the principal insurance company in the insurance holding company system is a question of fact, and an insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer shall set forth a brief statement of facts which will substantiate the filing insurer's claim that it, in fact, is the principal insurer in the insurance holding company system.

(i) The provisions of this section do not apply to any insurer, information, or transaction if and to the extent that the Commissioner by rule or order exempts the same from the provisions of this section.

(j) Any person may file with the Commissioner a disclaimer of ~~affiliation~~ affiliation, which includes the information outlined in G.S. 58-19-25(j)(1), with any authorized insurer, or such a disclaimer of affiliation may be filed by such insurer or any member of an insurance holding company ~~system.~~system as set forth in this subsection.

(1) ~~The disclaimer shall fully disclose all material relationships and bases for affiliation between such person and such insurer as well as the basis for disclaiming such affiliation. After a disclaimer has been filed, the insurer shall be relieved of any duty to register or report under this section that may arise out of the insurer's relationship with such person unless the Commissioner disallows such a disclaimer.~~ The Commissioner shall disallow such a disclaimer only after furnishing all parties in interest with notice and opportunity to be heard and after making specific findings of fact to support such disallowance. A disclaimer of affiliation shall be deemed to have been granted unless the Commissioner, within 30 days following the receipt of a complete disclaimer of affiliation, notifies the filing party that the disclaimer of affiliation is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer of affiliation has been granted by the Commissioner, or if the disclaimer of affiliation is deemed to have been approved.

(2) A disclaimer of affiliation pursuant to this subsection or a request for termination of registration pursuant to G.S. 58-19-25(f) claiming that a person does not, or will not upon the taking of some proposed action, control another person (hereinafter "subject") shall contain the following information:

a. The number of authorized, issued, and outstanding voting securities of the subject.

b. With respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject's voting securities, which are held of record or known to be beneficially owned, and the number of shares concerning which there is a right to acquire, directly or indirectly.

c. All material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person.

d. A statement explaining why the person should not be considered to control the subject.

(k) The failure to file a registration statement or any summary of the registration statement or enterprise risk filing thereto required by this section within the time specified for such filing is a violation of this section.

(l) Effective January 1, 2016, the ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report on Form F as prescribed by the Commissioner. The report shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the NAIC."

SECTION 1.5.(a) G.S. 58-19-30(b)(5) is recodified as G.S. 58-19-30(b)(6).

SECTION 1.5.(b) G.S. 58-19-30, as amended by subsection (a) of this section, reads as rewritten:

"§ 58-19-30. Standards and management of an insurer within ~~a~~ an insurance holding company system.

(a) Transactions within ~~a~~ an insurance holding company system to which an insurer subject to registration is a party are subject to all of the following standards:

(1) The terms shall be fair and reasonable.

(2) Charges or fees for services performed shall be reasonable.

(3) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied.

(4) The books, accounts, and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.

(5) The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(6) Agreements for cost-sharing services and management services shall include such provisions as required by this Article or rule and regulation issued by the Commissioner.

(b) The following transactions involving a domestic insurer and any person in its holding company ~~system~~ system, including amendments or modifications of affiliated agreements that were previously filed pursuant to this section and that are subject to any materiality standards contained in subdivision (1) through (7) of this section, may not be entered into unless the insurer has notified the Commissioner in writing of its intention to enter into the transaction at least 30 days before the transaction, or such shorter period as the Commissioner permits, and the Commissioner has not disapproved it within that ~~period:~~ period. The notice for amendments or modifications shall include the reason for the change and the financial impact on the domestic insurer. Informal notice shall be given to the Commissioner, within 30 days after termination of a previously filed agreement, so that the Commissioner may determine the type of filing required, if any. An insurer required to give notice of a proposed transaction pursuant to this subsection shall furnish the required information on a Form D, as prescribed by the Commissioner.

(1) Sales, purchases, exchanges, loans or extensions of credit, or investments, provided the transactions equal or exceed: (i) with respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders; (ii) with respect to life insurers, three percent (3%) of the insurer's admitted assets; each as of the preceding December 31.

(2) Loans or extensions of credit to any person who is not affiliated, where the insurer makes the loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit provided the transactions equal or exceed: (i) with respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders; (ii) with respect to life insurers, three percent (3%) of the insurer's admitted assets; each as of the preceding December 31.

(3) Reinsurance agreements or modifications to the ~~agreements~~ agreements, including the following:

a. Reinsurance pooling agreements.

b. Agreements in which either (i) the reinsurance premium or a change in the insurer's ~~liabilities~~ liabilities or (ii) the projected reinsurance premium or a change in the insurer's liabilities in any of the next three years equals or exceeds five percent (5%) of the insurer's surplus as regards policyholders, as of the preceding ~~December 31, including those agreements~~December 31.

c. Agreements that may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of the assets will be transferred to one or more affiliates of the insurer.

(4) All management agreements, service contracts, ~~guarantees,~~tax allocation agreements, or cost-sharing arrangements. Management agreements, service contracts, and cost-sharing arrangements shall at a minimum and as applicable:

a. Identify the person providing services and the nature of such services.

b. Set forth the methods to allocate costs.

c. Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the NAIC Accounting Practices and Procedures Manual.

d. Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement.

e. State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance.

f. Define books and records of the insurer to include all books and records developed or maintained under or related to the agreement.

g. Specify that all books and records of the insurer are and remain the property of the insurer and are subject to the control of the insurer.

h. State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer.

i. Include standards for termination of the agreement with and without cause.

j. Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services.

k. Specify that, if the insurer is placed in receivership or seized by the Commissioner under Article 30 of this Chapter:

1. All of the rights of the insurer under the agreement extend to the receiver or Commissioner.

2. All books and records will immediately be made available to the receiver or the Commissioner and shall be turned over to the receiver or Commissioner immediately upon the receiver's or the Commissioner's request.

l. Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed in receivership pursuant to Article 30 of this Chapter.

m. Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding a seizure by the Commissioner under Article 30 of this Chapter, and will make them available to the receiver, for so long as the affiliate continues to receive timely payment for services rendered.

(5) Guarantees when made by a domestic insurer; provided, however, that a guarantee which is quantifiable as to amount is not subject to the notice requirements of this subdivision unless it exceeds the lesser of one-half percent (0.5%) of the insurer's admitted assets or ten percent (10%) of surplus as regards policyholders as of the preceding December 31. Further, all guarantees which are not quantifiable as to amount are subject to the notice requirements of this subdivision.

(6) Any material transactions, specified by rule, that the Commissioner determines may adversely affect the interests of the insurer's policyholders.

Nothing in this section authorizes or permits any transactions that, in the case of an insurer, not a member of the same insurance holding company system, would be otherwise contrary to law. A domestic insurer may not enter into transactions that are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would otherwise occur. If the Commissioner determines that such separate transactions were entered into over any 12-month period for that purpose, the Commissioner may exercise the Commissioner's authority under G.S. 58-19-50. The Commissioner, in reviewing transactions pursuant to this subsection, shall consider whether the transactions comply with the standards set forth in subsection (a) of this section and whether they may adversely affect the interests of policyholders. The Commissioner shall be notified within 30 days after any investment of a domestic insurer in any one corporation if, as a result of the investment, the total investment in the corporation by the insurance holding company system exceeds ten percent (10%) of the corporation's voting securities.

(c) No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until (i) 30 days after the Commissioner has received notice of the declaration thereof and has not within that period disapproved the payment or (ii) the Commissioner has approved the payment within the 30-day period.

For the purposes of this section, an "extraordinary dividend" or "extraordinary distribution" includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding 12 months exceeds the greater of (i) ten percent (10%) of the insurer's surplus as regards policyholders as of the preceding December 31, or (ii) the net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the 12-month period ending the preceding December 31; but does not include pro rata distributions of any class of the insurer's own securities.

Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution that is conditional upon the Commissioner's approval, and the declaration shall confer no rights upon shareholders until (i) the Commissioner has approved the payment of the dividend or distribution or (ii) the Commissioner has not disapproved the payment within the 30-day period referred to above.

(d) For the purposes of this Article, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, ~~all of the following factors, among others, shall be considered:~~the factors set forth in subdivisions (1) through (11) of this subsection, among others, shall be considered. In determining the adequacy of an insurer's surplus, no single factor is controlling. The Commissioner will consider the net effect of all of the factors in subdivisions (1) through (11) of this subsection, plus other factors bearing on the financial condition of the insurer.

(1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria.

(2) The extent to which the insurer's business is diversified among the several kinds of insurance.

(3) The number and size of risks insured in each kind of insurance.

(4) The extent of the geographic dispersion of the insurer's insured risks.

(5) The nature and extent of the insurer's reinsurance program.

(6) The quality, diversification, and liquidity of the insurer's investment portfolio. In determining the quality and liquidity of investments in subsidiaries, the Commissioner will consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant.

(7) The recent past and projected future trend in the size of the insurer's surplus as regards policyholders.

(8) The surplus as regards policyholders maintained by other comparable insurers. In comparing the surplus maintained by other insurers, the Commissioner will consider the extent to which each of these factors varies from company to company.

(9) The adequacy of the insurer's reserves.

(10) The quality and liquidity of investments in affiliates. The Commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in his judgment such investment so warrants.

(11) The quality of the insurer's earnings and the extent to which the reported earnings of the insurer include extraordinary items.

(e) Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders made pursuant to subsection (c) of this section and prior notice of an ordinary dividend or any other ordinary distribution to shareholders under G.S. 58-19-25(d) shall include the following:

(1) The amount of the proposed dividend or distribution.

(2) The date established for payment of the dividend or distribution.

(3) A statement as to whether the dividend or distribution is to be in cash or other property and, if in property, a description thereof, its cost, and its fair market value together with an explanation of the basis for valuation.

(4) A statement identifying the dividend or distribution as an ordinary dividend or other ordinary distribution subject to G.S. 58-19-25(d) or as an extraordinary dividend or other extraordinary distribution as defined in subsection (c) of this section.

(5) A copy of the calculations determining whether the proposed dividend or distribution is an ordinary dividend or other ordinary distribution subject to G.S. 58-19-25(d), or an extraordinary dividend or other extraordinary distribution as defined in subsection (c) of this section. The work paper shall include the following information:

a. The amounts, dates, and form of payment of all dividends or distributions (including regular dividends but excluding distributions of the insurer's own securities) paid within the period of 12 consecutive months ending on the date fixed for payment of the proposed dividend for which notification is being given or approval is sought and commencing on the day after the same day of the same month in the last preceding year.

b. Surplus as regards policyholders as of the preceding December 31.

c. If the insurer is a life insurer, the net gain from operations for the 12-month period ending the preceding December 31.

d. If the insurer is not a life insurer, the net income less realized capital gains for the 12-month period ending the preceding December 31.

(6) A balance sheet and statement of income for the period between the last annual statement filed with the Commissioner and the end of the month preceding the month in which the request for approval or the prior notification of a dividend or distribution is submitted. The insurer shall indicate the amount of all unrealized capital gains included in unassigned funds.

(7) A brief statement as to the effect of the proposed dividend or distribution upon the insurer's surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs.

(8) A brief statement as to the intended use or uses of the proposed dividend or distribution by the parent, and if applicable, any upstream parent of the insurer.

A request for approval of an extraordinary dividend or any other extraordinary distribution shall be deemed to be incomplete unless all of the information required by this subsection has been included."

SECTION 1.6. G.S. 58-19-35 reads as rewritten:

"**§ 58-19-35. Examination.**

(a) Subject to the limitation contained in this section and in addition to the powers that the Commissioner has under other provisions of Articles 1 through 64 of this Chapter relating to the examination of insurers, the Commissioner also has the power to ~~order~~ examine any insurer registered under ~~G.S. 58-19-25~~G.S. 58-19-25, its affiliates, or any acquiring party ~~to produce such records, books, or other information in the possession of the insurer or its affiliates or the acquiring party as are reasonably necessary~~ to ascertain the financial condition of such ~~insurer~~ insurer, its affiliates, or acquiring ~~party or to determine compliance with Articles 1 through 64 of this Chapter.~~party, including the enterprise risk to the insurer by the ultimate controlling person, by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis. ~~In the event such insurer or acquiring party fails to comply with such order, the Commissioner shall have the power to examine such insurer or its affiliates or such acquiring party to obtain such information.~~

(b) The Commissioner may retain, at the expense of the registered insurer or acquiring party that is being examined, such attorneys, actuaries, economists, accountants, and other experts not otherwise a part of the Commissioner's staff as are reasonably necessary to assist in the conduct of the examination under subsection (a) of this section. Any persons so retained shall be under the direction and control of the Commissioner and shall act in a purely advisory capacity.

(c) Repealed by Session Laws 1995, c. 360, s. 2(h).

~~(d) The Commissioner shall exercise his power under subsection (a) of this section only if the examination of the insurer or acquiring party under other provisions of Articles 1 through 64 of this Chapter is inadequate or the interests of the policyholders of such insurer may be adversely affected.~~

(e) The Commissioner may order any insurer registered under G.S. 58-19-25 or any acquiring party to produce such records, books, or other information in the possession of the insurer, its affiliates, or acquiring party as reasonably necessary to determine compliance with this Chapter.

(f) To determine compliance with this Chapter, the Commissioner may order any insurer registered under G.S. 58-19-25 to produce information not in the possession of the insurer if the insurer can obtain access to such information pursuant to contractual relationships, statutory obligations, or other method. In the event the insurer cannot obtain the information requested by the Commissioner, the insurer shall provide the Commissioner a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of that information. Whenever it appears to the Commissioner that the detailed explanation is without merit, the Commissioner may require, after notice and hearing, the insurer to pay a penalty of one thousand dollars ($1,000) for each day's delay or may suspend or revoke the insurer's license.

(g) In the event the insurer fails to comply with an order, the Commissioner shall have the power to examine the affiliates to obtain the information. The Commissioner shall also have the power to issue subpoenas, to administer oaths, and to examine under oath any person for purposes of determining compliance with this section. Upon the failure or refusal of any person to obey a subpoena, the Commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. Every person shall be obligated to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. He or she shall be entitled to the same fees and mileage, if claimed, as a witness in the courts of the county specified in the subpoena as the site of the examination. Any fees, mileage, and actual expense necessarily incurred in securing the attendance of witnesses, and their testimony, shall be itemized and charged against, and be paid by, the company being examined."

SECTION 1.7. Article 19 of Chapter 58 of the General Statutes is amended by adding a new Section to read:

"**§ 58-19-37. Supervisory colleges.**

(a) With respect to any insurer registered under G.S. 58-19-25, and in accordance with subsection (c) of this section, the Commissioner shall also have the power to participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with this Chapter. The powers of the Commissioner with respect to supervisory colleges include, but are not limited to, the following:

(1) Initiating the establishment of a supervisory college.
(2) Clarifying the membership and participation of other supervisors in the supervisory college.
(3) Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor.
(4) Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing.
(5) Establishing a crisis management plan.

(b) Each registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the Commissioner's participation in a supervisory college in accordance with subsection (c) of this section, including reasonable travel expenses. For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates, and the Commissioner may establish a regular assessment to the insurer for the payment of these expenses.

(c) In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management, and governance processes, and as part of the examination of individual insurers in accordance with G.S. 58-19-35, the Commissioner may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal, and international regulatory agencies. The Commissioner may enter into agreements in accordance with G.S. 58-19-40 providing the basis for cooperation between the Commissioner and the other regulatory agencies and the activities of the supervisory college. Nothing in this section shall delegate to the supervisory college the authority of the Commissioner to regulate or supervise the insurer or its affiliates within its jurisdiction."

SECTION 1.8. G.S. 58-19-40 reads as rewritten:

"§ 58-19-40. Confidential treatment.

(a) Documents, materials, or other information in the possession or control of the Department that are ~~All information, documents, and copies thereof~~ obtained by or disclosed to the Commissioner or any other person in the course of an examination or investigation made pursuant to G.S. 58-19-35, and all information reported pursuant to subdivisions (12) and (13) of G.S. 58-19-15(g), ~~G.S. 58-19-25~~G.S. 58-19-25, and G.S. 58-19-30, shall be ~~given~~ confidential ~~treatment; shall not be subject to subpoena; and shall not be made~~by law and privileged, shall not be considered a public record under either G.S. 58-2-100 or Chapter 132 of the General Statutes, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties. The Commissioner shall not otherwise make the documents, materials, or other information public ~~by the Commissioner, the NAIC, or any other person, except to insurance regulators of other states,~~ without the prior written consent of the insurer ~~or acquiring party~~ to which it pertains unless the Commissioner, after giving the insurer and its affiliates ~~or the acquiring party that~~who would be affected thereby notice and opportunity to be heard, determines that the interest of ~~the insurer's policyholders~~policyholders, shareholders, or the public will be served by the publication thereof, in which event ~~he~~ the Commissioner may publish all or any part ~~thereof~~of the information in such manner as ~~he considers~~may be deemed appropriate.

(b) Neither the Commissioner nor any person who received documents, materials, or other information while acting under the authority of the Commissioner or with whom such documents, materials, or other information are shared pursuant to this Article shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (a) of this section.

(c) In order to assist in the performance of the duties imposed by this Article, the Commissioner:

(1) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (a) of this section, with other state, federal, and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, including members of any supervisory college described in G.S. 58-19-37, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information and has verified in writing the legal authority to maintain confidentiality.

(2) Notwithstanding subdivision (1) of this subsection, may only share confidential and privileged documents, material, or information reported pursuant to G.S. 58-19-25 with Commissioners of states having statutes or regulations substantially similar to subsection (a) of this section and who have agreed in writing not to disclose such information.

(3) May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information from the

NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(4) Shall enter into written agreements with the NAIC governing sharing and use of information provided pursuant to this Article consistent with this subsection that shall:

a. Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC and its affiliates and subsidiaries pursuant to this Article, including procedures and protocols for sharing by the NAIC with other state, federal, or international regulators;

b. Specify that ownership of information shared with the NAIC and its affiliates and subsidiaries pursuant to this Article remains with the Commissioner, and the NAIC's use of the information is subject to the direction of the Commissioner;

c. Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC pursuant to this Article is subject to a request or subpoena to the NAIC for disclosure or production; and

d. Require the NAIC and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the NAIC and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the NAIC and its affiliates and subsidiaries pursuant to Article 19 of this Chapter.

(d) The sharing of information by the Commissioner pursuant to this Article shall not constitute a delegation of regulatory authority or rule making, and the Commissioner is solely responsible for the administration, execution, and enforcement of the provisions of Article 19 of this Chapter.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (c) of this section.

(f) Documents, materials, or other information in the possession or control of the NAIC pursuant to a requirement of this Article shall be confidential by law and privileged, shall not be considered a public record under G.S. 58-2-100 or Chapter 132 of the General Statutes, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action."

SECTION 1.9. G.S. 58-19-50 is amended by adding a new subsection to read:

"(f) Whenever it appears to the Commissioner that any person has committed a violation of G.S. 58-19-15, and which prevents the full understanding of the enterprise risk to the insurer by the affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with Article 30 of this Chapter."

SECTION 1.10. G.S. 58-19-60 reads as rewritten:

"§ 58-19-60. Recovery.

(a) If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under such order has a right to recover on behalf of the insurer, (i) from any parent corporation or insurance holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions (other than distributions of shares of the same class of stock) paid by the insurer on its capital stock, or (ii) any payment in the form of a bonus, termination settlement, or extraordinary lump sum salary adjustment made by the insurer or its subsidiary or subsidiaries to a director, officer, or employee, where the distribution or payment pursuant to (i) or (ii) above is made at any time during the one year preceding the petition for liquidation or rehabilitation, as the case may be, subject to the limitations of subsections (b), (c), and (d) of this section.

(b) No such distribution is recoverable if the parent or affiliate shows that when paid such distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that such distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(c) Any person that was a parent corporation or insurance holding company or a person that otherwise controlled the insurer or affiliate at the time such distributions were paid is liable up to the amount of distributions or payments under subsection (a) of this section such person received. Any person who otherwise controlled the insurer at the time such distributions were declared is liable up to the amount of distributions he would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

(d) The maximum amount recoverable under this section is the amount needed in excess of all other available assets of the insurer to pay its contractual obligations and to reimburse any guaranty funds.

(e) To the extent that any person liable under subsection (c) of this section is insolvent or otherwise fails to pay claims due from it pursuant to that subsection, its parent corporation, insurance holding company, or person who otherwise controlled it at the time that the distribution was paid, are jointly and severally liable for any resulting deficiency in the amount recovered from such parent corporation or insurance holding company or person who otherwise controlled it."

SECTION 1.11. Article 19 of Chapter 58 of the General Statutes is amended by adding four new sections to read:

"**§ 58-19-75. Forms – general requirements.**

(a) Forms A, B, C, D, E, and F are intended to be guides in the preparation of the statements required by G.S. 58-19-15, 58-19-25, and 58-19-30. They are not intended to be fill-in-the-blank forms. The statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted, provided the answers are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer to the item is in the negative, an appropriate statement to that effect shall be made.

(b) A complete copy of each statement, including exhibits and all other papers and documents filed as a part of the statement, shall be filed with the Commissioner by personal delivery or mail addressed to the Commissioner and shall be signed in the manner prescribed on the form. Unsigned copies shall be conformed. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of the power of attorney or other authority shall also be filed with the statement.

(c) If an applicant requests a hearing on a consolidated basis under G.S. 58-19-15, in addition to filing the Form A with the Commissioner, the applicant shall file a copy of the Form A with the NAIC in electronic form.

(d) Statements should be prepared electronically. Statements shall be easily readable and suitable for review and reproduction. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United

States dollars. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency normally shall be converted into United States dollars.

"§ 58-19-80. Forms – incorporation by reference, summaries and omissions.

(a) Information required by any item of Form A, Form B, Form D, Form E, or Form F may be incorporated by reference in answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference in answer or partial answer to any item of Form A, Form B, Form D, Form E, or Form F provided the document is filed as an exhibit to the statement. Excerpts of documents may be filed as exhibits if the documents are extensive. Documents currently on file with the Commissioner which were filed within three years need not be attached as exhibits. References to information contained in exhibits or in documents already on file shall clearly identify the material and shall specifically indicate that such material is to be incorporated by reference in answer to the item. Such materials shall not be incorporated by reference in any case where the incorporation would render the statement incomplete, unclear, or confusing.

(b) Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the pertinent provisions of the document. In addition to the statement, the summary or outline must incorporate by reference particular parts of any exhibit or document currently on file with the Commissioner which was filed within three years and may be qualified in its entirety by such reference. In any case where two or more documents required to be filed as exhibits are substantially identical in all material respects except as to the parties thereto, the dates of execution, or other details, a copy of only one of the documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which those documents differ from the documents, a copy of which is filed.

"§ 58-19-85. Forms – information unknown or unavailable and extension of time to furnish.

If it is impractical to furnish any required information, document, or report at the time it is required to be filed, there shall be filed with the Commissioner a separate document:

(1) Identifying the information, document, or report in question.
(2) Stating why the filing thereof at the time required is impractical.
(3) Requesting an extension of time for filing the information, document, or report to a specified date. The request for extension shall be deemed granted unless the Commissioner after receipt of the request denies the request prior to the time the information, document, or report is required.

"§ 58-19-90. Forms – additional information and exhibits.

In addition to the information expressly required to be included in Form A, Form B, Form C, Form D, Form E, and Form F, the Commissioner may request such further material information, if any, as may be necessary to make the information contained therein not misleading. The person filing may also file such exhibits as it may desire in addition to those expressly required by the statement. The exhibits shall be so marked as to indicate clearly the subject matters to which they refer. Changes to Form A, B, C, D, or F shall include on the top of the cover page the phrase: "Change No. [insert number] to" and shall indicate the date of the change and not the date of the original filing."

SECTION 1.12. G.S. 58-10-12(e) reads as rewritten:

"(e) Except as specifically provided in a plan of conversion, for five years following the effective date of the conversion, no person or persons acting in concert (other than the former mutual, any parent company, or any employee benefit plans or trusts sponsored by the former mutual or a parent company) shall directly or indirectly acquire, or agree or offer to acquire, in any manner the beneficial ownership of five percent (5%) or more of the outstanding shares of any class of a voting security of the former mutual or any parent company without the prior approval of the Commissioner of a statement filed by that person with the Commissioner. The statement shall contain the information required by ~~G.S. 58-19-15(b)~~G.S. 58-19-15(g) and any other information required by the Commissioner. The Commissioner shall not approve an acquisition under this subsection unless the Commissioner finds that:

(1) ~~The requirements of G.S. 58-19-15(e) will be satisfied.~~None of the conditions set forth in G.S. 58-19-15(i) will exist.

(2) The acquisition will not ~~frustrate~~ impede the plan of conversion or the amendment to the articles of incorporation as approved by the members and the Commissioner.

(3) The boards of directors of the former mutual and any parent company have approved the acquisition.

(4) The acquisition would be in the best interest of the present and future policyholders of the former mutual without regard to any interest of policyholders as shareholders of the former mutual or any parent company."

PART II. REVISIONS TO RISK-BASED CAPITAL REQUIREMENTS FOR LIFE INSURERS

SECTION 2. G.S. 58-12-11(a) reads as rewritten:

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

(1) The filing of a risk-based capital report by an insurer that indicates ~~that:~~any of the following:

a. The insurer's total adjusted capital is greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based ~~capital; or~~capital.

b. In the case of a life or health insurer, the insurer has total adjusted capital that (i) is greater than or equal to its company action level risk-based capital but less than ~~the product of~~three times its authorized control level risk-based ~~capital and 2.5~~capital and (ii) has a negative ~~trend; or~~trend.

c. In the case of a property or casualty insurer or a health organization, the insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty or health organization risk-based capital instructions.

…."

PART III. UPDATE CORPORATE GOVERNANCE REQUIREMENTS FOR RISK RETENTION GROUPS

SECTION 3. G.S. 58-22-15 reads as rewritten:

"**§ 58-22-15. Risk retention groups chartered in this State.**

(a) General Requirements. – A risk retention group shall, pursuant to the provisions of Part 9 of Article 10 of this Chapter, be chartered and licensed to write only liability insurance pursuant to this Article and, except as provided elsewhere in this Article, must comply with all of the laws and rules applicable to such insurers chartered and licensed in this State and with G.S. 58-22-20 to the extent such requirements are not a limitation on laws, administrative rules, or requirements of this State.

(b) Plan of Operation. – Before it may offer insurance in any state, each risk retention group shall also submit for approval to the Commissioner of this State a plan of operation or feasibility study. The Commissioner may limit the net amount of risk retained by a risk retention group for any individual risk. The risk retention group shall submit an appropriate revision in the event of any subsequent material change in any item of the plan of operation or feasibility study, within 10 days after any such change. The group shall not offer any additional kinds of liability insurance, in this State or in any other state, until a revision of such plan or study is approved by the Commissioner.

(c) Required Information. – At the time of filing its application for a charter, the risk retention group shall provide to the Commissioner in summary form the following information: the identity of the initial members of the group, the identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group, the amount and nature of initial capitalization, the coverages to be afforded, and the states in which the group intends to operate. Upon receipt of this information, the Commissioner shall forward such information to the NAIC. Providing notification to the NAIC is in addition to and shall not be sufficient to satisfy the requirements of G.S. 58-22-20 or any other sections of this Article.

(d) Governance Standards. – Risk retention groups shall comply with the following governance standards:

(1) Board of directors. – The following standards apply to the board of directors of the risk retention group:

a. Definitions. – The following definitions apply in this subdivision:

1. Board of directors or board. – The governing body of the risk retention group elected by the shareholders or members to establish policy, elect or appoint officers and committees, and make other governing decisions.

2. Director. – A natural person designated in the articles of the risk retention group, or designated, elected, or appointed by any other manner, name, or title to act as a director.

b. Independent directors. – The board of directors of the risk retention group shall have a majority of independent directors. If the risk retention group is a reciprocal, then the attorney-in-fact would be required to adhere to the same standards regarding independence of operation and governance as imposed on the risk retention group's board of directors or subscribers advisory committee under these standards; and, to the extent permissible under State law, service providers of a reciprocal risk retention group should contract with the risk retention group and not the attorney-in-fact.

c. Determination of independence. – No director qualifies as independent unless the board of directors affirmatively determines that the director has no material relationship, as partially specified in sub-subdivision d. of this subdivision, with the risk retention group. Each risk retention group shall disclose these determinations to the Commissioner at least annually. For the purpose of this subdivision, any person that is a direct or indirect owner of or subscriber in the risk retention group (or is an officer, director, or employee of such an owner and insured, unless some other position of such officer, director, or employee constitutes a material relationship), as contemplated by Section 3901(a)(4)(E)(ii) of the federal Liability Risk Retention Act, is considered to be "independent."

d. Material relationship. – "Material relationship" of a person with the risk retention group includes, but is not limited to, the following:

1. The receipt in any one 12-month period of compensation or payment of any other item of value by such person, a member of such person's immediate family, or any business with which such person is affiliated from the risk retention group or a consultant or service provider to the risk retention group is greater than or equal to five percent (5%) of the risk retention group's gross written premium for such 12-month period or two percent (2%) of its surplus, whichever is greater, as measured at the end of any fiscal quarter falling in such a 12-month period. Such person or immediate family member of such person is not independent until one year after his/her compensation from the risk retention group falls below the threshold.
2. A relationship with an auditor as follows: a director or an immediate family member of a director who is affiliated with or employed in a professional capacity by a present or former internal or external auditor of the risk retention group is not independent until one year after the end of the affiliation, employment, or auditing relationship.
3. A relationship with a related entity as follows: a director or immediate family member of a director who is employed as an executive officer of another company where any of the risk retention group's present executives serve on that other company's board of directors is not independent until one year after the end of such service or the employment relationship.

(2) Service provider contracts. – The term of any material service provider contract with the risk retention group shall not exceed five years. Any such contract, or its renewal, shall require the approval of the majority of the risk retention group's independent directors. The risk retention group's board of directors shall have the right to terminate any service provider, audit, or actuarial contracts at any time for cause after providing adequate notice as defined in the contract. The service provider contract is deemed material if the amount to be paid for such contract is more than or equal to the greater of five percent (5%) of the risk retention group's annual gross written premium or two percent (2%) of its surplus.

a. For purposes of this standard, "service providers" shall include captive managers, auditors, accountants, actuaries, investment advisors, lawyers, managing general underwriters, or other party responsible for underwriting, determination of rates, collection of premium, adjusting and settling claims, or the preparation of financial statements. Any reference to "lawyers" in the prior sentence of this sub-subdivision does not include defense counsel retained by the risk retention group to defend claims, unless the amount of fees paid to such lawyers are "material" under the standard set forth in this subdivision for a service provider contract.

b. No service provider contract shall be entered into with a person meeting the definition of "material relationship" contained in sub-subdivision (1)d. of this subsection unless the risk retention group has notified the Commissioner in writing of its intention to enter into such transaction at least 30 days prior thereto and the Commissioner has not disapproved it within such period.

(3) Written policy. – The risk retention group's board of directors shall adopt a written policy in the plan of operation as approved by the board that requires the board to do all of the following:

a. Assure that all owner/insureds of the risk retention group receive evidence of ownership interest.

b. Develop a set of governance standards applicable to the risk retention group.

c. Oversee the evaluation of the risk retention group's management including, but not limited to, the performance of the captive manager, managing general underwriter, or other party or parties responsible for underwriting, determination of rates, collection of premium, adjusting or settling claims, or the preparation of financial statements.

d. Review and approve the amount to be paid for all material service providers.

e. Review and approve, at least annually, all of the following:

1. Risk retention group's goals and objectives relevant to the compensation of officers and service providers.

2. The officers' and service providers' performance in light of those goals and objectives.

3. The continued engagement of the officers and material service providers.

(4) Governance standards. – The board of directors shall adopt and disclose governance standards. For purposes of this subdivision, "disclose" means making such information available through electronic or other means, such as posting on the risk retention group's Web site, and providing such information to members or insureds upon request. The standards to be disclosed shall include all of the following:

a. A process by which the directors are elected by the owner/insureds.

b. Director qualification standards.

c. Director responsibilities.

d. Director access to management and, as necessary and appropriate, independent advisors.

e. Director compensation.

f. Director orientation and continuing education.

g. The policies and procedures that are followed for management succession.

h. The policies and procedures that are followed for annual performance evaluation of the board.

(5) Business conduct and ethics. – The board of directors shall adopt and disclose a code of business conduct and ethics for directors, officers, and employees and promptly disclose to the board of directors any waivers of the code for directors or executive officers. The code of business conduct and ethics shall include the following topics:

a. Conflicts of interest.

b. Matters covered under the corporate opportunities doctrine as that doctrine has been interpreted by the courts of this State.

c. Confidentiality.

d. Fair dealing.

e. Protection and proper use of risk retention group assets.

f. Duty of compliance with all applicable laws, rules, and regulations.

g. A requirement to report any illegal or unethical behavior which affects the operation of the risk retention group.

(6) Reporting noncompliance. – The captive manager or the president or chief executive officer of the risk retention group shall promptly notify the Commissioner in writing if either becomes aware of any material noncompliance with the governance standards set forth in this subsection."

PART IV. EFFECTIVE DATE

SECTION 4. Section 2 of this act becomes effective January 1, 2017. The remainder of this act becomes effective July 1, 2015.

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

INSURANCE COMMITTEE REPORT
Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL

HB **163** Captive Insurance Amendments.

Draft Number:	H163-PCS10337-TU-6
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Tine

HB **288** Insurance Technical Changes.-AB

Draft Number:	H288-PCS20284-TU-5
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes
Floor Manager:	Setzer

TOTAL REPORTED: 2

EXHIBIT 14

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

INSURANCE COMMITTEE REPORT
Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

HB **287** Amend Insurance Laws.-AB

Draft Number:	H287-PCS30303-RG-2
Serial Referral:	None
Recommended Referral:	**APPROPRIATIONS**
Long Title Amended:	Yes
Floor Manager:	Setzer

TOTAL REPORTED: 1

CMR140-V-1

Corrected #1: H646 Removed. H147, H148, H361, H496 and H809 Added

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Tuesday, April 21, 2015
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 182	Property Insurance Fairness.	Representative Millis Representative Lewis Representative Hager
HB 262	Surplus Lines Amendments.	Representative Pendleton Representative Tine Representative Setzer
HB 306	NC Cancer Treatment Fairness.	Representative Lewis Representative L. Hall Representative Avila Representative Lambeth
HB 528	Establish Chiropractor Co-Pay Parity.	Representative Burr Representative Jones Representative Hanes
HB 667	StudyAthletic Trainer/Health Coverage Option.	Representative Hager Representative Dobson
HB 683	Occup. Therapy/Choice of Provider.	Representative Avila Representative Blackwell Representative Hurley Representative Holley
HB 361	Principle-Based Reserving/Revise Ins. Laws.	Representative Collins Representative Tine Representative Setzer
HB 496	Surcharge Transparency.	Representative Collins Representative Cleveland Representative Jordan Representative Baskerville
HB 148	Insurance Required for Mopeds.	Representative Shepard Representative R. Brown

		Representative Waddell
		Representative Adams
HB 809	Third-Party Premium Payments.	Representative Avila
		Representative Lewis
		Representative Collins
		Representative Setzer
HB 147	Update Fire and Rescue Comm'n. Membership.	Representative Ross
		Representative Saine
		Representative Boles
		Representative J. Bell

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 3:26 PM on Wednesday, October 07, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margie Penven (Committee Assistant)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Tuesday, April 21, 2015
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**

The following bills will be considered:

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HB 182	Property Insurance Fairness.	Representative Millis Representative Lewis Representative Hager
HB 262	Surplus Lines Amendments.	Representative Pendleton Representative Tine Representative Setzer
HB 306	NC Cancer Treatment Fairness.	Representative Lewis Representative L. Hall Representative Avila Representative Lambeth
HB 528	Establish Chiropractor Co-Pay Parity.	Representative Burr Representative Jones Representative Hanes
HB 646	Insurance Coverage for Autism Treatment.	Representative McGrady Representative Hager Representative Jeter Representative Jackson
HB 667	Athletic Trainer/Health Coverage Option.	Representative Hager Representative Dobson
HB 683	Occup. Therapy/Choice of Provider.	Representative Avila Representative Blackwell Representative Hurley Representative Holley

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 11:49 AM on Wednesday, April 15, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margaret Herring (Committee Assistant)

House Committee on Insurance
Tuesday, April 21, 2015, 1:00 PM
1228/1327 Legislative Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 306	NC Cancer Treatment Fairness.	Representative Lewis Representative L. Hall Representative Avila Representative Lambeth
HB 667	StudyAthletic Trainer/Health Coverage Option.	Representative Hager Representative Dobson
HB 262	Surplus Lines Amendments.	Representative Pendleton Representative Tine Representative Setzer
HB 809	Third-Party Premium Payments.	Representative Avila Representative Lewis Representative Collins Representative Setzer
HB 683	Occup. Therapy/Choice of Provider.	Representative Avila Representative Blackwell Representative Hurley Representative Holley
HB 147	Update Fire and Rescue Comm'n. Membership.	Representative Ross Representative Saine Representative Boles Representative J. Bell
HB 148	Insurance Required for Mopeds.	Representative Shepard Representative R. Brown Representative Waddell Representative Adams
HB 528	Establish Chiropractor Co-Pay Parity.	Representative Burr Representative Jones Representative Hanes
HB 496	Surcharge Transparency.	Representative Collins Representative Cleveland Representative Jordan Representative Baskerville
HB 361	Principle-Based Reserving/Revise Ins.	Representative Collins

	Laws.	Representative Tine Representative Setzer
HB 182	Property Insurance Fairness.	Representative Millis Representative Lewis Representative Hager

Presentations

Other Business

Adjournment

House Committee on Insurance
Tuesday, April 21, 2015 at 1:00 PM
Room 1228/1327 of the Legislative Building

MINUTES

The House Committee on Insurance met at 1:00 PM on April 21, 2015 in Room 1228/1327 of the Legislative Building. Representatives Arp, Baskerville, Boles, Brawley, Bumgardner, Burr, Collins, Dobson, Dollar, Earle, Gill, C. Graham, D. Hall, Hamilton, Hanes, Hastings, Horn, Howard, Iler, Insko, Jackson, Lambeth, Langdon, Lucas, McElraft, Pendleton, Pierce, Setzer, Shepard, Tine, Warren, and Wray attended.

Representative Mitchell S. Setzer, Chair, presided. The Visitor Registration is attached as Exhibit 1. A list of Assistant Sergeants-at-Arms serving the committee is attached as Exhibit 2. A list of Pages serving the committee is attached as Exhibit 3.

The following bills were on the agenda:
HB 306 NC Cancer Treatment Fairness. (Representatives Lewis, L. Hall, Avila, Lambeth)
HB 667 StudyAthletic Trainer/Health Coverage Option. (Representatives Hager, Dobson)
HB 262 Surplus Lines Amendments. (Representatives Pendleton, Tine, Setzer)
HB 809 Third-Party Premium Payments. (Representatives Avila, Lewis, Collins, Setzer)
HB 683 Occup. Therapy/Choice of Provider. (Representatives Avila, Blackwell, Hurley, Holley)
HB 147 Update Fire and Rescue Comm'n. Membership. (Representatives Ross, Saine, Boles, J. Bell)
HB 148 Insurance Required for Mopeds. (Representatives Shepard, R. Brown, Waddell, Adams)
HB 528 Establish Chiropractor Co-Pay Parity. (Representatives Burr, Jones, Hanes)
HB 496 Surcharge Transparency. (Representatives Collins, Cleveland, Jordan, Baskerville)
HB 361 Principle-Based Reserving. (Representatives Collins, Tine, Setzer)
HB 182 Property Insurance Fairness. (Representatives Millis, Lewis, Hager)

The first bill to be considered was HB 306, NC CANCER TREATMENT FAIRNESS. Representative David Lewis was recognized to present the bill. There was no discussion. Representative Howard made a motion for a favorable report for the bill. The motion carried and the bill received a favorable report. A copy of the Bill Summary is attached as Exhibit 4. A copy of the bill is attached as Exhibit 5.

The second bill to be considered was HB 809, THIRD-PARTY PREMIUM PAYMENTS. Representative Howard moved that a proposed committee substitute (PCS) for HB809 be brought before the Committee for consideration. The motion carried and Representative Avila was recognized to explain the PCS for HB 809. Discussion included questions answered from LaVarne Burton with the American Kidney Fund and a statement from Mark Fleming with Blue Cross Blue Shield. Representative Dollar made a motion for a favorable report for the PCS for

H809. The motion carried for a favorable report. A copy of the PCS is attached as Exhibit 6. A copy of the Bill Summary is attached as Exhibit 7. The original bill is attached as Exhibit 8.

Representative Dollar moved that a proposed committee substitute (PCS) for HB 667, STUDY ATHLETIC TRAINER/HEALTH COVERAGE OPTION be brought before the committee for consideration. The motion carried and Representative Hager explained the PCS for HB 667. There was no discussion. Representative Howard made a motion for a favorable report for the PCS for H667. The motion carried for a favorable report. The PCS is attached as Exhibit 9. The Bill Summary is attached as Exhibit 10. The original bill is attached as Exhibit 11.

Representative Ross was recognized to explain HB 147, UPDATE FIRE AND RESCUE COMM'N. MEMBERSHIP. There was no discussion. Representative Horn moved to give the bill a favorable report. The motion carried. The Bill Summary is attached as Exhibit 12. The original bill is attached as Exhibit 13.

Representative Howard moved that a proposed committee substitute (PCS) for HB 262, SURPLUS LINES AMENDMENTS be brought before the Committee for consideration. The motion carried and Representative Pendleton was recognized to explain the bill. Representative Pendleton moved to have an amendment before the committee. The motion carried. The original Amendment is attached as Exhibit 14. Representative Collins moved for the adoption and to give a favorable report to the Amendment. The motion carried. The PCS is attached as Exhibit 15. The Bill Summary is attached as Exhibit 16. The original bill is attached as Exhibit 17.

Representative Avila was recognized to explain HB 683, OCCUP. THERAPY/CHOICE OF PROVIDER. There was brief discussion, after which Representative Warren made a motion for a favorable report for the bill. The motion carried and the bill received a favorable report. The Bill Summary is attached as Exhibit 18. The original bill is attached as Exhibit 19.

Representatives Shepherd, Brown and Adams were recognized to explain HB 148, INSURANCE REQUIRED FOR MOPEDS. The Bill Summary is attached as Exhibit 20. The original bill is attached as Exhibit 21

Representative Setzer recessed the meeting at 2:00 PM to reconvene 15 minutes after session.

Due to the length of Session Chairman Setzer adjourned the meeting at the end of Session to reconvene April 28, 2015 at 1:00 PM.

Mitchell S. Setzer

Representative Mitchell S. Setzer, Chair
Presiding

Margaret Herring

Margaret Herring, Committee Clerk

Exhibit 1

VISITOR REGISTRATION SHEET

House Comm. on Insurance 04/21/15

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Edna Williams	North Carolina Assn. of REALTORS RE/MAX Advantage Raleigh NC
Patrice Willetts	NC Association of Realtors The Property Shop - Wilm. NC
Lori Ann Harris	LAHA
Andy Chase	KMA
David Ferrell	VB
Amy Fulk	30 PR
Kevin Mentz	Fresenius Medical Care
Tim Bradley	NCSFA
Deb Clan	NCSP-NCCFA
Alison Rooks	NCDMV
Kelly Thomas	DMV

VISITOR REGISTRATION SHEET

House Comm. on Insurance 04/21/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	[illegible]
Robert Paschal	Young Moore
Edith Davis	NC Reinsurance Facility
Ray Evans	NCRB
Russ Dubisky	IFNC
David Stoller	State Farmer
Mark Mansfield	NC Association of Realtors
Cirila Cothran	NC Assoc of Realtors
Sonny Watts	TWL GRP
Debbie Ragan	NC Physical Therapy Association
Flint Benson	SEANC
[illegible]	CSS

VISITOR REGISTRATION SHEET

House Comm. on Insurance 04/21/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tamera Ruggiero	American Kidney Fund
Eric Dolby	American Kidney Fund Volunteer
LaVarne Burton	American Kidney Fund
Jason Harloff	NC Physical Therapy Assoc.
Mary Kay Hannah	NC Physical Therapy Association
Bob Mack	NCDOI
Fred Fuller	NCDOI
Roger Langley	Regulatory & Corp Services, Ltd
Bill Robinson	
Dan Simpson	SA
Jennifer McMullen	DaVita

VISITOR REGISTRATION SHEET

House Comm. on Insurance 04/21/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cameron Hardy	MLH
David Ward	MiCare
Kathy [illegible]	[illegible]

VISITOR REGISTRATION SHEET

House Comm. on Insurance 04/21/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John McMillan	MF+S
Michelle Frazier	NF+S
[illegible]	NMRS
Michael Davenport	REALTOR
Willo Kelly	REALTOR
AARON PRice	NPAF
Don [illegible] Coord. volunteers	NPAF
Nathan [illegible]	NPAF
Sr. manager volunteers - field Operations Jenna Adkins	National Patient Advocate Founda.
Austin Pruitt	Perkinson Law
JULIAN PHILPOTT	NC FARM BUREAU

VISITOR REGISTRATION SHEET

House Comm. on Insurance 04/21/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Susan Valauri	Nationwide
Tom Fetzer	FSP
William H. McBride	Hunton & Williams LLP Raleigh NC
Angel Sams	WCSR
lauradevin	.wcsr
Dr. Joe Siragusa	NC Chiropractic Assoc.
Kyle Kaylor	Kaylor Law Firm
David Liggett	[illegible]
G. Stephen Allen	N.C. Surplus Lines Assoc
Glenn Jernigan	Integon Ins
Joyce Peterson	CSS

VISITOR REGISTRATION SHEET

House Comm. on Insurance 04/21/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Christine Weason	ACS CAN
Benyam Mulurch	NCOP / UNC IX
Ben Popkin	NCDOI
BEN DOVER	NCDOJ
Jean Halliday	NCDOI
[illegible]	UNC Sch Govt
Mike Strickland	N.C. Rate Bureau - counsel
Chris McClure	BP
ART LYON	NATIONAL GENERAL
Gregg Thompson	NFIB
[illegible]	NCAHP
[illegible]	CSS

VISITOR REGISTRATION SHEET

House Comm. on Insurance 04/21/15
Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Marty Bocock	Prime Therapeutics
[illegible]	MWC
Heather Jarman	BASE
Sarah Wolfe	MWC
Bryan Schwartz	BCBSNC

Exhibit 2

Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Insurance

DATE: 04/21/15 Room: 1228

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name:
5. Name:

Senate Sgt-At Arms:

1. Name:
2. Name:
3. Name:
4. Name:
5. Name:

Exhibit 3

Pages

Tuesday, April 21 INSURANCE | **Room** 1228/1327 | **Time** 1:00 pm

Name	County	Sponsor
Jacob Johnson	Haywood	Joe Sam Queen
Byrde Wells Jr.	Dare	Paul Tine

(Bird

Exhibit 4

HOUSE BILL 306:
NC Cancer Treatment Fairness

2013-2014 General Assembly

Committee:	House Insurance	**Date:**	April 21, 2015
Introduced by:	Reps. Lewis, L. Hall, Avila, Lambeth	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	First Edition		

***SUMMARY:** House Bill 306 requires health benefit plans that provide coverage for prescribed orally administered cancer drugs to provide coverage for the prescribed, oral anticancer drugs in a manner no less favorable from IV or injectable anticancer drugs. Oral cancer drugs may not be subject to prior authorization, deductibles, coinsurance, or other out-of-pocket expense that does not apply to IV or injectable drugs. A health benefit plan may not comply with the law by reclassifying anticancer drugs or by increasing patient cost-sharing.*

[As introduced, this bill was identical to S390, as introduced by Sens. Tarte, Hise, which is currently in Rules and Operations of the Senate.]

BILL ANALYSIS:

House Bill 306 would require health benefit plans that provide coverage for prescribed, orally administrated to provide coverage for those prescribed, orally administrated anticancer drugs on a basis no less favorable than that which is provided for intravenously administered (I/V) or injected anticancer drugs. Additionally, coverage for the orally administered anticancer drugs could not be required to be subject to any prior authorization, dollar limit, co-payment, coinsurance, or deductible provision, or to any other out-of pocket expense that does not also apply to I/V or injectable cancer drugs.

House Bill 306 would prohibit a health benefit plan from achieving compliance with the law by reclassifying anticancer drugs or increases patient cost-sharing. Any change in a policy, contract, or plan that would increase the insured's out-of-pocket expense must also be applied to the majority of comparable medical or pharmaceutical benefits covered by the plan.

EFFECTIVE DATE: The bill is effective January 1, 2016, and applies to insurance contracts issued, renewed, or amended on or after that date. The act will not become effective if the act is determined by the federal government to create a state-required benefit that is in excess of the essential health benefits.

Exhibit 5

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 1

HOUSE BILL 306

Short Title: NC Cancer Treatment Fairness. (Public)

Sponsors: Representatives Lewis, L. Hall, Avila, and Lambeth (Primary Sponsors).
For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.

Referred to: Insurance.

March 19, 2015

A BILL TO BE ENTITLED

AN ACT RELATING TO HEALTH BENEFIT PLAN COVERAGE FOR ORALLY ADMINISTERED ANTICANCER DRUGS.

Whereas, advances in medical research have led to significant new developments of various medical treatments; and

Whereas, these treatments offer patients a wide range of new choices to combat very serious diseases; and

Whereas, the area of cancer treatment has been one of the fields that has seen these significant new medical advancements; and

Whereas, in recent years, oral chemotherapy treatments have been developed that provide viable alternatives to traditional intravenous cancer treatments for patients; and

Whereas, this oral chemotherapy treatment offers the treating physician and the patient a choice in relation to treatment options; and

Whereas, this choice is sometimes limited as the oral chemotherapy treatments are in most cases covered under the prescription drug benefit of an insurance plan rather than under the major medical insurance benefit of an insurance plan; and

Whereas, this discrepancy in coverage can limit a patient's ability to choose the oral chemotherapy treatment because of the cost associated with the disparate treatment; Now, therefore,

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 as follows:

"**§ 58-3-282. Coverage for orally administered anticancer drugs.**

(a) Every health benefit plan offered by an insurer, as defined in G.S. 58-3-167(a), that provides coverage for prescribed, orally administered anticancer drugs that are used to kill or slow the growth of cancerous cells and that provides coverage for intravenously administered or injected anticancer drugs shall provide coverage for prescribed, orally administered anticancer drugs on a basis no less favorable than the coverage the policy, contract, or plan provides for the intravenously administered or injected anticancer drugs.

(b) Coverage for orally administered anticancer drugs shall not be subject to any prior authorization, dollar limit, co-payment, coinsurance, or deductible provision or to any other out-of-pocket expense that does not apply to intravenously administered or injected anticancer drugs.

(c) A policy, contract, or plan provider shall not achieve compliance with this section by reclassifying anticancer drugs or by increasing patient cost-sharing, including any

<u>coinsurance, co-payment, deductible, or other out-of-pocket expenses imposed on anticancer drugs. Any policy, contract, or plan change that otherwise increases an out-of-pocket expense applied to anticancer drugs must also be applied to the majority of comparable medical or pharmaceutical benefits covered by the policy, contract, or plan.</u>"

SECTION 2. This act becomes effective January 1, 2016, and applies to insurance contracts or policies issued, renewed, or amended on or after that date, but the act shall not become effective if the act is determined by the federal government to create a state-required benefit that is in excess of the essential health benefits pursuant to 45 C.F.R. 155.170(a)(3).

Exhibit 6

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H **D**

HOUSE BILL 809*
PROPOSED COMMITTEE SUBSTITUTE H809-PCS30331-TK-18

Short Title: Third-Party Premium Payments. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO ALLOW THIRD-PARTY PREMIUM PAYMENTS FOR HEALTH BENEFIT PLANS.

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:

"**<u>§ 58-3-305. Third-party premium payments; refusal of acceptance.</u>**

<u>(a) A health benefit plan must accept a premium payment made by a third party to the insurance contract provided the payment is made from or pursuant to a fund or grant established by any of the following:</u>

<u>(1) The Ryan White HIV/AIDS program pursuant to Title XXVI of the Public Health Service Act.</u>

<u>(2) Native American tribes or tribal organizations.</u>

<u>(3) State or federal government programs.</u>

<u>(4) The American Kidney Fund.</u>

<u>(b) Nothing in this section shall be construed to require a health benefit plan to accept a third-party premium payment for a health care provider.</u>

<u>(c) As used in this section, "health benefit plan" is as defined in G.S. 58-3-167(a)(1).</u>"

SECTION 2. This act becomes effective October 1, 2015, and applies to health benefit contracts issued, renewed, or amended on or after that date.

H809-PCS30331-TK-18

Exhibit 7

HOUSE BILL 809:
Third-Party Premium Payments

2015-2016 General Assembly

Committee:	House Insurance	**Date:**	April 21, 2015
Introduced by:	Reps. Avila, Lewis, Collins, Setzer	**Prepared by:**	Amy Jo Johnson
Analysis of:	PCS to First Edition H809-CSTK-18		Committee Counsel

SUMMARY:* *House Bill 809 would require that health benefit plans accept a premium payment made by the following third parties: The Ryan White HIV/AIDS program, Native American tribes or tribal organization, State or federal government programs, and the American Kidney Fund. The PCS makes a technical change.

[As introduced, this bill was identical to S582, as introduced by Sen. Pate, which is currently in Senate Re-ref to Health Care. If fav, re-ref to Insurance.]

CURRENT LAW:

Federal law requires health insurance issuers offering qualified health plans (i.e. plans eligible to be sold on the health benefit exchanges) in the individual market to accept the premium and cost-sharing payments from the following third-party entities on behalf of plan enrollees:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs. 45 C.F.R. 156.1250

BILL ANALYSIS:

House Bill 809 would add the American Kidney Fund to the list of entities from which a health benefit plan must accept a premium payment made on behalf of a plan enrollee. Additionally, the federal law applies only to qualified health plans. House Bill 809 would apply to all health benefit plans regulated by the Chapter 58 of the North Carolina General Statutes.

House Bill 809 specifies that it should be construed to require a health benefit plan to accept a third-party premium payment for a health care provider.

EFFECTIVE DATE: This act becomes effective October 1, 2015, and applies to health benefit contracts issued, renewed, or amended on or after that date.

8

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 1

HOUSE BILL 809*

Short Title: Third-Party Premium Payments. (Public)

Sponsors: Representatives Avila, Lewis, Collins, and Setzer (Primary Sponsors).
For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.

Referred to: Insurance.

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO ALLOW THIRD-PARTY PREMIUM PAYMENTS FOR HEALTH BENEFIT PLANS.

The General Assembly of North Carolina enacts:

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

"**§ 58-3-305. Third-party premium payments; refusal of acceptance.**

(a) A health benefit plan must accept a premium payment made by a third party to the insurance contract provided the payment is made from or pursuant to a fund or grant established by any of the following:

(1) The Ryan White HIV/AIDS program pursuant to Title XXVI of the Public Health Service Act.

(2) Native American tribes or tribal organizations.

(3) State or federal government programs.

(4) The American Kidney Foundation.

(b) Nothing in this section shall be construed to require a health benefit plan to accept a third-party premium payment for a health care provider.

(c) As used in this section, "health benefit plan" is as defined in G.S. 58-3-167(a)(1)."

SECTION 2. This act becomes effective October 1, 2015, and applies to health benefit contracts issued, renewed, or amended on or after that date.

H809-V-1

Exhibit 9

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H **D**

HOUSE BILL 667
PROPOSED COMMITTEE SUBSTITUTE H667-PCS30330-TK-13

Short Title: StudyAthletic Trainer/Health Coverage Option. (Public)

Sponsors:

Referred to:

April 14, 2015

A BILL TO BE ENTITLED

AN ACT TO STUDY WHETHER TO ENSURE THAT PATIENTS HAVE THE OPTION OF SELECTING THEIR ATHLETIC TRAINER UNDER THEIR HEALTH BENEFIT PLAN.

The General Assembly of North Carolina enacts:

SECTION 1. The Legislative Research Commission (LRC) shall study whether to ensure that North Carolina patients have a right to choose their athletic trainer under their health benefit plans. As part of its study, the LRC shall consider whether to add athletic trainers to G.S. 58-50-30.

SECTION 2. The LRC shall report its findings, together with any proposed legislation, to the 2016 Regular Session of the 2015 General Assembly upon its convening.

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

Exhibit 10

HOUSE BILL 667:
Study Athletic Trainer/Health Coverage Option

2013-2014 General Assembly

Committee:	House Insurance	**Date:**	April 21, 2015
Introduced by:	Reps. Hager, Dobson	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	PCS to First Edition H667-CSTK-13		

SUMMARY: The PCS to House Bill 667 would require the Legislative Research Commission to study whether patients should have the option of selecting their athletic trainer under their health benefit plan.

CURRENT LAW: G.S. 58-50-30 lists the various types of health care providers from which a policy holder, insured, or beneficiary ("insured") may choose under a health benefit plan, subscriber contract, or policy of insurance ("policy"). The services must be of a nature that the policy provides coverage of, or payment or reimbursement. If the policy requires use of network providers, the insured must choose a provider of services within the network. If the policy requires use of network providers as a condition of obtaining a higher level of benefits, the insured must choose a provider of services within network in order to obtain the higher level of benefits.

G.S. 58-50-30 also lists the provider types who are able to complete a certification of disability. When a policy provides for a certification of disability that is within the scope of the enumerated providers, the insured is entitled to benefits as long as one of the listed provider types has completed the certification of disability, notwithstanding any provisions contained in the policy. The insured has the right to choose the provider of services.

The provisions of G.S. 58-50-30 are applicable to the State Health Plan pursuant to G.S. 135-48.51.

BILL ANALYSIS:

The PCS would require the Legislative Research Commission (LRC) to study whether to ensure that North Carolina patients have an option to choose their athletic trainer under their health benefit plans. As part of its study, the LRC must consider whether to add athletic trainers to the list of health care providers enumerated in G.S. 58-50-30. The LRC must report its finding and any proposed legislation to the 2016 Regulation Session of the 2015 General Assembly upon its convening.

EFFECTIVE DATE: This act is effective when it becomes law.

Exhibit 11

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H **1**

HOUSE BILL 667

Short Title:	Athletic Trainer/Health Coverage Option.	(Public)
Sponsors:	Representatives Hager and Dobson (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Insurance.	

April 14, 2015

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT PATIENTS HAVE THE OPTION OF SELECTING THEIR ATHLETIC TRAINER UNDER THEIR HEALTH BENEFIT PLAN.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-30(b) reads as rewritten:

"(b) This section applies to the following provider types:

…

(16) An athletic trainer licensed by the North Carolina Board of Athletic Trainer Examiners pursuant to Article 34 of Chapter 90 of the General Statutes."

SECTION 2. This act becomes effective October 1, 2015, and applies to health benefit contracts issued, renewed, or amended on or after that date.

H667-V-1

Exhibit 12

HOUSE BILL 147:
Update Fire and Rescue Comm'n. Membership

2015-2016 General Assembly

Committee:	House Insurance	**Date:**	April 20, 2015
Introduced by:	Reps. Ross, Saine, Boles, J. Bell	**Prepared by:**	Tim Hovis
Analysis of:	First Edition		Committee Counsel

SUMMARY: House Bill 147 makes changes to update the membership of the State and Fire Rescue Commission.

BACKGROUND: The State and Fire Rescue Commission is housed within the Department of Insurance and is charged with adopting a State Fire and Education and Rescue Plan and other plans for rescue services and fire prevention control.

ANALYSIS: Section 1 of the bill amends G.S. 58-78-1 to change the membership of the Commission. Current law provides for 15 voting members of the Commission with 12 members appointed by the Commissioner of Insurance. The bill amends subsection (a) of G.S. 58-78-1 to provide that one of the Commissioner's appointees is to be selected from nominations submitted by the North Carolina Chapter of the International Association of Arson Investigators and deletes language providing for one appointee from nominations submitted by the North Carolina Association of County Fire Marshals.

Section 1 also removes language prohibiting public members of the Commission from being involved in firefighting or rescue services.

Section 2 amends G.S. 58-78-5(a)(14b) to clarify the Commission's powers include the authority to issue, deny, suspend, revoke, or take similar actions regarding certifications issued by the Commission of minimal professional qualifications established under this subdivision.

EFFECTIVE DATE: House Bill 147 would become effective July 1, 2015, and applies to appointments made on or after this date.

*This summary was substantially contributed to by the Legislative Reporting Service of the University of North Carolina School of Government.

Exhibit 13

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H **1**

HOUSE BILL 147

Short Title:	Update Fire and Rescue Comm'n. Membership.	(Public)
Sponsors:	Representatives Ross, Saine, Boles, and J. Bell (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Insurance.	

March 4, 2015

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE MEMBERSHIP OF THE FIRE AND RESCUE COMMISSION TO REFLECT THE MERGER OF TWO ORGANIZATIONS, TO ADD REPRESENTATION FROM THE STATE CHAPTER OF THE INTERNATIONAL ASSOCIATION OF ARSON INVESTIGATORS, AND TO CLARIFY THE POWERS OF THE COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-78-1 reads as rewritten:

"**§ 58-78-1. State Fire and Rescue Commission created; membership.**

(a) There is created the State Fire and Rescue Commission of the Department, which shall be composed of 15 voting members to be appointed as follows:

(1) The Commissioner shall appoint 12 members, two from nominations submitted by the North Carolina State Firemen's Association, one from nominations submitted by the North Carolina Association of Fire Chiefs, one from nominations submitted by the Professional Firefighters of North Carolina Association, one from nominations submitted by the North Carolina Society of Fire Service Instructors, ~~one from nominations submitted by the North Carolina Association of County Fire Marshals,~~ one from nominations submitted by the North Carolina Fire Marshal's Association, two from nominations submitted by the North Carolina Association of Rescue and Emergency Medical Services, Inc., one from nominations submitted by the North Carolina Chapter of the International Association of Arson Investigators, one mayor or other elected city official nominated by the President of the League of Municipalities, one county commissioner nominated by the President of the Association of County Commissioners, and one from the public ~~at large;~~at-large.

(2) The Governor shall appoint one member from the public ~~at large; and~~at large.

(3) The General Assembly shall appoint two members from the public at large, one upon the recommendation of the Speaker of the House of Representatives pursuant to G.S. 120-121, and one upon the recommendation of the President Pro Tempore of the Senate pursuant to G.S. 120-121.

Public members may not be employed in State ~~government and may not be directly involved in fire fighting or rescue services.~~government.

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(b) Of the members initially appointed by the Commissioner, the nominees of the North Carolina State Firemen's Association and the nominees of the North Carolina Association of Fire Chiefs and the nominees of the Professional Firefighters of North Carolina Association and of the North Carolina Association of Rescue and Emergency Medical Services, Inc., shall serve three-year terms; the nominees from the North Carolina Society of Fire Service Instructors, ~~the North Carolina Association of County Fire Marshals,~~ the North Carolina Chapter of the International Association of Arson Investigators and the North Carolina Fire Marshal's Association shall serve two-year terms; and the mayor or other elected city official, the county commissioner, and the member from the public at large shall serve one-year terms. The Governor's initial appointee shall serve a three-year term. The General Assembly's initial appointees shall serve two-year terms. Thereafter all terms shall be for three years.

…."

SECTION 2. G.S. 58-78-5(a)(14b) reads as rewritten:

"(14b) To establish voluntary minimum professional qualifications for all levels of fire service and rescue service ~~personnel;~~personnel, and to issue, deny, suspend, revoke or take similar actions with respect to certifications issued by the Commission of minimum professional qualifications established under this subdivision."

SECTION 3. G.S. 58-78-10 reads as rewritten:

"**§ 58-78-10. State Fire and Rescue Commission – Organization; rules and regulations; meetings.**

(a) Organization. – The Commission shall elect from its voting members a ~~chairman~~ chair and ~~vice-chairman~~vice-chair to serve as provided by the rules adopted by the Commission.

…."

SECTION 4. Section 1 of this act becomes effective July 1, 2015, and applies to State Fire and Rescue Commission appointments made on or after that date. The remainder of this act is effective July 1, 2015.

Exhibit 14

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 262

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

H262-AMH-7 [v.2]

Amends Title [NO]
PCS H262-CSMH-1

Date ________________________,2015

Representative Pendleton

moves to amend the bill on page 2, line 36, by rewriting the lines to read:

"**SECTION 5.** G.S. 58-21-70 reads as rewritten:

"**§ 58-21-70. Surplus lines licensees may accept business from other agents or ~~brokers; countersignatures required; remittance of premium tax.~~brokers.**

(a) A surplus lines licensee may originate surplus lines insurance or accept such insurance from any other duly licensed agent or broker, and the surplus lines licensee may compensate such agent or broker therefor.

~~(b) Every report filed by a nonresident licensee under G.S. 58-21-35(a) shall, before being filed with the Commissioner, be countersigned by a resident licensee or by a regulatory support organization. The resident licensee or regulatory support organization may charge the nonresident licensee a countersignature fee.~~

~~(c) Every resident licensee and regulatory support organization that countersigns a report under subsection (b) of this section is responsible for remitting the premium tax for the coverage, as specified in G.S. 58-21-85, to the Commissioner.~~"".

SIGNED ________________________________
Amendment Sponsor

SIGNED ________________________________
Committee Chair if Senate Committee Amendment

ADOPTED ______________ FAILED ______________ TABLED ______________

H262-AMH-7-V-2

Exhibit 15

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2015

H D

HOUSE BILL 262

PROPOSED COMMITTEE SUBSTITUTE H262-CSMH-1 [v.2]

3/19/2015 3:58:07 PM

Short Title: Surplus Lines Amendments. (Public)

Sponsors:

Referred to:

March 18, 2015

A BILL TO BE ENTITLED

AN ACT TO MODERNIZE THE SURPLUS LINES ACT BY INCLUDING ALIEN INSURERS IN THE DEFINITION OF AN ELIGIBLE SURPLUS LINES INSURER, BY REPEALING COUNTERSIGNING REQUIREMENTS, AND BY PROVIDING GREATER FLEXIBILITY FOR THE MANNER OF COLLECTION AND REFUND OF THE SURPLUS LINES TAX.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-21-10(3) reads as rewritten:

"(3) "Eligible surplus lines insurer" means <u>an alien insurer as defined in G.S. 58-21-17 or</u> a nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance under G.S. 58-21-20."

SECTION 2. G.S. 58-21-35(a) reads as rewritten:

"(a) Within 30 days after the placing of any surplus lines insurance, the surplus lines licensee shall file with the Commissioner<u> or the stamping office, as appropriate,</u> 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 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."

SECTION 3. G.S. 58-21-40 reads as rewritten:

"§ 58-21-40. Surplus lines regulatory support organization.

(a) A surplus lines regulatory support organization of surplus lines licensees shall be formed ~~to:~~<u>carry out the following functions:</u>

(1) Facilitate and encourage compliance by resident and nonresident surplus lines licensees with the laws of this State and the rules and regulations of the Commissioner relative to surplus lines ~~insurance;~~<u>insurance.</u>

H262-CSMH-1-V-2

(2) Communicate with organizations of admitted insurers with respect to the proper use of the surplus lines ~~market;~~market.

(3) Receive and disseminate to surplus lines licensees information about surplus lines insurance, including, without limitation, new electronic filing procedures approved by the Commissioner, changes in the list of eligible surplus lines insurers, and modifications in coverages, procedures, and requirements as may be requested by the ~~Commissioner; and~~Commissioner.

(4) ~~Countersign nonresident produced surplus lines coverages and remit premium taxes for those coverages under G.S. 58-21-70 by means satisfactory to the Commissioner; and charge the nonresident surplus lines licensee a fee for the certification and countersignature as approved by the Commissioner.~~Establish a stamping office to process all surplus lines insurance and remit premium taxes for those coverages under G.S. 58-21-85 by means satisfactory to the Commissioner, and charge surplus lines licensees a fee for such processing.

…

(d) Each ~~resident~~ surplus lines licensee shall maintain active membership in a regulatory support organization as a condition of continued licensure under this Article."

SECTION 4. G.S. 58-21-65(c) reads as rewritten:

"§ 58-21-65. Licensing of surplus lines licensee.

…

(c) Corporations shall be eligible to be ~~resident~~ surplus lines licensees, upon the following conditions:

(1) The corporate licensee shall list individuals within the corporation who have satisfied all requirements of this Article to become surplus lines licensees; and

(2) Only those individuals listed on the corporate license and who are surplus lines licensees shall transact surplus lines business.

…

(e) Any person who does not renew a surplus lines license and applies for another surplus lines license more than two years after the expiration date of the previous license shall be required to satisfy every condition in this section, including the written exam, before the Commissioner issues another surplus lines license to that person. ~~Nonresident surplus lines licensees shall be licensed in accordance with Article 33 of this Chapter.~~

…."

SECTION 5. G.S. 58-21-70(b) and (c) are repealed.

SECTION 6. G.S. 58-21-85 reads as rewritten:

"§ 58-21-85. Surplus lines tax.

(a) Gross premiums charged, less any return premiums, for surplus lines insurance on insureds for whom North Carolina is the home state are subject to a premium receipts tax of five percent (5%), which shall be collected ~~by the surplus lines licensee as specified~~ in a manner approved by the Commissioner, in addition to the full amount of the gross premium charged by the insurer for the insurance. The tax on any portion of the premium unearned at termination of insurance having been credited by the State to the licensee shall be returned to the policyholder ~~directly by the surplus lines licensee or through the producing broker, if any.~~directly. The surplus lines licensee is prohibited from absorbing such tax and from rebating for any reason, any part of such tax. To the extent that other states in which portions of the properties, risks, or exposures reside have failed to enter into a compact or reciprocal allocation procedure with this State, the premium tax collected shall be retained by this State.

~~(b) At the same time that he files his quarterly report as set forth in G.S. 58-21-80, each surplus lines licensee shall pay the premium receipts tax due for the period covered by the report.~~

…."

SECTION 7. This act is effective when it becomes law.

Exhibit 16

HOUSE BILL 262:
Surplus Lines Amendments

2015-2016 General Assembly

Committee:	House Insurance	**Date:**	April 19, 2015
Introduced by:	Reps. Pendleton, Tine, Setzer	**Prepared by:**	Tim Hovis
Analysis of:	PCS to First Edition		Committee Counsel
	H262-CSMH-1		

SUMMARY: ***The proposed committee substitute for House Bill 262 would make changes to the Surplus Lines Act, Article 21 of Chapter 58 of the General Statutes.***

BILL ANALYSIS: Section 1 amends the definition of "eligible surplus lines insurer" to include an "alien insurer." An alien insurer is an insurer domiciled outside the United States and listed by the National Association of Insurance Commissioners.

Sections 2 and 3 allow a surplus lines insurer to file with the appropriate stamping office, in addition to filing relevant information with the Commissioner. A stamping office would be established by a surplus lines regulatory support organization for the purpose of remitting premium taxes in a means satisfactory to the Commissioner.

Section 4 deletes the requirement that nonresident surplus lines licensees be licensed under Article 33 of Chapter 58, Licensing of Agents, Brokers, Limited Representatives and Adjusters.

Section 5 deletes language requiring a surplus lines licensee to have required reports to the Department countersigned by a resident licensee or by a regulatory support organization.

Section 6 makes changes to the remittance of the surplus lines tax to conform to other changes in the bill.

EFFECTIVE DATE: The PCS for House Bill 262 is effective when it becomes law.

Exhibit 17

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 1

HOUSE BILL 262

Short Title:	Surplus Lines Amendments.	(Public)
Sponsors:	Representatives Pendleton, Tine, and Setzer (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Insurance.	

March 18, 2015

A BILL TO BE ENTITLED

AN ACT TO MODERNIZE THE SURPLUS LINES ACT BY INCLUDING ALIEN INSURERS IN THE DEFINITION OF AN ELIGIBLE SURPLUS LINES INSURER, BY REPEALING COUNTERSIGNING REQUIREMENTS, AND BY PROVIDING GREATER FLEXIBILITY FOR THE MANNER OF COLLECTION AND REFUND OF THE SURPLUS LINES TAX.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-21-10(3) reads as rewritten:

"(3) "Eligible surplus lines insurer" means an alien insurer as defined in G.S. 58-21-17 or a nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance under G.S. 58-21-20."

SECTION 2. G.S. 58-21-40 reads as rewritten:

"**§ 58-21-40. Surplus lines regulatory support organization.**

(a) A surplus lines regulatory support organization of surplus lines licensees shall be formed to:

(1) Facilitate and encourage compliance by resident and nonresident surplus lines licensees with the laws of this State and the rules and regulations of the Commissioner relative to surplus lines insurance;

(2) Communicate with organizations of admitted insurers with respect to the proper use of the surplus lines market;

(3) Receive and disseminate to surplus lines licensees information about surplus lines insurance, including, without limitation, new electronic filing procedures approved by the Commissioner, changes in the list of eligible surplus lines insurers, and modifications in coverages, procedures, and requirements as may be requested by the Commissioner; and

(4) ~~Countersign nonresident produced surplus lines coverages and remit premium taxes for those coverages under G.S. 58-21-70 by means satisfactory to the Commissioner; and charge the nonresident surplus lines licensee a fee for the certification and countersignature as approved by the Commissioner.~~Establish a stamping office to process all surplus lines insurance and remit premium taxes for those coverages under G.S. 58-21-85 by means satisfactory to the Commissioner, and charge surplus lines licensees a fee for such processing.

(b) The regulatory support organization shall file with the Commissioner:

(1) A copy of its constitution, articles of agreement or association, or certificate of incorporation;

(2) A copy of its bylaws and rules governing its activities;

(3) An annually updated list of resident and nonresident licensees;

(4) The name and address of a resident of this State upon whom notices or orders of the Commissioner or processes issued at his direction may be served; and

(5) An agreement that the Commissioner may examine the regulatory support organization in accordance with subsection (c) of this section.

(c) The Commissioner may, at times deemed appropriate, make or cause to be made an examination of each regulatory support organization; in which case the provisions of G.S. 58-2-131, 58-2-132, 58-2-133, 58-2-134, 58-2-150, 58-2-155, 58-2-180, 58-2-185, 58-2-190, 58-2-195, and 58-2-200 shall apply. If the Commissioner finds the regulatory support organization or any surplus lines licensee, whether resident or nonresident, to be in violation of this Article, the Commissioner may issue an order requiring the discontinuance of the violation.

(d) Each resident surplus lines licensee shall maintain active membership in a regulatory support organization as a condition of continued licensure under this Article."

SECTION 3. G.S. 58-21-70 reads as rewritten:

"**§ 58-21-70. Surplus lines licensees may accept business from other agents or brokers; countersignatures required; remittance of premium tax.**

(a) A surplus lines licensee may originate surplus lines insurance or accept such insurance from any other duly licensed agent or broker, and the surplus lines licensee may compensate such agent or broker therefor.

~~(b) Every report filed by a nonresident licensee under G.S. 58-21-35(a) shall, before being filed with the Commissioner, be countersigned by a resident licensee or by a regulatory support organization. The resident licensee or regulatory support organization may charge the nonresident licensee a countersignature fee.~~

~~(c) Every resident licensee and regulatory support organization that countersigns a report under subsection (b) of this section is responsible for remitting the premium tax for the coverage, as specified in G.S. 58-21-85, to the Commissioner.~~"

SECTION 4. G.S. 58-21-85 reads as rewritten:

"**§ 58-21-85. Surplus lines tax.**

(a) Gross premiums charged, less any return premiums, for surplus lines insurance on insureds for whom North Carolina is the home state are subject to a premium receipts tax of five percent (5%), which shall be collected ~~by the surplus lines licensee as specified~~ <u>in a manner approved</u> by the Commissioner, in addition to the full amount of the gross premium charged by the insurer for the insurance. The tax on any portion of the premium unearned at termination of insurance having been credited by the State to the licensee shall be returned to the policyholder ~~directly by the surplus lines licensee or through the producing broker, if any.~~<u>directly.</u> The surplus lines licensee is prohibited from absorbing such tax and from rebating for any reason, any part of such tax. To the extent that other states in which portions of the properties, risks, or exposures reside have failed to enter into a compact or reciprocal allocation procedure with this State, the premium tax collected shall be retained by this State.

~~(b) At the same time that he files his quarterly report as set forth in G.S. 58-21-80, each surplus lines licensee shall pay the premium receipts tax due for the period covered by the report.~~

…."

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

Exhibit 18

2013-2014 General Assembly

HOUSE BILL 683:
Occup. Therapy/Choice of Provider

Committee:	House Insurance	**Date:**	April 21, 2015
Introduced by:	Reps. Avila, Blackwell, Hurley, Holley	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	First Edition		

***SUMMARY:* House Bill 683 adds occupational therapists to the list of providers from which an individual has the right to choose the provider of services under a health benefit plan.**

CURRENT LAW: G.S. 58-50-30 lists the various types of health care providers from which a policy holder, insured, or beneficiary ("insured") may choose under a health benefit plan, subscriber contract, or policy of insurance ("policy"). The services must be of a nature that the policy provides coverage of, or payment or reimbursement. If the policy requires use of network providers, the insured must choose a provider of services within the network. If the policy requires use of network providers as a condition of obtaining a higher level of benefits, the insured must choose a provider of services within network in order to obtain the higher level of benefits.

The provisions of G.S. 58-50-30 are applicable to the State Health Plan pursuant to G.S. 135-48.51.

BILL ANALYSIS:

House Bill 683 amends G.S. 58-50-30 to add "an occupational therapist licensed by the North Carolina Board of Occupational Therapy pursuant to Article 18D of Chapter 90 of the General Statutes" to the list of health care providers from which an insured may choose under a policy.

EFFECTIVE DATE: The act becomes effective October 1, 2015 and applies to health benefit contracts issued, renewed, or amended on or after that date.

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GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H **1**

HOUSE BILL 683

Short Title:	Occup. Therapy/Choice of Provider.	(Public)
Sponsors:	Representatives Avila, Blackwell, Hurley, and Holley (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Insurance.	

April 14, 2015

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT PATIENTS HAVE THE RIGHT TO CHOOSE THEIR OCCUPATIONAL THERAPIST UNDER THEIR HEALTH BENEFIT PLANS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-30(b) is amended by adding a new subdivision to read:

"**§ 58-50-30. Right to choose services of certain providers.**

…

(b) This section applies to the following provider types:

…

(16) An occupational therapist licensed by the North Carolina Board of Occupational Therapy pursuant to Article 18D of Chapter 90 of the General Statutes."

SECTION 2. This act becomes effective October 1, 2015, and applies to health benefit contracts issued, renewed, or amended on or after that date.

H683-V-1

Exhibit 20

HOUSE BILL 148: Insurance Required for Mopeds

2015-2016 General Assembly

Committee:	House Insurance	**Date:**	April 20, 2015
Introduced by:	Reps. Shepard, R. Brown, Waddell, Adams	**Prepared by:**	Tim Hovis
Analysis of:	Second Edition		Committee Counsel

SUMMARY: House Bill 148 would amend the law related to mopeds by:

- ***Requiring mopeds to be insured;***
- ***Clarifying that sellers of mopeds are not required to be licensed as motor vehicle dealers; and***
- ***Clarifying that mopeds do not have to be titled.***

CURRENT LAW: A moped is defined as a vehicle that has two or three wheels, no external shifting device, and a motor that does not exceed 50 cubic centimeters piston displacement and cannot propel the vehicle at a speed greater than 30 miles per hour on a level surface (G.S. 105-164.3). Mopeds are not generally treated as motor vehicles under State laws (G.S. 20-4.01(23)). Mopeds are currently not required to be inspected (G.S. 20-183.2) or insured (G.S. 20-309).

Operators must be at least 16 years old to operate a moped on a highway or public vehicular area (G.S. 20-10.1) but are not required to be licensed (G.S. 20-8). Operators are 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 (G.S. 20-140.4).

While mopeds are not currently required to be registered, legislation was enacted last year (S.L. 2014-114) that will require registration of mopeds beginning on July 1, 2015. The registration fee is the same as for motorcycles ($18). In order to be registered with the Division and operated on the highways, a moped must have a manufacturer's certificate of origin and be designed and manufactured for highway use. An applicant who is unable to provide a manufacturer's certificate of origin must provide an affidavit stating why a certificate is not available and attesting that the applicant is entitled to register the vehicle.

BILL ANALYSIS: House Bill 148 would require that operators of mopeds have liability insurance and make clarifying changes to other motor vehicle laws related to mopeds.

Insurance: Sections 2 through 7 would make it unlawful to operate a moped on a street or highway without having liability insurance coverage. Companies writing moped liability insurance or theft and physical damage insurance would be authorized to incorporate both types of insurance as an endorsement to liability and physical damage policies. Liability insurance on a moped would not be eligible for transfer to the North Carolina Motor Vehicle Reinsurance Facility, and a moped would not be considered a private passenger motor vehicle for purposes of the regulation of insurance rates.

No dealer license required: Section 8 would clarify that mopeds are not included in the definition of motor vehicle for the purposes of the motor vehicle dealers and manufacturers licensing law. Under this law, a person must be licensed as a motor vehicle dealer to sell motor vehicles that are required to be *No dealer license required:* Section 8 would clarify that mopeds are not included in the definition of motor vehicle for the purposes of the motor vehicle dealers and manufacturers licensing law. Under this law, a person must be licensed as a motor vehicle dealer to sell motor vehicles that are required to be registered. This would make clear that moped dealers do not have to be licensed after the new moped registration requirement goes into effect.

No certificate of title required: Section 9 would clarify that mopeds do not have to be titled. Generally, an owner of a vehicle subject to registration must also apply to the Division for a certificate of title. This section would provide that the owner of a moped subject to registration under the new law is not required to apply for, nor is the Division required to issue, a certificate of title.

EFFECTIVE DATE: Clarifying changes related to motor vehicle dealer licensing and titling would become effective July 1, 2015, to coincide with the effective date of the new moped registration requirement. The remainder of the act would become effective July 1, 2016, and would apply to offenses committed on or after that date.

*This summary was substantially contributed to by Wendy Graf Ray, Research Division.

Exhibit 21

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H **2**

HOUSE BILL 148
Committee Substitute Favorable 3/24/15

Short Title: Insurance Required for Mopeds. (Public)

Sponsors:

Referred to:

March 5, 2015

A BILL TO BE ENTITLED

AN ACT TO REQUIRE OWNERS OF MOPEDS TO HAVE IN FULL FORCE AND EFFECT A POLICY OF FINANCIAL RESPONSIBILITY AND TO MAKE CLARIFYING CHANGES RELATED TO THE LAW REQUIRING THE REGISTRATION OF MOPEDS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 20-4.01(23) reads as rewritten:

"(23) Motor Vehicle. – Every vehicle which is self-propelled and every vehicle designed to run upon the highways which is pulled by a self-propelled vehicle. ~~This~~Except as specifically provided otherwise, this term shall not include mopeds as defined in G.S. 20-4.01(27)d1."

SECTION 2. G.S. 20-279.1 is amended by adding a new subdivision to read:

"(6a) Motor vehicle. – This term includes mopeds, as that term is defined in G.S. 20-4.01."

SECTION 3. G.S. 20-309(a) reads as rewritten:

"(a) No motor vehicle shall be registered in this State unless the owner at the time of registration provides proof of financial responsibility for the operation of such motor vehicle, as provided in this Article. The owner of each motor vehicle registered in this State shall maintain financial responsibility continuously throughout the period of registration. For purposes of this Article, the term "motor vehicle" includes mopeds, as that term is defined in G.S. 20-4.01."

SECTION 4. G.S. 58-36-3 reads as rewritten:

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

(a) The Bureau has no jurisdiction over:

…

(7) Personal excess liability or personal "umbrella" insurance.

(8) Liability insurance and theft or physical damage insurance on mopeds, as defined in G.S. 105-164.3.

(b) Member companies writing motorcycle liability insurance under this Article and writing insurance against theft of or physical damage to motorcycles under Article 40 of this Chapter may incorporate motorcycle theft and physical damage coverage as an endorsement to the liability policy issued under this Article. Member companies writing moped liability insurance or theft and physical damage insurance under Article 40 of this Chapter may incorporate either or both types of insurance as an endorsement to liability and physical damage policies issued under this Article.

…."

SECTION 5. G.S. 58-37-1(6) reads as rewritten:

"(6) "Motor vehicle" means every self-propelled vehicle that is designed for use upon a highway, including trailers and semitrailers designed for use with such vehicles (except traction engines, road rollers, farm tractors, tractor cranes, power shovels, and well drillers). "Motor vehicle" also means a motorcycle, as defined in G.S. 20-4.01(27)d. "Motor vehicle" does not mean a moped, as defined in G.S. 105-164.3. Notwithstanding any other provisions of this Article, liability insurance on a moped is not eligible for cession to the Facility."

SECTION 6. G.S. 58-40-10(1) reads as rewritten:

"(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 14,000 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. A moped, as defined in G.S. 105-164.3, is not considered a motorcycle, motorized scooter, or other similar motorized vehicle."

SECTION 7. G.S. 58-40-15 reads as rewritten:

"§ 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:~~except for all of the following:

(1) Reinsurance, other than joint reinsurance to the extent stated in ~~G.S. 58-40-60;~~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;~~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;~~policies.

(4) Accident, health, or life ~~insurance;~~insurance.

(5) ~~Annuities;~~Annuities.

(6) Repealed by Session Laws 1985, c. 666, s. 43.

(7) Mortgage guaranty ~~insurance;~~insurance.

(8) Workers' compensation and employers' liability insurance written in connection ~~therewith;~~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; except this Article applies to motor vehicle liability insurance, automobile medical payments insurance, uninsured motorists' coverage, and theft or physical damage insurance on mopeds, as defined in G.S. 105-164.3.

(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~~G.S. 20-4.01(27)d.

(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; 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."

SECTION 8. G.S. 20-286(10) reads as rewritten:

"(10) Motor vehicle. – Any motor propelled vehicle, trailer or semitrailer, required to be registered under the laws of this State. This term does not include mopeds, as that term is defined in G.S. 20-4.01.

a. "New motor vehicle" means a motor vehicle that has never been the subject of a completed, successful, or conditional sale that was subsequently approved other than between new motor vehicle dealers, or between manufacturer and dealer of the same franchise.

b. "Used motor vehicle" means a motor vehicle other than described in paragraph (10)a above."

SECTION 9. G.S. 20-53.4 reads as rewritten:

"§ 20-53.4. Registration of ~~Mopeds.~~mopeds; certificate of title.

(a) Registration. – Mopeds shall be registered with the Division. The owner of the moped shall pay the same base fee 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 manufacturer's certificate of origin.

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

(b) Certificate of Title. – Notwithstanding G.S. 20-52 and G.S. 20-57, the owner of a moped is not required to apply for, and the Division is not required to issue, a certificate of title."

SECTION 10. Sections 8 and 9 of this act become effective July 1, 2015. The remainder of this act becomes effective July 1, 2016, and applies to offenses committed on or after that date.

Exhibit 22

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

INSURANCE COMMITTEE REPORT
Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

FAVORABLE

HB **147** Update Fire and Rescue Commn. Membership.

Draft Number:	None
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Ross

HB **306** NC Cancer Treatment Fairness.

Draft Number:	None
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Lewis

HB **683** Occup. Therapy/Choice of Provider.

Draft Number:	None
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Avila

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL

HB **262** Surplus Lines Amendments.

Draft Number:	H262-PCS30340-MH-1
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Pendleton

HB **667** Athletic Trainer/Health Coverage Option.

Draft Number:	H667-PCS30330-TK-13
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes
Floor Manager:	Hager

* C M R 2 0 6 - V - 1 *

HB **809** Third-Party Premium Payments.

Draft Number:	H809-PCS30331-TK-18
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Avila

TOTAL REPORTED: 6

CMR206-V-1

Corrected #6: H729 added and H715 removed

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Tuesday, April 28, 2015
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 196	DOI License Processing Fees.	Representative Dollar Representative Lucas
HB 182	Property Insurance Fairness.	Representative Millis Representative Lewis Representative Hager
HB 599	Impounding Vehicles with Lapsed/No Insurance.	Representative Cleveland
HB 528	Establish Chiropractor Co-Pay Parity.	Representative Burr Representative Jones Representative Hanes
HB 361	Principle-Based Reserving.	Representative Collins Representative Tine Representative Setzer
HB 496	Surcharge Transparency.	Representative Collins Representative Cleveland Representative Jordan Representative Baskerville
HB 148	Insurance Required for Mopeds.	Representative Shepard Representative R. Brown Representative Waddell Representative Adams
HB 821	Proper Administration of Step Therapy.	Representative Lewis Representative Wray
HB 142	Require Safety Helmets / Under 21.	Representative Torbett Representative Speciale
HB 497	SDIP Opt-Out.	Representative Collins Representative Burr Representative Boles

HB 729	Standards for Chiropractic Peer Review.	Representative Bumgardner Representative Conrad Representative Bryan Representative Setzer

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 8:14 AM on Tuesday, April 28, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margie Penven (Committee Assistant)

Corrected #5: House Bill 497 added

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Tuesday, April 28, 2015
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 196	DOI License Processing Fees.	Representative Dollar Representative Lucas
HB 182	Property Insurance Fairness.	Representative Millis Representative Lewis Representative Hager
HB 599	Impounding Vehicles with Lapsed/No Insurance.	Representative Cleveland
HB 528	Establish Chiropractor Co-Pay Parity.	Representative Burr Representative Jones Representative Hanes
HB 361	Principle-Based Reserving.	Representative Collins Representative Tine Representative Setzer
HB 496	Surcharge Transparency.	Representative Collins Representative Cleveland Representative Jordan Representative Baskerville
HB 715	Payments for Ambulance Services.	Representative Bishop Representative Jeter Representative Setzer
HB 148	Insurance Required for Mopeds.	Representative Shepard Representative R. Brown Representative Waddell Representative Adams
HB 821	Proper Administration of Step Therapy.	Representative Lewis Representative Wray
HB 142	Require Safety Helmets / Under 21.	Representative Torbett Representative Speciale

HB 497	SDIP Opt-Out.	Representative Collins Representative Burr Representative Boles Representative Bumgardner

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 4:16 PM on Monday, April 27, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margie Penven (Committee Assistant)

Corrected #4: House Bill 142 added

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Tuesday, April 28, 2015
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 196	DOI License Processing Fees.	Representative Dollar Representative Lucas
HB 182	Property Insurance Fairness.	Representative Millis Representative Lewis Representative Hager
HB 599	Impounding Vehicles with Lapsed/No Insurance.	Representative Cleveland
HB 528	Establish Chiropractor Co-Pay Parity.	Representative Burr Representative Jones Representative Hanes
HB 361	Principle-Based Reserving.	Representative Collins Representative Tine Representative Setzer
HB 496	Surcharge Transparency.	Representative Collins Representative Cleveland Representative Jordan Representative Baskerville
HB 715	Payments for Ambulance Services.	Representative Bishop Representative Jeter Representative Setzer
HB 148	Insurance Required for Mopeds.	Representative Shepard Representative R. Brown Representative Waddell Representative Adams
HB 821	Proper Administration of Step Therapy.	Representative Lewis Representative Wray
HB 142	Require Safety Helmets / Under 21.	Representative Torbett Representative Speciale

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 1:40 PM on Monday, April 27, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margie Penven (Committee Assistant)

Corrected #3: H715 was inadvertently left off the last notice

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Tuesday, April 28, 2015
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 196	DOI License Processing Fees.	Representative Dollar Representative Lucas
HB 182	Property Insurance Fairness.	Representative Millis Representative Lewis Representative Hager
HB 599	Impounding Vehicles with Lapsed/No Insurance.	Representative Cleveland
HB 528	Establish Chiropractor Co-Pay Parity.	Representative Burr Representative Jones Representative Hanes
HB 361	Principle-Based Reserving.	Representative Collins Representative Tine Representative Setzer
HB 496	Surcharge Transparency.	Representative Collins Representative Cleveland Representative Jordan Representative Baskerville
HB 715	Payments for Ambulance Services.	Representative Bishop Representative Jeter Representative Setzer
HB 148	Insurance Required for Mopeds.	Representative Shepard Representative R. Brown Representative Waddell Representative Adams
HB 821	Proper Administration of Step Therapy.	Representative Lewis Representative Wray

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 12:09 PM on Friday, April 24, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margie Penven (Committee Assistant)

Corrected #2: H599 and H821 added

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Tuesday, April 28, 2015
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 196	DOI License Processing Fees.	Representative Dollar Representative Lucas
HB 182	Property Insurance Fairness.	Representative Millis Representative Lewis Representative Hager
HB 599	Impounding Vehicles with Lapsed/No Insurance.	Representative Cleveland
HB 528	Establish Chiropractor Co-Pay Parity.	Representative Burr Representative Jones Representative Hanes
HB 361	Principle-Based Reserving.	Representative Collins Representative Tine Representative Setzer
HB 496	Surcharge Transparency.	Representative Collins Representative Cleveland Representative Jordan Representative Baskerville
HB 148	Insurance Required for Mopeds.	Representative Shepard Representative R. Brown Representative Waddell Representative Adams
HB 821	Proper Administration of Step Therapy.	Representative Lewis Representative Wray

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 9:13 AM on Thursday, April 23, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margie Penven (Committee Assistant)

Corrected #1: Date and Time Change, HB 715 added

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Tuesday, April 28, 2015
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 196	DOI License Processing Fees.	Representative Dollar
		Representative Lucas
HB 361	Principle-Based Reserving.	Representative Collins
		Representative Tine
		Representative Setzer
HB 496	Surcharge Transparency.	Representative Collins
		Representative Cleveland
		Representative Jordan
		Representative Baskerville
HB 182	Property Insurance Fairness.	Representative Millis
		Representative Lewis
		Representative Hager
HB 715	Payments for Ambulance Services.	Representative Bishop
		Representative Jeter
		Representative Setzer
HB 148	Insurance Required for Mopeds.	Representative Shepard
		Representative R. Brown
		Representative Waddell
		Representative Adams
HB 528	Establish Chiropractor Co-Pay Parity.	Representative Burr
		Representative Jones
		Representative Hanes

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 12:59 PM on Wednesday, April 22, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margie Penven (Committee Assistant)

House Committee on Insurance
Tuesday, April 28, 2015, 1:00 PM
1228/1327 Legislative Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 196	DOI License Processing Fees.	Representative Dollar Representative Lucas
HB 182	Property Insurance Fairness.	Representative Millis Representative Lewis Representative Hager
HB 599	Impounding Vehicles with Lapsed/No Insurance.	Representative Cleveland
HB 528	Establish Chiropractor Co-Pay Parity.	Representative Burr Representative Jones Representative Hanes
HB 361	Principle-Based Reserving/Revise Ins. Laws.	Representative Collins Representative Tine Representative Setzer
HB 496	Surcharge Transparency.	Representative Collins Representative Cleveland Representative Jordan Representative Baskerville
HB 148	Insurance Required for Mopeds.	Representative Shepard Representative R. Brown Representative Waddell Representative Adams
HB 821	Proper Administration of Step Therapy.	Representative Lewis Representative Wray
HB 142	Require Safety Helmets / Under 21.	Representative Torbett Representative Speciale
HB 497	SDIP Opt-Out.	Representative Collins Representative Burr Representative Boles Representative Bumgardner
HB 729	Standards for Chiropractic Peer Review.	Representative Conrad Representative Bryan Representative Setzer

Presentations

Other Business

Adjournment

House Committee on Insurance
Tuesday, April 28, 2015 at 1:00 PM
Room 1228/1327 of the Legislative Building

MINUTES

The House Committee on Insurance met at 1:00 PM on April 28, 2015, in Room 1228/1327 of the Legislative Building. Representatives Arp, Baskerville, Boles, Brawley, Brisson, Bumgardner, Burr, Collins, Dobson, Dollar, Earle, Gill, C. Graham, D. Hall, Hanes, Hastings, Holloway, Horn, Howard, Iler, Insko, Jackson, Lambeth, Langdon, Lucas, McElraft, Pendleton, Pierce, Setzer, Shepard, Tine, Warren, and Wray attended.

Chairman Dana Bumgardner presided and called the meeting to order at 1:00 p.m. Visitor registration is attached as Exhibit 1. A list of Assistant Sergeants-at-Arms serving the committee is attached as Exhibit 2, and a list of Pages serving the committee is attached as Exhibit 3.

The following bills were on the agenda: HB 196, DOI License Processing Fees (Representatives Dollar, Lucas); HB 182, Property Insurance Fairness (Representatives Millis, Lewis, Hager); HB 599, Impounding Vehicles with Lapsed/No Insurance (Representative Cleveland); HB 528, Establish Chiropractor Co-Pay Parity (Representatives Burr, Jones, Hanes); HB 361, Principle-Based Reserving (Representatives Collins, Tine, Setzer); HB 496, Surcharge Transparency (Representatives Collins, Cleveland, Jordan, Baskerville); HB 148, Insurance Required for Mopeds (Representatives Shepard, R. Brown, Waddell, Adams); HB 821, Proper Administration of Step Therapy (Representatives Lewis, Wray); HB 142, Require Safety Helmets /Under 21 (Representatives Torbett, Speciale); HB 497, SDIP Opt-Out (Representatives Collins, Burr, Boles, Bumgardner); HB 729, Standards for Chiropractic Peer Review (Representatives Conrad, Bryan, Setzer). A copy of the agenda is attached as Exhibit 4.

Representative Dollar explained HB 196, A BILL TO BE ENTITLED AN ACT TO REQUIRE THAT THE DEPARTMENT OF INSURANCE INCLUDE DIFFERENTIAL LICENSE PROCESSING FEES WHEN ISSUING ITS NEXT REQUEST FOR PROPOSAL FOR A LICENSING ADMINISTRATIVE SERVICES CONTRACT. A copy of HB 196 is attached as Exhibit 5. A copy of the bill summary, which was prepared by Tim Hovis, Committee Counsel, is attached as Exhibit 6. Representative Warren moved that HB 196 be given a favorable report and the motion passed unanimously.

Representative Collins explained HB 361, A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR PRINCIPLE-BASED VALUATION IN THE LIFE INSURANCE STANDARD VALUATION LAW AND STANDARD NONFORFEITURE PROVISIONS IN THE NORTH CAROLINA INSURANCE LAW. A copy of HB 361 is attached as Exhibit 7. A copy of the bill summary, which was prepared by Kristen Harris, Committee Counsel, is attached as Exhibit 8. Representative Warren moved that HB 361 be given a favorable report, and the motion passed unanimously.

Representative Tine moved to bring a proposed committee substitute (PCS) for HB 182 before the committee for consideration. The motion carried. Representative Millis began an explanation,

but the bill was temporarily displaced until copies of the latest PCS could be distributed to committee members.

Representative Burr explained HB 528, A BILL TO BE ENTITLED AN ACT TO REENACT A LAW CONCERNING HEALTH BENEFIT PLAN CO-PAYMENTS FOR SERVICES PERFORMED BY CHIROPRACTORS. A copy of HB 528 is attached as Exhibit 9. A copy of the bill summary, which was prepared by Amy Jo Johnson, Committee Counsel, is attached as Exhibit 10.

A copy of a memorandum from the Office of the State Treasurer opposing HB 528 is attached as Exhibit ll.

Speaking in favor of the bill were Dr. Joe Siragusa, Executive Director of the NC Chiropractic Association, and Ms. Flo Moses representing NC Physical Therapy Association.

Speaking against HB 528 were Ms. Chris Evans, representing NC Health Care, and Mr. Gary Salamido, Vice President, Government Affairs, North Carolina Chamber of Commerce.

Representative Pendleton sent forth an amendment to limit the first five visits as primary care annually, thereafter treating each visit as a visit to a specialist. The proposed amendment is attached as Exhibit 12. Representative Burr said he was against the amendment, and on a voice vote the amendment failed. Representative Setzer moved that HB 528 be given a favorable report, and on a show of hands the motion carried 16-14.

The proposed committee substitute for HB 182, was before the committee on a previous motion by Representative Tine. Copies of the PCS were passed out and Representative Millis explained the PCS for HB 182, A BILL TO BE ENTITLED AN ACT TO INCREASE THE FAIRNESS AND EQUITY OF PROPERTY INSURANCE RATE MAKING IN NORTH CAROLINA BY REQUIRING THAT CERTAIN PROPERTY INSURANCE DATA BE MADE AVAILABLE TO THE PUBLIC; BY PROVIDING THE NORTH CAROLINA INSURANCE UNDERWRITING ASSOCIATION THE AUTHORITY TO HAVE ISSUED TAX-EXEMPT BONDS TO COVER LOSS-RELATED LIABILITIES; BY REFORMING CONSENT TO RATE PRACTICES; BY REQUIRING THAT CATASTROPHE MODELING USED FOR PROPERTY RATE-MAKING PURPOSES MORE ACCURATELY REFLECT POTENTIAL IMPACTS IN NORTH CAROLINA; AND BY CREATING THE JOINT LEGISLATIVE STUDY COMMITTEE ON PROPERTY INSURANCE RATE MAKING. A copy of the PCS for HB 182 is attached as Exhibit 13. The bill summary, which was prepared by Tim Hovis, Committee Counsel, is attached as Exhibit 14. Representative Lucas moved that the PCS for HB 182 be given a favorable report, unfavorable as to the original bill. The motion carried with a serial referral to the Finance Committee.

Representative Shepard moved that at PCS for HB 599 be brought before the Committee. The motion passed, and a copy the PCS for HB 599 is attached as Exhibit 15. Representative Cleveland explained the PCS for HB 599, A BILL TO BE ENTITLED AN ACT TO REQUIRE THE VEHICLE BEING OPERATED BY A DRIVER WHO HAS FAILED TO MAINTAIN

FINANCIAL RESPONSIBILITY TO BE SEIZED AND FORFEITED. A copy of the bill summary for the PCS for HB 599, which was prepared by Tim Hovis and Kristen Harris, Committee Counsel, is attached as Exhibit 16.

There was committee discussion, but time ran out without a vote so the bill was held over.

The meeting adjourned at 1:55 p.m. The committee reports are attached as Exhibits 17 and 18.

Respectfully submitted:

Rep. D Bumgardner

Representative Dana Bumgardner, Chair
Presiding

Margie Penven

Margie Penven, Committee Clerk

Exhibits:

1. Visitor Registration
2. Assistant Sergeants-at-Arms Serving Committee
3. Pages Serving Committee
4. Agenda
5. HB 196
6. Summary for HB 196
7. HB 361
8. Summary for HB 361
9. HB 528
10. Summary for HB 528
11. Handout from Janet Cowell, Treasurer Regarding HB 528
12. Pendleton Amendment (Failed)
13. PCS for HB 182
14. Summary for PCS for HB 182
15. HB 599
16. Summary for HB 599
17. Committee Report #1
18. Committee Report #2

EXHIBIT 1

VISITOR REGISTRATION SHEET

House Comm. on Insurance 04/28/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mark Fleming	BCBSNC.
[illegible]	FSP
Robert PAschal	Young Moore
Edith Davis	NC Reinsurance Facility
R.E. Lee,	AOV, Ret.
[illegible]	BRNC
[illegible]	GSK
J Peters	CSS
Curtis McDonald	BMS
Amy Fulk	30 PR
Chris Dillon	WAKE

VISITOR REGISTRATION SHEET

House Comm. on Insurance 04/28/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Harry Kaplan	MWC
TJ Bugbee	NP
Mike Smallwood	SOV
Tonya Horton	TJS
Jason Daniel	NCDMV
Adam Sholar	DHHS
Connie Allen	TISPC
[illegible] Starnes	Treasurer
VANCE KINLAW	NC CHIROPRACTIC BOAR
Hayden Burgess	FSP
Lori Ann Harris	LAHA

VISITOR REGISTRATION SHEET

House Comm. on Insurance 04/28/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	N/A
JAKE PARKER	NCFB
Sarah Bales	Brubaker, Assoc.
John Bode	B & H
W H Potter Jr	NC PHYS Ther Assoc
JASON HARLOFF	NCPTA
Flo Moses	NCPTA

VISITOR REGISTRATION SHEET

House Comm. on Insurance 04/28/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Angel Sams	WCSR
CAROL ORNITZ	NC Brain Injury Advisory Council
JOE SIRAGUSA	NC CHIROPRACTIC ASSOC.
SOLARI	DST
FRIEDMAN	DST
CHARLIE BOONE	CONCERNED BIKERS ASSOC. OF NC.
Ben Twilley	Express Scripts
Gregg Thompson	NFIB
[illegible]	CSS
Ricky Tomlin	The Cien[illegible]
McDonald	WJ

VISITOR REGISTRATION SHEET

House Comm. on Insurance 04/28/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Marty Bocock	Prime Therapeutics
[illegible]	NMRS
Michelle Frazier	MFTS
Liz Reynolds	NAMIC
Billy Trott	Young, Moore Henderson, PA
Ray Evans	NCRB
Mickey Spivey	Young Moore and Henderson, PA.
Kelly Thomas	DMV
Judy Jenkins	Otsuka
[illegible]	CSS
David Ward	MetLife

VISITOR REGISTRATION SHEET

House Comm. on Insurance 04/28/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jim Harrell	BH
Joanna Spruill	NCAFP
Jennifer Carponni	NCMS
Wendy Kelly	Focus Carolina
Cady Thomas	Focus Carolina
Chris McClure	BP
Will Stephenson	Team Powersports
John Hill	Select Cycle
Kevin Lacy	NCDOT
[illegible]	Misc

EXHIBIT 2

Committee Sergeants-at Arms
House Committee on Insurance
April 28, 2015

Young Bay
Bill Morris
Jim Moran

EXHIBIT 3

Pages Assigned to Insurance Committee on April 28, 2015, at 1:00 p.m. in Room 1228/1327:

Name	County	Sponsor
Phillip Armentrout	Craven	John R. Bell IV
Kaitlin Avery	Pitt	Susan Martin

EXHIBIT4

House Committee on Insurance
Tuesday, April 28, 2015, 1:00 PM
1228/1327 Legislative Building

AGENDA
Chairman Bumgardner, Presiding

Welcome and Opening Remarks

Introduction of Pages and Assistant Sergeants-at-Arms

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 196	DOI License Processing Fees.	Representative Dollar Representative Lucas
HB 182	Property Insurance Fairness.	Representative Millis Representative Lewis Representative Hager
HB 599	Impounding Vehicles with Lapsed/No Insurance.	Representative Cleveland
HB 528	Establish Chiropractor Co-Pay Parity.	Representative Burr Representative Jones Representative Hanes
HB 361	Principle-Based Reserving.	Representative Collins Representative Tine Representative Setzer
HB 496	Surcharge Transparency.	Representative Collins Representative Cleveland Representative Jordan Representative Baskerville
HB 148	Insurance Required for Mopeds.	Representative Shepard Representative R. Brown Representative Waddell Representative Adams
HB 821	Proper Administration of Step Therapy.	Representative Lewis Representative Wray
HB 142	Require Safety Helmets / Under 21.	Representative Torbett Representative Speciale
HB 497	SDIP Opt-Out.	Representative Collins Representative Burr Representative Boles Representative Bumgardner
HB 729	Standards for Chiropractic Peer Review.	Representative Conrad Representative Bryan Representative Setzer

Adjournment

EXHIBIT5

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H **1**

HOUSE BILL 196

Short Title:	DOI License Processing Fees.	(Public)
Sponsors:	Representatives Dollar and Lucas (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Insurance.	

March 11, 2015

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT THE DEPARTMENT OF INSURANCE INCLUDE DIFFERENTIAL LICENSE PROCESSING FEES WHEN ISSUING ITS NEXT REQUEST FOR PROPOSAL FOR A LICENSING ADMINISTRATIVE SERVICES CONTRACT.

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, 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 provision of online services, the provision of administrative 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. With respect to contracts between the Agent Services Division of the Department of Insurance and other contracting parties that include the provision of license application processing after the receipt of an application, the contract may allow the other contracting party the option to charge different fees based on the effort necessary to process licenses for each category of applicant or licensee provided services under 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 contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subsection to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all contracts to be awarded by the Commissioner under this subsection a standard clause which provides that the State Auditor and internal auditors of the Commissioner may audit the records of the contractor during and after the term of the agreement or contract to verify accounts and data affecting fees and performance. The Commissioner shall not award a cost plus percentage of cost agreement or contract for any purpose."

SECTION 2. This act is effective when it becomes law, and applies to any contract for license processing services entered into by the Department on or after that date.

HOUSE BILL 196:
DOI License Processing Fees

2015-2016 General Assembly

Committee:	House Insurance	**Date:**	April 28, 2015
Introduced by:	Reps. Dollar, Lucas	**Prepared by:**	Tim Hovis
Analysis of:	First Edition		Committee Counsel

SUMMARY:

[As introduced, this bill was identical to S120, as introduced by Sen. Hartsell, which is currently in Senate Finance.]

CURRENT LAW: Current law allows the Department of Insurance to contract with the National Association of Insurance Commissioners (NAIC) or other persons for the provisions of online services to applicants and licensees, the provision of administrative services, the provisions of license processing and support services, and regulatory data systems.

BILL ANALYSIS: With respect to contracts between the Agent Services Division (ASD) of the Department and other contracting parties that include license application processing, the bill would allow the contracting party the option to charge different fees based on the effort necessary to process licenses for each category of applicant or licensees.

House Bill 196 is a recommendation of the Joint Legislative Program Evaluation Oversight Committee.

EFFECTIVE DATE: House Bill 196 is effective when it becomes law and applies to any contract entered into by the Department on or after that date.

O. Walker Reagan
Director

CHECKED OUT

Research Division
(919) 733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H **1**

HOUSE BILL 196

Short Title:	DOI License Processing Fees.	(Public)
Sponsors:	Representatives Dollar and Lucas (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Insurance.	

March 11, 2015

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT THE DEPARTMENT OF INSURANCE INCLUDE DIFFERENTIAL LICENSE PROCESSING FEES WHEN ISSUING ITS NEXT REQUEST FOR PROPOSAL FOR A LICENSING ADMINISTRATIVE SERVICES CONTRACT.

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, 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 provision of online services, the provision of administrative 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. With respect to contracts between the Agent Services Division of the Department of Insurance and other contracting parties that include the provision of license application processing after the receipt of an application, the contract may allow the other contracting party the option to charge different fees based on the effort necessary to process licenses for each category of applicant or licensee provided services under 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 contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this subsection to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all contracts to be awarded by the Commissioner under this subsection a standard clause which provides that the State Auditor and internal auditors of the Commissioner may audit the records of the contractor during and after the term of the agreement or contract to verify accounts and data affecting fees and performance. The Commissioner shall not award a cost plus percentage of cost agreement or contract for any purpose."

SECTION 2. This act is effective when it becomes law, and applies to any contract for license processing services entered into by the Department on or after that date.

EXHIBIT 7

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 1

HOUSE BILL 361

Short Title:	Principle-Based Reserving.	(Public)
Sponsors:	Representatives Collins, Tine, and Setzer (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Insurance.	

March 26, 2015

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR PRINCIPLE-BASED VALUATION IN THE LIFE INSURANCE STANDARD VALUATION LAW AND STANDARD NONFORFEITURE PROVISIONS IN THE NORTH CAROLINA INSURANCE LAW.

The General Assembly of North Carolina enacts:

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

"**§ 58-58-50. Standard Valuation Law.**

(a) This section shall be known as the Standard Valuation Law.

(a1) As used in this section:

(1) Appointed actuary. – A qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in subsection (j1) of this section.

(2) Company. – An entity which has written, issued or reinsured life insurance contracts, accident and health insurance contracts, annuity contracts, pure endowment contracts or deposit type contracts (i) in this State and has at least one such policy in force or on claim, or (ii) in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, annuity contract, pure endowment or deposit-type contracts in this State.

(3) Deposit-type contract. – A contract that does not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

(4) Policyholder behavior. – Any action a policyholder, contract holder, or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this section, including, but not limited to, lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

(5) Principle-based valuation. – A reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with subsection (n) of this section as specified in the valuation manual.

(6) Qualified actuary. – An individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of

Actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual.

(7) Reserves. – Reserve liabilities.

(8) Tail risk. – A risk that occurs either where the frequency of low probability events is higher than expected under a normal probability distribution or where there are observed events of very significant size or magnitude.

(9) Valuation manual. – The manual of valuation instructions adopted by the NAIC as specified in this section or as subsequently amended.

(b) This subsection applies to policies and contracts issued prior to the operative date of the valuation manual. Each year the Commissioner shall value or cause to be valued the ~~reserve liabilities ("reserves")~~reserves for all outstanding life insurance policies, annuity contracts, ~~and~~ pure endowment ~~contracts~~ contracts, accident and health insurance contracts, and deposit-type contracts of every life insurance company doing business in this State. In the case of an alien company, the valuation shall be limited to its United States business. ~~The Commissioner may certify the amount of each company's reserves, specifying the mortality or morbidity tables, withdrawal rates, and other assumptions regarding when, and the degree to which, policyholders exercise contract options, such as full or partial withdrawal, rate or rates of interest, and methods, such as net level premium method or other, used in the Commissioner's calculation of the company's reserves.~~ Group methods and approximate averages for fractions of a year or otherwise may be used by the Commissioner in calculating the company's reserves, and the Commissioner may accept the valuation made by the company upon evidence of its correctness that the Commissioner requires. For foreign or alien insurance companies, the Commissioner may accept any valuation made or caused to be made by the insurance regulator of any state or other jurisdiction if ~~(i)~~ that valuation complies with the minimum standard provided in this ~~section and (ii) that regulator accepts as legally sufficient and valid the Commissioner's certificate of valuation when that certificate states that the valuation has been made in a specified manner according to which the aggregate reserves would be at least as great as if they had been computed in the manner prescribed by the law of that state or jurisdiction.~~section.

(b1) The provisions set forth in subsections (c), (d), (d1), (e), (f), (g), (h), and (k) of this section shall apply to all policies and contracts, as appropriate, subject to this section issued on or after the effective date of this section and prior to the operative date of the valuation manual. The provisions set forth in subsections (m) and (n) of this section shall not apply to policies issued prior to the operative date of the valuation manual.

(b2) This subsection applies to policies and contracts issued on or after the operative date of the valuation manual. The Commissioner shall annually value, or cause to be valued, the reserves for all outstanding life insurance contracts, annuity contracts, pure endowment contracts, accident and health insurance contracts, and deposit-type contracts of every company issued on or after the operative date of the valuation manual. In lieu of the valuation of the reserves required of a foreign or alien company, the Commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any State or other jurisdiction when that valuation complies with the minimum standard provided in this section.

(b3) The provisions set forth in subsections (m) and (n) of this section shall apply to all policies and contracts issued on or after the operative date of the valuation manual.

(c) (1) Except as otherwise provided in subdivisions (3) and (4) of this subsection, or in subsection (k), the minimum standard for the valuation of all such policies and contracts issued before the effective date of this section shall be that provided by the laws in effect immediately before that date, except that the minimum standard for the valuation of annuities and pure endowments purchased under group annuity and pure endowment contracts issued before that date shall be that provided by the laws in effect immediately before that date but replacing the interest rates specified in such laws by an interest rate of five percent (5%) per annum, and five and one-half percent (5 ½%) interest for single premium life insurance policies.

(2) Except as otherwise provided in subdivisions (3) and (4) of this subsection, or in subsection (k), the minimum standards for the valuation of all such policies and contracts issued on or after the effective date of this section shall be the Commissioner's reserve valuation methods defined in subsections (d), ~~(d-1)~~(d1), ~~and~~ (g), and (k), five percent (5%) interest for group annuity and pure endowment contracts and three and one-half percent (3 ½%) interest for all other policies and contracts, or, in the case of policies and contracts other than annuity and pure endowment contracts, issued on or after July 1, 1975, four percent (4%) interest for such policies issued prior to April 19, 1979, and four and one-half percent (4 ½%) interest for such policies issued on or after April 19, 1979, and the following tables:

…

(3) Except as provided in subdivision (4) of this subsection, the minimum standard ~~for the~~of valuation ~~of all~~for individual annuity and pure endowment contracts issued on or after the operative date of this subdivision (3), as defined herein, and for ~~all~~ annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts, shall be the Commissioner's reserve valuation methods defined in subsections (d) and ~~(d-1)~~(d1) and the following tables and interest rates:

…

After July 1, 1975, any company may file with the Commissioner a written notice of its election to comply with the provisions of this subdivision (3) after a specified date before January 1, 1979, which shall be the operative date of this subdivision for such company, provided, a company may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If a company makes no such election, the operative date of this subdivision for such company shall be January 1, 1979.

(4) a. Applicability of ~~This Subdivision.~~this subdivision. The interest rates used in determining the minimum standard for the valuation of:

1. ~~All life~~Life insurance policies issued in a particular calendar year, on or after the operative date of subdivision (e)(4) of G.S. 58-58-55,
2. ~~All individual~~Individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1982,
3. ~~All annuities~~Annuities and pure endowments purchased in a particular calendar year on or after January 1, 1982, under group annuity and pure endowment contracts, and
4. The net increase, if any, in a particular calendar year after January 1, 1982, in amounts held under guaranteed interest contracts

shall be the calendar year statutory valuation interest rates as defined in this subdivision.

…

(d) Except as otherwise provided in subsections ~~(d-1) and~~(d1), (g), and (k) reserves according to the Commissioner's reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of (1) and (2), as follows:

(1) A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that such net level annual premium shall not exceed the net level annual premium on the 19-year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of such policy.

(2) A net one year term premium for such benefits provided for in the first policy year.

Provided that for any life insurance policy issued on or after January 1, 1985, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefits are provided in the first year for such excess and which provides an endowment benefit or a cash surrender value of a combination thereof in an amount greater than such excess premium, the reserve according to the Commissioner's reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in subsection (g), be the greater of the reserve as of such policy anniversary calculated as described in the first paragraph of this subsection and the reserve as of such policy anniversary calculated as described in that paragraph, but with (i) the value defined in subparagraph (1) of that paragraph being reduced by fifteen percent (15%) of the amount of such excess first year premium, (ii) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date, (iii) the policy being assumed to mature on such date as an endowment, and (iv) the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in subdivisions (2) and (4) of subsection (c) shall be used.

Reserves according to the Commissioner's reserve valuation method for: (i) life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums; (ii) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as now or hereafter amended; (iii) disability and accidental death benefits in all policies and contracts; and (iv) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of this subsection except that any extra premiums charged because of impairments or special hazards shall be disregarded in the determination of modified net premiums.

~~(d-1)~~(d1) This subsection shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as now or hereafter amended.

Reserves according to the Commissioner's annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate, or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

(e) In no event shall a company's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued on or after the effective date of this section, be less than the aggregate reserves calculated in accordance with the methods set forth in subsections (d), ~~(d-1),~~(d1), (g) and (h) of this section and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies. In no event shall the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined by the ~~qualified~~ appointed actuary to be necessary to render the opinion required by subsection (i) or subsection (j1) of this section.

(f) Reserves for all policies and contracts issued before the effective date of this section may be calculated, at the option of the company, according to any standards that produce greater aggregate reserves for those policies and contracts than the minimum reserves required by the laws in effect immediately before that date.

Reserves for any category of policies, contracts or benefits as established by the Commissioner, issued on or after the effective date of this section may be calculated, at the option of the company, according to any standards that produce greater aggregate reserves for such category than those calculated according to the minimum standard herein provided, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be ~~higher~~ greater than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided ~~for therein.~~in the policies or contracts.

Any such company that adopts any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard herein provided may, with the approval of the Commissioner, adopt any lower standard of valuation, but not lower than the minimum ~~herein provided.~~provided in this section. Provided, however, that for the purposes of this section, the holding of additional reserves previously determined by ~~a qualified~~the appointed actuary to be necessary to render the opinion required by subsection ~~(c)~~(i) or (j1) of this section shall not be deemed to be the adoption of a higher standard of valuation.

(g) If in any contract year the gross premium charged by any ~~life insurance~~ company on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for such policy or contract, or the reserve calculated by the method actually used for such policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this subsection are those standards stated in subdivisions (1), (2) and (4) of subsection (c).

Provided that for any life insurance policy issued on or after January 1, 1985, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this subsection ~~(g)~~ shall be applied as if the method actually used in calculating the reserve for such policy were the method described in subsection (d), ignoring the second paragraph of subsection (d). The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with subsection (d), including the second paragraph of that subsection, and the minimum reserve calculated in accordance with this ~~subsection (g).~~subsection.

(h) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in subsections (d), ~~(d-1),~~(d1) and (g), the reserves which are held under any such plan must:

(1) Be appropriate in relation to the benefits and the pattern of premiums for that plan, and

(2) Be computed by a method which is consistent with the principles of this Standard Valuation Law, as determined by regulations promulgated by the Commissioner.

(i) ~~Every~~ Prior to the operative date of the valuation manual as specified in G.S. 58-58-51, every life insurance company doing business in this State shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the Commissioner by rule are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with previously reported amounts, and comply with applicable laws of this State. The Commissioner by rule shall define the specifics of this opinion and add any other items deemed to be necessary to its scope. Every life insurance company, except as exempted by or pursuant to rule, shall also annually include in the opinion required by this subsection, an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the Commissioner by rule, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts. The Commissioner may provide by rule for a transition period for establishing any higher reserves that the qualified actuary may deem to be necessary in order to render the opinion required by this subsection.

(j) Each opinion required by subsection (i) of this section shall be governed by the following provisions:

…

~~(7) For the purposes of this section, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirement set forth in such rules.~~

…

(j1) On or after the operative date of the valuation manual, every company with outstanding life insurance contracts, annuity contracts, pure endowment contracts, accident and health insurance contracts or deposit-type contracts in this State and subject to regulation by the Commissioner shall annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with previously reported amounts, and comply with applicable laws of this State. The valuation manual shall prescribe the specifics of this opinion, including any items deemed to be necessary to its scope. Every company with outstanding life insurance contracts, annuity contracts, pure endowment contracts, accident and health insurance contracts or deposit-type contracts in this State and subject to regulation by the Commissioner, except as exempted in the valuation manual, shall also annually include in the opinion required by this subsection, an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including, but not limited to, the benefits under and expenses associated with the policies and contracts.

(j2) Each opinion required by subsection (j1) of this section shall be governed by the following provisions:

(1) A memorandum, in form and substance as specified in the valuation manual and acceptable to the Commissioner, shall be prepared to support each actuarial opinion.

(2) If the company fails to provide a supporting memorandum at the request of the Commissioner within a period specified in the valuation manual or the Commissioner determines that the supporting memorandum provided by the company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the Commissioner, the Commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the Commissioner.

(3) The opinion shall be in form and substance as specified in the valuation manual and acceptable to the Commissioner.

(4) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after the operative date of the valuation manual.

(5) The opinion shall apply to all policies and contracts subject to subsection (j1) of this section plus other actuarial liabilities as specified in the valuation manual.

(6) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board or its successor and on such additional standards as may be prescribed in the valuation manual.

(7) In the case of an opinion required to be submitted by a foreign or alien company, the Commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the Commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this State.

(8) Except in cases of fraud or willful misconduct, the appointed actuary shall not be liable for damages to any person (other than the company and the Commissioner) for any act, error, omission, decision, or conduct with respect to the appointed actuary's opinion.

(9) Disciplinary action by the Commissioner against the company or the appointed actuary shall be defined in rules by the Commissioner.

(k) The Commissioner shall adopt rules containing the minimum standards applicable to the valuation of accident and health ~~plans.~~insurance contracts issued prior to the operative

<u>date of the valuation manual.</u> The Commissioner may also adopt rules for the purpose of recognizing new annuity mortality tables for use in determining reserve liabilities for annuities and may adopt rules that govern minimum valuation standards for reserves of life insurance companies. In adopting these rules, the Commissioner may consider model laws and regulations promulgated and amended from time to time by the NAIC.

(l) The Commissioner may adopt rules for life insurers for the following matters:

(1) Reserves for contracts issued by insurers.

(2) Optional smoker-nonsmoker mortality tables permitted for use in determining minimum reserve liabilities and nonforfeiture benefits.

(3) Optional blended gender mortality tables permitted for use in determining nonforfeiture benefits for individual life policies.

(4) Optional tables acceptable for use in determining reserves and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

(5) Assumptions for policyholder withdrawal rates for use in determining minimum reserve liabilities.

In adopting these rules, the Commissioner may consider model laws and regulations promulgated and amended from time to time by the NAIC.

<u>(m) The valuation manual shall apply as described in this subsection.</u>

<u>(1) For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under subsections (b2) and (b3) of this section, except as provided under subdivisions (5) or (7) of this subsection.</u>

<u>(2) The operative date of the valuation manual is specified in G.S. 58-58-51(b).</u>

<u>(3) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January 1 of the year following the date when the change to the valuation manual has been adopted by the NAIC by an affirmative vote representing each of the following:</u>

<u>a. At least three-fourths of the members of the NAIC voting, but not less than a majority of the total membership.</u>

<u>b. Members of the NAIC representing jurisdictions totaling more than seventy-five percent (75%) of the direct premiums written as reported in the following annual statements most recently available prior to the vote described in this subdivision: life, accident and health annual statements; health annual statements; and fraternal annual statements.</u>

<u>(4) The valuation manual must specify all of the following:</u>

<u>a. Minimum valuation standards for and definitions of the policies or contracts subject to subsections (b2) and (b3) of this section. Such minimum valuation standards shall be as follows:</u>

<u>1. The Commissioner's reserve valuation method for life insurance contracts subject to subsections (b2) and (b3) of this section.</u>

<u>2. The Commissioner's annuity reserve valuation method for annuity contracts subject to subsections (b2) and (b3) of this section.</u>

<u>3. Minimum reserves for all other policies or contracts subject to subsections (b2) and (b3) of this section.</u>

<u>b. The policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation as</u>

described in subsection (n) of this section and the minimum valuation standards consistent with those requirements.

c. For policies and contracts subject to a principle-based valuation under subsection (n) of this section, each of the following:

1. Requirements for the format of reports to the Commissioner under sub-subdivision (2)(c) of subsection (n) of this section. Such reports shall include information necessary to determine if the valuation is appropriate and in compliance with this section.

2. Assumptions shall be prescribed for risks over which the company does not have significant control or influence.

3. Procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of such procedures.

d. For policies not subject to a principle-based valuation under subsection (n) of this section, the minimum valuation standard shall either:

1. Be consistent with the minimum standard of valuation prior to the operative date of the valuation manual; or

2. Develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring.

e. Other requirements, including, but not limited to, those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules and internal controls.

f. The data and form of the data required under subsection (o) of this section, to whom the data must be submitted, and may specify other requirements, including data analyses and reporting of analyses.

(5) In the absence of a specific valuation requirement, or if a specific valuation requirement in the valuation manual is not, in the opinion of the Commissioner, in compliance with this section, then the company shall, with respect to such requirements, comply with minimum valuation standards prescribed by the Commissioner by rule.

(6) The Commissioner may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in this section. The Commissioner may rely upon the opinion, regarding provisions contained in this section, of a qualified actuary engaged by the insurance regulator of another state, district, or territory of the United States. As used in this subdivision, the term "engage" includes employment and contracting.

(7) The Commissioner may require a company to change any assumption or method that in the opinion of the Commissioner is necessary in order to comply with the requirements of the valuation manual or this section; and the company shall adjust the reserves as required by the Commissioner. The

Commissioner may take other disciplinary action as specified in rules adopted by the Commissioner.

(n) The requirements of this subsection shall apply to any principle-based valuation of policies issued on or after the operative date of the valuation manual.

(1) A company using a principle-based valuation for one or more policies or contracts subject to this subsection as specified in the valuation manual must establish, for those policies and contracts, reserves that meet all of the following:

a. Quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. For policies or contracts with significant tail risk, the reserves shall reflect conditions appropriately adverse to quantify the tail risk.

b. Incorporate assumptions, risk analysis methods and financial models and management techniques that are consistent with, but not necessarily identical to, those utilized within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods.

c. Incorporate assumptions that are derived in one of the following manners:

1. The assumption is prescribed in the valuation manual.

2. For assumptions that are not prescribed, the assumptions shall (i) be established utilizing the company's available experience, to the extent it is relevant and statistically credible; or (ii) to the extent that company data is not available, relevant, or statistically credible, be established utilizing other relevant, statistically credible experience.

d. Provide margins for uncertainty, including adverse deviation and estimation error, such that the greater the uncertainty, the larger the margin and resulting reserve.

(2) A company using a principle-based valuation for one or more policies or contracts subject to this subsection as specified in the valuation manual shall do the following:

a. Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual.

b. Provide to the Commissioner and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. Such controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation, and that valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year.

c. Develop, and file with the Commissioner upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

(o) A company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

(p) The confidentiality of documents, materials, and other information provided to the Commissioner under this section shall be maintained as described in this subsection.

(1) For purposes of this subsection, "confidential information" shall include all of the following:

a. A memorandum in support of an opinion submitted under subsections (i) or (j1) of this section and any other documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the Commissioner or any other person in connection with such memorandum.

b. All documents, materials, and other information, including, but not limited to, all working papers and copies thereof, created, produced or obtained by or disclosed to the Commissioner or any other person in the course of an examination made under subdivision (6) of subsection (m) of this section; provided, however, that if an examination report or other material prepared in connection with an examination made under the Examination Law (G.S. 58-2-131 through G.S. 58-2-134) is not held as private and confidential information under the Examination Law, an examination report or other material prepared in connection with an examination made under subdivision (6) of subsection (m) of this section shall not be "confidential information" to the same extent as if such examination report or other material had been prepared under the Examination Law.

c. Any reports, documents, materials and other information developed by a company in support of, or in connection with, an annual certification by the company under sub-subdivision (2)b. of subsection (n) of this section evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the Commissioner or any other person in connection with such reports, documents, materials and other information.

d. Any principle-based valuation report developed under sub-subdivision (2)c. of subsection (n) of this section and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the Commissioner or any other person in connection with such report.

e. Any documents, materials, data and other information submitted by a company under subsection (o) of this section (collectively, "experience data") and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created or produced in connection with such experience data, in each case that includes any potentially company-identifying or personally identifiable information, that is provided to or obtained by the Commissioner (together with any "experience data," the "experience materials") and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the Commissioner or any other person in connection with such experience materials.

(2) Except as provided in this subsection, a company's confidential information is confidential by law and privileged, shall not be subject to or considered public record under G.S. 58-2-100 or Chapter 132 of the General Statutes, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the confidential information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties.

(3) Neither the Commissioner nor any person who received confidential information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential information.

(4) In order to assist in the performance of the Commissioner's duties, the Commissioner may share confidential information (i) with other state, federal, and international regulatory agencies and with the NAIC and its affiliates and subsidiaries and (ii) in the case of confidential information specified in sub-subdivisions (1)a. and (1)d. of this subsection only, with the Actuarial Board for Counseling and Discipline or its successor upon request stating that the confidential information is required for the purpose of professional disciplinary proceedings and with state, federal, and international law enforcement officials; in the case of (i) and (ii), provided that such recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of such documents, materials, data and other information in the same manner and to the same extent as required for the Commissioner.

(5) The Commissioner may receive documents, materials, data and other information, including otherwise confidential and privileged documents, materials, data or information, from the NAIC and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions and from the Actuarial Board for Counseling and Discipline or its successor and shall maintain as confidential or privileged any document, material, data or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or other information.

(6) The Commissioner may enter into agreements governing the sharing and use of information consistent with this subsection.

(7) No waiver of any applicable privilege or claim of confidentiality in the confidential information shall occur as a result of disclosure to the Commissioner under this subsection or as a result of sharing as authorized in subdivision (4) of this subsection.

(8) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any proceeding in, and in any court of, this State.

(9) In this subsection, "regulatory agency," "law enforcement agency" and the "NAIC" include, but are not limited to, their employees, agents, consultants, and contractors.

(10) Notwithstanding subdivisions (2) through (9) of this subsection, confidential information specified in sub-subdivisions (1)a. and (1)d. of this subsection may be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under subsection (i) or (j1) of this section or principle-based valuation report developed under sub-subdivision (2)c. of subsection (n) of this section by reason of an action required by this section or by rules promulgated by the Commissioner. Such confidential information may otherwise be released by the Commissioner with the written consent of the company. Once any portion of a memorandum in support of an opinion submitted under subsection (i) or (j1) of this section or a principle-based valuation report developed under sub-subdivision (2)c. of subsection (n) of this section is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of such memorandum or report shall no longer be confidential.

(q) The Commissioner may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in this State from the requirements of subsection (m) of this section provided (i) the Commissioner has issued an exemption in writing to the company and has not subsequently revoked the exemption in writing; and (ii) the company computes reserves using assumptions and methods used prior to the operative date of the valuation manual in addition to any requirements established by the Commissioner by rule. For any company granted an exemption under this subsection, the following subsections of this section shall be applicable: (c), (d), (d1), (e), (f), (g), (h), (i), (j), (j1), (j2) and (k), excluding any references to subsection (m) found therein.

(r) The Department shall have full authority to enter into contracts or other agreements with the National Association of Insurance Commissioners, or any other state, entity, or person to fulfill the requirements of this section. Such contracts shall not be subject to Articles 3, 3C, and 8 of Chapter 143 of the General Statutes, or any rules and procedures adopted under those Articles concerning procurement, contracting, and contract review."

SECTION 2. G.S. 58-58-55 reads as rewritten:

"§ 58-58-55. Standard nonforfeiture provisions.

…

(e) (1) This subdivision (1) of subsection (e) shall not apply to policies issued on or after the operative date of subdivision (4) of subsection (e) as defined therein. Except as provided in the third paragraph of this subdivision, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding any extra premiums charged because of impairments or special hazards, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of (i) the then present value of the future guaranteed benefits provided for by the policy; (ii) two percent (2%) of the amount of insurance, if the insurance be uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy; (iii) forty percent (40%) of the adjusted premium for the first policy year; (iv) twenty-five percent (25%) of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less. Provided, however, that in applying the percentages specified in (iii) and (iv) above, no adjusted premium shall be deemed to exceed four percent (4%) of the amount of insurance or uniform amount equivalent thereto. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount thereof for the purpose of this section shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy, provided, however, that in the case of a policy providing a varying amount of insurance issued on the life of a child under age 10, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age 10 were the amount provided by such policy at age 10.

The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to (i) the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by (ii) the adjusted premiums for such term insurance, the foregoing items (i) and (ii) being calculated separately and as specified in the first two paragraphs of this subsection except that, for the purposes of (ii), (iii) and (iv) of the first such paragraph, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in (ii) of this paragraph shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in (i).

Except as otherwise provided in subdivisions (2) and (3) of this subsection, all adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of the Commissioner's 1941 Standard Ordinary Mortality Table, provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than three years younger than the actual age of the insured, and such calculations for all policies of industrial insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest, not exceeding three and one-half percent (3 1/2%) per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may not be more than one hundred and thirty percent (130%) of the rates of mortality according to such applicable table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the Commissioner.

…

(4) a. This subdivision shall apply to all policies issued on or after the operative date of this subdivision (4) of subsection (e) as defined herein. Except as provided in paragraph g of this subdivision, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of (i) the then present value of the future guaranteed benefits provided for by the policy; (ii) one percent (1%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years; and (iii) one hundred twenty-five percent (125%) of the nonforfeiture net level premium as hereinafter defined. Provided, however, that in applying the percentage specified in (iii) above no nonforfeiture net level premium shall be deemed to exceed four percent (4%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years. The date of issue of a policy for the purpose of this subdivision shall be the date as of which the rated age of the insured is determined.

…

h. All adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of (i) the Commissioner's 1980 Standard Ordinary Mortality Table or (ii) at the election of the company for any one or more specified plans of life insurance, the Commissioner's 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; shall for all policies of industrial insurance be calculated on the basis of the Commissioner's 1961 Standard Industrial Mortality Table; and shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this subdivision for policies issued in that calendar year. Provided, however, that:

…

6. ~~Any~~ For policies issued prior to the operative date of the valuation manual, which is defined in G.S. 58-58-51, any Commissioners Standard ordinary mortality tables, adopted after 1980 by the NAIC, that are approved by regulation promulgated by the Commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioner's 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioner's 1980 Extended Term Insurance Table. For

policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioners Standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. If the Commissioner approves by regulation any Commissioners Standard ordinary mortality table adopted by the NAIC for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

7. ~~Any~~ For policies issued prior to the operative date of the valuation manual, any Commissioners Standard industrial mortality tables, adopted after 1980 by the NAIC, that are approved by regulation promulgated by the Commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioner's 1961 Standard Industrial Mortality Table or the Commissioner's 1961 Industrial Extended Term Insurance Table. For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioners Standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1961 Industrial Extended Term Insurance Table. If the Commissioner approves by regulation any Commissioners Standard industrial mortality table adopted by the NAIC for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

i. ~~The~~For policies issued prior to the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to one hundred and twenty-five percent (125%) of the calendar year statutory valuation interest rate for such policy as defined in the Standard Valuation Law, rounded to the nearer one quarter of one percent ~~(1/4 of 1%).~~(1/4 of 1%), but not less than four percent (4%). For policies issued on or after the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be provided by the valuation manual.

…."

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

"**§ 58-58-51. NAIC valuation manual operative date.**

(a) As used in the section, "valuation manual" means the manual of valuation instructions adopted by the NAIC or as subsequently amended.

(b) The operative date of the valuation manual is January 1 of the first calendar year that begins following the first July 1 as of which all of the following have occurred:

(1) The valuation manual has been adopted by the NAIC by an affirmative vote of at least 42 members, or three-fourths of the members voting, whichever is greater.

(2) The model Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing more than seventy-five percent (75%) of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident and health annual statements; health annual statements; and fraternal annual statements.

(3) The model Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least 42 of the following 55 jurisdictions: the 50 states of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico."

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

"(j) Each opinion required by subsection (i) of this section shall be governed by the following provisions:

(1) A memorandum, in form and substance acceptable to the Commissioner as specified by rule, shall be prepared to support each actuarial opinion.

(2) If the insurance company fails to provide a supporting memorandum at the request of the Commissioner within a period specified by rule or the Commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the rules or is otherwise unacceptable to the Commissioner, the Commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the Commissioner.

(3) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1994.

(4) The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the Commissioner as specified by rule.

(5) The opinion shall be based on standards adopted from time to time by the actuarial standards board and on such additional standards as the Commissioner may by rule prescribe.

(6) In the case of an opinion required to be submitted by a foreign or alien company, the Commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the Commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this State.

(7) For the purposes of this section, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirement set forth in such rules.

(8) Except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person (other than the insurance company and the Commissioner) for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

(9) Disciplinary action by the Commissioner against the company or the qualified actuary shall be defined in rules by the Commissioner.

~~(10) Any memorandum in support of the opinion, and any other material provided by the company to the Commissioner in connection therewith, shall be kept confidential by the Commissioner and shall not be made public and shall not be subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this section or by rules adopted under this section; provided, however, that the memorandum or other material may otherwise be released by the Commissioner (i) with the written consent of the company or (ii) to the American Academy of Actuaries upon request stating the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the Commissioner for preserving the confidentiality of the memorandum or other material. Once any portion of the confidential memorandum is cited by the company in its marketing or is cited before any governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum shall be no longer confidential.~~Except as provided in subdivisions (14), (15), and (16) of this subsection, documents, materials, or other information in the possession or control of the Commissioner that are included in a memorandum in support of the opinion, and any other material provided by the company to the Commissioner in connection with the opinion, shall be confidential by law and privileged, shall not be subject to or public records under G.S. 58-2-100 or Chapter 132 of the General Statutes, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties.

(11) Neither the Commissioner nor any person who received documents, materials or other information while acting under the authority of the Commissioner shall be permitted or required to testify concerning any confidential documents, materials or information subject to subdivision (10) of this subsection in any private civil action.

(12) In order to assist in the performance of the Commissioner's duties, the Commissioner may do any of the following:

a. Share documents, materials or other information, including the confidential and privileged documents, materials, or information subject to subdivision (10) of this subsection, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information.

b. Receive documents, materials, or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

c. Enter into agreements governing sharing and use of information consistent with subdivisions (10) through (12) of this subsection.

(13) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing authorized by subdivision (12) of this subsection.

(14) A memorandum in support of an opinion, and any other material provided by the company in connection with the memorandum, may be subject to subpoena for the purpose of defending an action seeking damages from the actuary submitting the memorandum by reason of any action required by this section or by rules adopted under this section.

(15) The memorandum or other material may otherwise be released by the Commissioner (i) with the written consent of the company or (ii) to the American Academy of Actuaries upon request stating the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the Commissioner for preserving the confidentiality of the memorandum or other material.

(16) Once any portion of the confidential memorandum is cited by the company in its marketing or is cited before any governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum shall no longer be confidential."

SECTION 5. If any section or provision of this act is declared unconstitutional, preempted, or otherwise invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional, preempted, or otherwise invalid.

SECTION 6. Sections 1 and 2 of this act become effective on the operative date of the manual of valuation instructions adopted by the National Association of Insurance Commissioners as provided in G.S. 58-58-51. The remainder of this act is effective when it becomes law.

EXHIBIT 8

HOUSE BILL 361: Principle-Based Reserving

2015-2016 General Assembly

Committee:	House Insurance	**Date:**	April 21, 2015
Introduced by:	Reps. Collins, Tine, Setzer	**Prepared by:**	Kristen Harris
Analysis of:	First Edition		Committee Counsel

SUMMARY: House Bill 361 would provide for a principle-based reserving approach to valuing life insurance reserves in North Carolina and make minor conforming changes to the Standard Nonforfeiture Law.

[As introduced, this bill is identical to S667, as introduced by Sen. Apodaca, which is currently in Senate Insurance.]

BACKGROUND AND CURRENT LAW:

North Carolina currently uses a formula-based approach based on mortality tables and interest rates to calculate life insurance policy reserves.

In 2009, the National Association of Insurance Commissioners (NAIC) adopted the Standard Valuation Law (SVL) which introduced a new method for calculating life insurance policy reserves called "principle-based reserving" (PBR). The PBR approach replaces the formulaic approach by adopting a Valuation Manual which is maintained by the NAIC. To date, 21 states have enacted legislation to implement principle-based reserving. Once at least 42 states, representing 75% of the total U.S. premium adopt the revisions to the SVL, PBR will be implemented over approximately three years and only for new business.[1]

It is anticipated that PBR will become an NAIC accreditation requirement by 2016 or 2017.

BILL ANALYSIS:

Section 1 would incorporate model language from the NAIC's Standard Valuation Law for new business issued after the operative date of the valuation manual, as defined in Section 3. The current statutory language would apply to business issued prior to the manual's operative date. The bill would require the Commissioner to value annually reserves for various types of contracts in the State issued on or after the operative date of the manual. Every company with outstanding contracts would be required to submit annually the opinion of the appointed actuary in accordance with the guidelines prescribed in the manual. A provision would be included addressing the confidentiality of documents, materials, and other information provided to the Commissioner. The Commissioner would be allowed to exempt specific product forms and lines of a domestic company from the manual's requirements under certain circumstances. The Department of Insurance would have authority to enter into contracts with the NAIC, other states, entities, or persons to fulfill the requirements of this section.

Section 2 would make conforming changes to the Standard Nonforfeiture Law to maintain consistency with the Standard Valuation Law in Section 1.

Section 3 would define the operative date of the NAIC valuation manual.

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[1] http://www.naic.org/documents/committees_ex_pbr_implementation_tf_related_150301_pbr_implementation.pdf

Section 4 would incorporate model language from the NAIC's Standard Valuation Law.

EFFECTIVE DATE: Sections 1 and 2 of this act become effective on the operative date of the manual of valuation instructions adopted by the National Association of Insurance Commissioners as provided in G.S. 58-58-51. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 1

HOUSE BILL 528

Short Title:	Establish Chiropractor Co-Pay Parity.	(Public)
Sponsors:	Representatives Burr, Jones, and Hanes (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Insurance, if favorable, Appropriations.	

April 2, 2015

A BILL TO BE ENTITLED

AN ACT TO REENACT A LAW CONCERNING HEALTH BENEFIT PLAN CO-PAYMENTS FOR SERVICES PERFORMED BY CHIROPRACTORS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-30(a3) reads as rewritten:

"(a3) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 unless a comparable limitation is imposed on the medically necessary treatment if performed or authorized by any other duly licensed physician. <u>An insurer shall not impose upon an insured as a limitation on treatment or level of coverage a co-payment amount for services performed by a duly licensed chiropractor that is higher than the co-payment amount imposed upon the insured for services performed by a duly licensed primary care physician for a comparable, medically necessary treatment or condition.</u>"

SECTION 2. This act becomes effective January 1, 2016, and applies to health benefit contracts entered into on or after that date.

EXHIBIT 10

HOUSE BILL 528: Establish Chiropractor Co-Pay Parity

2015-2016 General Assembly

Committee:	House Insurance, if favorable, Appropriations	**Date:**	April 20, 2015
Introduced by:	Reps. Burr, Jones, Hanes	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	First Edition		

SUMMARY:* *House Bill528 would prohibit health benefit plans and the State Health Plan for Teachers and State Employees from charging a copayment for services performed by a licensed chiropractor that is higher than the copayment for services performed by a licensed primary care physician for a comparable, medically necessary treatment or condition.

CURRENT LAW: Health benefit plans are able to charge copayments for chiropractor care at levels that are set by the health benefit plans. The State Health Plan for Teachers and State Employees charges a copay that is higher for chiropractic services than for primary care services.

BILL ANALYSIS:

House Bill 528 amends G.S. 58-50-30(a3) which would prohibit health benefit plans and the State Health Plan for Teachers and State Employees from charging a copayment for services performed by a licensed chiropractor that is higher than the copayment for services performed by a licensed primary care physician for a comparable, medically necessary treatment or condition.

House Bill 528 would also apply to the State Health Plan. G.S. 135-48.51 directs that all provisions under G.S. 58-50-30 apply to the State Health Plan.

EFFECTIVE DATE: This act becomes effective January 1, 2016.

EXHIBIT 11

NORTH CAROLINA

OFFICE OF THE TREASURER

JANET COWELL, TREASURER

House 528

"Establish Chiropractor Co-Pay Parity"

Dear Member of the House Insurance Committee:

Today you will consider House 528, entitled "Establish Chiropractor Co-Pay Parity."

The Office of the State Treasurer is strongly opposed to this measure.

Our reasons are as follows:

- There is no funding accompanying this measure. As such, it is an "unfunded mandate" that will add to the cost of the State Health Plan.
- The General Assembly has instructed the Board of Trustees of the plan to control costs. This measure moves us in the opposite direction.
- The Board of Trustees has already considered this measure and decided against it.

And lastly, but perhaps most importantly:

- One of the principal reasons the General Assembly sent the Health Plan to the Treasurer's office was to get out of making decisions like this. Thus far, the General Assembly has refrained from legislating plan benefits, leaving those decisions to the Board of Trustees. This measure, if adopted, would represent a significant departure from this practice – one that has worked well thus far. It would encourage groups who are not satisfied with board decisions to come to the General Assembly for redress, putting you once again in the position of legislating the State Health Plan.

For all these reasons, we encourage you to vote <u>no</u> on this measure.

325 NORTH SALISBURY STREET, RALEIGH, NORTH CAROLINA 27603-1385 · (919) 508-5176 · FAX (919) 508-5167
WWW.NCTREASURER.COM

EXHIBIT 12

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. ____________

H. B. No. 1328

DATE ____________

S. B. No. ____________

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

COMMITTEE SUBSTITUTE ____________

Rep.) Pendleton
Sen.)

moves to amend the bill on page 1, line 16

( ) WHICH CHANGES THE TITLE

by adding the following to the end of the line:

These ~~shall~~ requirements shall be limited to the first five visits to a chiropractor annually. as primary care, Thereafter treated as a specialist.

SIGNED ____________

ADOPTED ____________ FAILED ____________ TABLED ____________ failed

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

EXHIBIT 13

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 182*
PROPOSED COMMITTEE SUBSTITUTE H182-CSRG-3 [v.10]
4/27/2015 6:23:16 PM

Short Title: Property Insurance Fairness. (Public)

Sponsors:

Referred to:

March 11, 2015

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE FAIRNESS AND EQUITY OF PROPERTY INSURANCE RATE MAKING IN NORTH CAROLINA BY REQUIRING THAT CERTAIN PROPERTY INSURANCE DATA BE MADE AVAILABLE TO THE PUBLIC; BY PROVIDING THE NORTH CAROLINA INSURANCE UNDERWRITING ASSOCIATION THE AUTHORITY TO HAVE ISSUED TAX-EXEMPT BONDS TO COVER LOSS-RELATED LIABILITIES; BY REFORMING CONSENT TO RATE PRACTICES; BY REQUIRING THAT CATASTROPHE MODELING USED FOR PROPERTY RATE-MAKING PURPOSES MORE ACCURATELY REFLECT POTENTIAL IMPACTS IN NORTH CAROLINA; AND BY CREATING THE JOINT LEGISLATIVE STUDY COMMITTEE ON PROPERTY INSURANCE RATE MAKING.

The General Assembly of North Carolina enacts:

PART I. PROPERTY INSURANCE CLARITY

SECTION 1. G.S. 58-36-15 is amended by adding a new subsection to read:

(d2) With respect to homeowners insurance rate filings, the Bureau shall do the following:

(1) Submit to the Department computations of the total amount of direct incurred losses, direct earned premiums, house years and statewide expenses for the most recent five years included in the filing.

(2) Report the computations to the Department by rate territory where available.

(3) Provide this information for each of the following policy categories:

i. All full homeowners policies.

ii. All homeowners policies that exclude windstorm coverage.

iii. All policies that only include windstorm coverage.

For the purposes of this subsection, homeowners insurance policies shall include condominium insurance and renters insurance, but shall not include creditor-placed policies, condominium association policies or commercial policies.

(4) Submit to the Department catastrophic wind and hail information pursuant to a data call by the Department based on a specific catastrophic event.

Information received by the Department under this subsection shall be posted on the Department's website. Any information reported to the Department by an insurer pursuant to this subsection is considered a trade secret as defined in G.S. 66-152 and shall be treated as confidential information by the Department. However, once the information from all property insurers is aggregated, then the Department may provide such information in accordance with

H182-CSRG-3-V-10

this subsection. Notice of at least 10 business days shall be given to the insurer if confidential information pertaining to that insurer is ordered by a court of competent jurisdiction to be released to the Department."

PART II. BONDING AUTHORITY

SECTION 2.1. Chapter 58 of the General Statutes is amended by adding a new Article to read:

"Article 45A.

"Recovery Finance Authority.

"**§ 58-45A-1. Name.**

This Article shall be known as the "North Carolina Recovery Finance Authority Act."

"**§ 58-45A-5. Legislative Findings.**

The General Assembly finds that the likelihood of one or more hurricanes or other catastrophic events causing sufficient damage and destruction for the Association to incur losses and loss expenses, including loss adjustment expenses, that exceed the combination of available surplus, reinsurance, and other sources of funding, including assessments on its member companies, is significant. The General Assembly finds that in any such event it will be beneficial to the residents and property owners in this State and will increase the insurance capacity and the overall functioning of the State's insurance industry that all or a portion of the obligations to pay claims under policies issued by the Association and related to the hurricane or other catastrophic event resulting in such excess losses and loss expenses, including loss adjustment expenses, could be financed by a State entity through bonded indebtedness paid from amounts including catastrophe recovery charges imposed on residential and commercial property insurance policyholders Statewide with their annual policy premiums. The General Assembly therefore finds that, as an additional or alternative method to borrowing by the Association for the purpose of paying such excess losses and loss expenses including loss adjustment expenses, the creation of a State authority to acquire the obligation to pay such claims under such policies and provide for the issuance of bonded indebtedness is necessary and desirable to provide the most efficient mechanisms for addressing excess losses and loss expenses, including loss adjustment expenses, that may arise from hurricanes or other catastrophic events in the State.

"**§ 58-45A-10. Definitions.**

The following definitions apply to this Article:

(1) Assessment. – A nonrecoupable fee or charge levied on members in the Association pursuant to G.S. 58-45-47(a).

(2) Association. – The North Carolina Insurance Underwriting Association, established under Article 45 of this Chapter.

(3) Authority Board. – The governing body of the Recovery Finance Authority.

(4) Bonds. – Bonds, notes, debentures, loan agreements or other types of obligations of the Recovery Finance Authority.

(5) Catastrophe Recovery Charge. – A charge calculated as a uniform percentage of written premiums to be paid with annual premiums on all residential and commercial property insurance policies Statewide.

(6) Deficit. – The amount of losses and loss expenses of the Association relating to a particular Event that will exceed the combination of available surplus, reinsurance, and other sources of funding, including assessments, for the Association to fund losses and loss expenses, including loss adjustment expenses, resulting from Events in that calendar year.

(7) Event. – A hurricane or other catastrophic event causing loss or loss expenses to the Association for property in the State.

(8) Recovery Finance Authority. – The North Carolina Recovery Finance Authority, a public agency created by this Article.

"§ 58-45A-15. North Carolina Recovery Finance Authority.

(a) Creation. – There is created a body politic and corporate to be known as the "North Carolina Recovery Finance Authority." The Recovery Finance Authority is constituted as a public agency, and the exercise by the Authority of the powers conferred by this Article in the financing of deficits of the Association related to catastrophic events shall be deemed and held to be the performance of an essential governmental function.

(b) Administrative Placement. – The Authority shall be located with the Department for administrative purposes, but shall exercise all of its powers independently of the Association and the Department except as otherwise specified in this Article.

(c) Authority Board. – The Authority shall be governed by a nine-member Authority Board consisting of two members appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate in accordance with G.S. 120-121, two members appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives in accordance with G.S. 120-121, two members appointed by the Governor, two members appointed by the Association, and the Commissioner of Insurance or the Commissioner's designee. Each appointing authority shall appoint members who reside in diverse regions of the State. The Chair of the Authority shall be selected by the Authority Board.

(d) Staggered Terms. – The initial appointments to the Authority Board by the General Assembly upon the recommendation of the President Pro Tempore of the Senate and by the Governor shall be for terms ending April 1, 2017. The initial appointments to the Authority Board by the General Assembly upon the recommendation of the Speaker of the House of Representatives and by the Association shall be appointed to terms ending April 1, 2019. The Commissioner of Insurance or the Commissioner's designee shall serve at all times as ex officio voting member of the Board. Thereafter, at the expiration of each stipulated term of office, all appointments shall be to a term of four years from the date of the expiration of the term; provided all members of the Authority Board shall remain in office until their successors are appointed and qualified. The original appointing authority may appoint a member to serve out the unexpired term of any member appointed by such authority.

(e) Removal of Board Members. – Each member of the Authority Board, notwithstanding subsection (d) of this section, shall serve at the pleasure of the original appointing authority. The chair of the Authority serves at the pleasure of the Authority Board.

(f) Conflicts of Interest, Ethics. – Members of the Authority Board shall be subject to the provisions of Chapter 138A of the General Statutes as well as any ethics or conflicts policies promulgated by the Governor for boards of State agencies in addition to the requirements of this subsection. If any member of the Authority shall be: (1) interested either directly or indirectly; or (2) an officer or employee of or have an ownership interest in, any firm or corporation, not including units of local government or the Association, interested directly or indirectly, in any contract with the Authority, the interest shall be disclosed to the Authority and shall be set forth in the minutes of the Authority. The member having an interest shall not participate on behalf of the Authority in the authorization of such contract. Other provisions of law notwithstanding, failure to take any or all actions necessary to carry out the purposes of this subsection do not affect the validity of any bonds issued under this Article. Members, officers, and employees of the Authority shall be subject to the provisions of G.S. 14-234.

(g) Compensation. – The appointed members of the Authority Board shall receive no salary for their services but shall be entitled to receive per diem and travel allowances in accordance with the provisions of G.S. 138-5 and G.S. 138-6 as appropriate.

(h) Initial Meeting. – The initial meeting of the Authority may be called by the Commissioner of Insurance or any other four members.

(i) Bylaws. – The Authority Board shall adopt, change, or amend bylaws with respect to the calling of meetings, quorums, voting procedures, the keeping of records, and other organizational, staffing, and administrative matters as the Authority Board may determine. Any amendments to the bylaws after their initial adoption shall be submitted to the Commissioner of Insurance for review and comment at least 45 days prior to adoption by the Authority Board.

"§ 58-45A-20. Powers of the Recovery Finance Authority.

(a) The Recovery Finance Authority shall have all of the powers necessary to execute the provisions of this Article, including the following:

(1) The powers of a corporate body, including the power to sue and be sued, to make contracts, to adopt and use a common seal, and to alter the adopted seal as needed.

(2) To issue bonds of the Authority as provided in this Article and use the proceeds of such bonds to finance obligations to pay claims with respect to policies assigned to it in connection with Events with the debt service on such bonds payable from catastrophe recovery charges under G.S. 58-45-47, other revenues of the Authority or other payments by the Association or its members. Proceeds of such bonds may be used to pay issuance expenses, interest on the bonds for a period of up to one year, and to create a reserve fund for the bonds.

(3) To invest the proceeds of bonds of the Authority that are pending disbursement or other idle funds of the Authority in any investment authorized by G.S. 159-30.

(4) To pay all necessary costs and expenses in the formation, organization, administration, and operation of the Authority.

(5) To apply for, accept, and administer loans and grants of money or real or personal property from the United States of America or any federal agency, the State or its political subdivisions, local governments, or any other public or private sources available.

(6) To adopt, alter, or repeal its own bylaws or rules implementing the provisions of this Article.

(7) To contract for the services of consulting attorneys and other consultants; to employ administrative staff as may be required in the judgment of the Authority; and to fix and pay fees or compensation to the contractors, and administrative employees from funds available to the Authority.

(8) To receive and use appropriations from the State and federal government.

(9) To adopt procedures to govern its procurement of services.

(10) To perform or procure any portion of services required by the Authority.

(11) To use officers, employees, agents, and facilities of the Department or the Association for the purposes and upon the terms as may be mutually agreeable.

(12) To enter into partnership agreements with the Department or the Association, agreements with political subdivisions of the State, and agreements with private entities, and to expend such funds as it deems necessary, pursuant to such agreements, for its purposes.

(13) To enter into swap agreements pursuant to Article 13 of Chapter 159 of the General Statutes.

(14) To receive, administer, and comply with the conditions and requirements respecting any gift, grant, or donation of any property or money.

(15) To acquire by purchase, lease, gift, or otherwise, or to obtain options for the acquisition of, any real or personal property or interest therein.

(16) To sell, lease, exchange, transfer, or otherwise dispose of, or to grant options for any of these purposes with respect to, any real or personal property or interest therein.

(17) Subject to the provisions of this Article, to pledge, assign, mortgage, or otherwise grant a security interest in any real or personal property or interest therein, including a leasehold interest, including the right and power to pledge, assign, or otherwise grant a security interest in any money, rents, charges, or other revenues and any proceeds derived by the Authority from any and all sources.

(18) To do all acts and terms necessary, convenient, or desirable to carry out the purpose and exercise the specific powers granted to it herein.

"§ 58-45A–25. Taxation of property of Recovery Finance Authority.

Property owned by the Recovery Finance Authority is exempt from taxation in accordance with Section 2 of Article V of the North Carolina Constitution.

"§ 58-45A–30. Audit.

The operations of the Recovery Finance Authority shall be subject to the oversight of the State Auditor pursuant to Article 5A of Chapter 147 of the General Statutes.

"§ 58-45A–35. Recovery Finance Authority bonds.

(a) The Recovery Finance Authority shall be a municipality for purposes of Article 5 of Chapter 159 of the General Statutes, the State and Local Government Revenue Bond Act, and may issue revenue bonds pursuant to that Act to pay all or a portion of the cost of a Deficit or to refund any previously issued bonds. In connection with the issuance of revenue bonds, the Authority shall have all powers of a municipality under the State and Local Government Revenue Bond Act, and revenue bonds issued by the Authority shall be entitled to the protection of all provisions of the State and Local Government Revenue Bond Act.

(b) In addition to swap agreements permitted by Article 13 of Chapter 159 of the General Statutes, in connection with or incidental to the acquisition or carrying of any investment relating to bonds, program of investment relating to bonds, or carrying of bonds, the Authority may, with the approval of the Local Government Commission, enter into a contract to place the investment or obligation of the Authority, as represented by the bonds, investment, or program of investment and the contract or contracts, in whole or in part, on an interest rate, currency, cash flow, or other basis, including the following:

(1) Interest rate swap agreements, currency swap agreements, insurance agreements, forward payment conversion agreements, and futures.

(2) Contracts providing for payments based on levels of, or changes in, interest rates, currency exchange rates, event-related indices, or stock or other indices.

(3) Contracts to exchange cash flows or a series of payments.

(4) Contracts to hedge payment, currency, rate, spread, or similar exposure, including interest rate floors or caps, options, puts, and calls.

The Authority may enter a contract of this type in connection with, or incidental to, entering into or maintaining any agreement that secures bonds. A contract shall contain the payment, security, term, default, remedy, and other terms and conditions the Authority Board considers appropriate. The Authority may enter a contract of this type with any person after giving due consideration, where applicable, to the person's creditworthiness as determined by a rating by a nationally recognized rating agency or any other criteria the Authority Board considers appropriate. In connection with, or incidental to, the issuance or carrying of bonds, or the entering into any contract described in this subsection, the Authority may enter into credit enhancement or liquidity agreements, with payment, interest rate, termination date, currency, security, default, remedy, and other terms and conditions as the Authority determines. Proceeds of bonds and any moneys set aside and pledged to secure payment of bonds or any of the contracts entered into under this subsection may be pledged to and used to service any of the contracts entered into under this section.

(c) If requested by the Association to issue bonds pursuant to G.S. 58-45-47(c)(2), the Authority shall do all of the following:

(1) Take assignment, without recourse, of the Association's obligation to pay claims with respect to insurance policies issued by the Association in an amount estimated to be in excess of the Association's losses and expenses resulting from Events in any calendar year that exceed available surplus, reinsurance, and other sources of funding of Association losses, including permissible assessments on Association member companies, as a result of a hurricane or other catastrophic event.

(2) Issue bonds to finance such obligations.

(3) Utilize catastrophe recovery charges imposed pursuant to G.S. 58-45-47 to provide amounts to pay such bonds.

(4) Contract with the Association to act as agent for the Authority to collect such catastrophe recovery charges imposed pursuant to G.S. 58-45-47 and to take all such other actions as may be necessary in connection with the bond issuance, the catastrophe recovery charges, and related activities.

(5) Assign such amounts as may be required as security for the Authority's bonds.

(d) Except as provided in this Section, the provisions of Chapter 159 of the General Statutes, the Local Government Finance Act, apply to revenue bonds issued by the Authority.

"**§ 58-45A–40. Sale of Recovery Finance Authority revenue bonds.**

Revenue bonds of the Recovery Finance Authority issued pursuant to this Article and the State and Local Government Revenue Bond Act shall be sold in accordance with and pursuant to Article 7 of Chapter 159 of the General Statutes.

"**§ 58-45A–45. Faith and credit of State and units of local government not pledged.**

Bonds issued under this Article shall not constitute a debt secured by a pledge of the faith and credit of the State or a political subdivision of the State and shall be payable solely from the revenues, property, and other funds pledged for their payment. The bonds issued by the Recovery Finance Authority shall contain a statement that the Authority is obligated to pay the bond or the interest on the bond only from the revenues, property, or other funds pledged for their payment and that neither the faith and credit nor the taxing power of the State or any political subdivision of the State is pledged as security for the payment of the principal of or the interest or premium on the bonds.

"**§ 58-45A–50. Bonds eligible for investment.**

Bonds issued under this Article are hereby made securities in which all public officers, agencies, and public bodies of the State and its political subdivisions, all insurance companies, trust companies, investment companies, banks, savings banks, building and loan associations, credit unions, pension or retirement funds, other financial institutions engaged in business in the State, executors, administrators, trustees, and other fiduciaries may properly and legally invest funds, including capital in their control or belonging to them. These bonds are hereby made securities that may properly and legally be deposited with and received by any officer or agency of the State or political subdivision of the State for any purpose for which the deposit of bonds, notes, or obligations of the State or any political subdivision of the State is authorized by law. This section does not apply to any State pension or retirement fund or a pension or retirement fund of a political subdivision of the State.

"**§ 58-45A–55. Taxation of revenue bonds.**

Any bonds issued by the Recovery Finance Authority under the provisions of this Article shall be exempt from all State, county, and municipal taxation or assessment, direct or indirect, general or special, whether imposed for the purpose of general revenue or otherwise, excluding inheritance and gift taxes, income taxes on the gain from the transfer of bonds, and franchise taxes. The interest on bonds issued by the Authority under the provisions of this Article shall not be subject to taxation as to income.

"**§ 58-45A–60. Members not liable.**

No member of the Authority Board shall be subject to any personal liability or accountability by reason of the execution of any bonds or the issuance of any bonds.

SECTION 2.2. G.S. 58–45–47 reads as rewritten:

"**§ 58-45-47. Deficit event.**

(a) Nonrecoupable Assessment. – In the event ~~of~~ the Association expects to incur losses and expenses ~~to the Association~~ exceeding available surplus, reinsurance, and other sources of funding of Association losses, with such availability determined taking into account sources committed with respect to losses and expenses expected from prior events, the Association is authorized to issue a nonrecoupable assessment upon its ~~members~~ member companies in accordance with its Plan of Operation. Member assessments shall not exceed one billion dollars ($1,000,000,000) for losses incurred from any event or series of events that occur in a given calendar year, regardless of when such assessments are actually levied on or collected from member companies.

(b) Deficit Event. – When the Association ~~knows that it has incurred~~determines that it expects it will incur losses and loss expenses in a particular calendar year that will exceed the combination of available surplus, reinsurance, and other sources of funding, including permissible member company assessments, then the Association shall immediately give notice to the Commissioner and the North Carolina Recovery Finance Authority that a deficit event ~~has occurred.~~will occur. With such notice the Association shall provide evidence with respect to its estimates of the total losses and loss expenses the Association expects to incur within the calendar year and the amounts available to it from available surplus, reinsurance, and other sources of funding, including member company assessments, with such availability determined by taking into account sources committed with respect to losses and expenses expected by prior events. The Association shall make such evidence and related material available to the Commissioner for review and verification.

(c) Imposition of Catastrophe Recovery Charge. – Upon agreement by the Commissioner with a determination by the Association that a deficit event ~~has occurred,~~ will occur, the Association shall determine, in its discretion, the appropriate means of financing the ~~deficit.~~deficit in whole or in part, which may include, but is not limited to, the purchase of reinsurance, arranging lines of credit, ~~or~~ other forms of borrowing or ~~financing.~~financing, including a North Carolina Recovery Finance Authority financing as described in subdivision (2) of this subsection, or any combination of these means. If the Association determines that the member companies ~~have paid~~ has issued one billion dollars ($1,000,000,000) in nonrecoupable assessments for losses and expenses incurred in any given year pursuant to subsection (a) of this section, the Association may, subject to the verification by the Commissioner that the dollar value of losses and expenses has reached the level necessary for a catastrophe recovery charge, take either of the following actions:

(1) ~~authorize~~ Authorize member companies to impose a catastrophe recovery charge on their residential and commercial property insurance policyholders statewide. ~~Catastrophe recovery charges shall be charged as a uniform percentage of written premiums as prescribed by the Commissioner and shall not exceed an aggregate amount of ten percent (10%) of the annual policy premium on any one policy of insurance.~~ Catastrophe recovery charges collected under this ~~section~~ subsection shall be transferred on a periodic basis, as determined by the Association and ordered by the Commissioner, directly to the ~~Association~~ Association, or, at the Association's direction, to a trustee for the Association's creditors in a financing.~~on a periodic basis as~~

~~determined by the Association and ordered by the Commissioner. The Association and the FAIR Plan also shall charge their policyholders a catastrophe recovery charge as provided in this section.~~

(2) Inform the North Carolina Recovery Finance Authority and the Commissioner that it will assign without recourse to the North Carolina Recovery Finance Authority the Association's obligation to pay claims with respect to policies issued by the Association in an amount estimated to be in excess of its losses and expenses that exceed available surplus, reinsurance, and other sources of funding of Association losses, including permissible assessments on member coimpanies, and act as agent for the North Carolina Recovery Finance Authority to collect catastrophe recovery charges imposed pursuant to G.S. 58-45-47 and direct amounts so collected to the North Carolina Recovery Finance Authority or at its direction.

(d) Requirements for Catastrophe Recovery Charge. – Catastrophe recovery charges imposed under this section shall be charged as a uniform percentage of written premiums as prescribed by the Commissioner, shall not exceed an aggregate amount of ten percent (10%) of the annual policy premium on any one policy of insurance, and shall also be imposed upon policyholders with insurance from the Association and the FAIR Plan established under Article 46 of this Chapter. The catastrophe recovery charge shall be clearly identified to policyholders on the premium statement, declarations page, or by other appropriate electronic or written method. The identification shall refer to the post-catastrophe loss for which the charge was imposed. Any such catastrophe recovery charge shall not be considered premium for any purpose, including premium taxes or commissions, except that failure to pay the catastrophe recovery charge shall be treated as failure to pay premium and shall be grounds for termination of insurance. The identified catastrophe recovery charge shall be accompanied by an explanation of the charge and shall appear on the medium by which the charge is conveyed to the policyholder. The explanatory language shall be prescribed by the Commissioner.

(e) Report. – The Association shall report quarterly to the Commissioner and the North Carolina Recovery Finance Authority providing all financial information for each catastrophe recovery charge authorized by this section, including total catastrophe recovery charge funds recovered to date and any information reasonably requested by the ~~Commissioner.~~Commissioner or the North Carolina Recovery Finance Authority.

(f) Periodic Revision of Catastrophe Recovery Charge. – The Association shall recalculate the catastrophe recovery charge amount annually for any such charge imposed pursuant to subdivision (c)(1) of this section and, subject to procedure approved by the Commissioner, adjust the charge percentage as needed. The North Carolina Recovery Finance Authority shall recalculate the catastrophe recovery charge amount annually for any such charge imposed pursuant to subdivision (c)(2) of this section and adjust the charge percentage as needed.

(g) Cessation; Treatment of Excess Charges. – The catastrophe recovery charge amount shall continue until financing or refinancing of the deficit event has been paid in full. The State of North Carolina does pledge to and agree with any creditors of the Association under financings pursuant to subdivision (c)(1) of this section that so long as any such financing is outstanding and unpaid the State will not limit the rights to catastrophe recovery charges vested in the Association at the time of incurrence its obligations under such financings. Upon order of cessation, any catastrophe recovery charge amounts imposed pursuant to subdivision (c)(1) of this section collected by member companies, the Association or the FAIR Plan that exceed amounts necessary for payment of the debt shall be remitted to the Association and added to the surplus for the purposes of offsetting future Association losses or expenses. Any catastrophe recovery charge amounts imposed pursuant to subdivision (c)(2) of this section collected by member companies, the Association or the FAIR Plan that exceed amounts necessary for payment of the debt shall first be remitted to the North Carolina Recovery Finance Authority for payment of reasonable outstanding expenses associated with the issuance and repayment of the debt and other necessary related activities of the North Carolina Recovery Finance Authority. Charge amounts remaining after expenses shall be remitted to the Association.

(h) Limitations. – Nothing contained in this section prohibits the Association from entering into any financing arrangements for the purpose of financing a deficit, provided that the pledge of catastrophe recovery charge amounts under such financing agreements shall not result in the actual levying of any catastrophe recovery charge until after the Association has incurred a deficit and until after the Commissioner has approved implementation of the Association's catastrophe recovery charge plan. Nothing in this section prevents the Association from utilizing financings under both subdivisions (c)(1) and (c)(2) of this section or either of them in the same calendar year or there being in existence more than one catastrophe recovery charge under either subsection or both subsections at the same time; provided all catastrophe recovery charges, whether imposed by the Association or the North Carolina Recovery Finance Authority, may not in the aggregate exceed ten percent (10%) of the annual policy premium on any one policy of insurance."

SECTION 2.3. G.S. 120-123 is amended by adding a new subdivision to read:

"(81) The North Carolina Recovery Finance Authority."

SECTION 2.4. G.S. 159-81(1) reads as rewritten:

"(1) "Municipality" means a county, city, town, incorporated village, sanitary district, metropolitan sewerage district, metropolitan water district, metropolitan water and sewerage district, county water and sewer district, water and sewer authority, hospital authority, hospital district, parking authority, special airport district, special district created under Article 43 of Chapter 105 of the General Statutes, regional public transportation authority, regional transportation authority, regional natural gas district, regional sports authority, airport authority, joint agency created pursuant to Part 1 of Article 20 of Chapter 160A of the General Statutes, a joint agency authorized by agreement between two cities to operate an airport pursuant to G.S. 63-56, the North Carolina Recovery Finance Authority described in Article 45A of Chapter 58 of the General Statutes, and the North Carolina Turnpike Authority described in Article 6H of Chapter 136 of the General Statutes and transferred to the Department of Transportation pursuant to G.S. 136-89.182(b), but not any other forms of State or local government."

SECTION 2.5. G.S. 159-81(3) reads as rewritten:

"(3) "Revenue bond project" means any undertaking for the acquisition, construction, reconstruction, improvement, enlargement, betterment, or extension of any one or combination of the revenue-producing utility or public service enterprise facilities or systems listed in this subdivision, to be financed through the issuance of revenue bonds, thereby providing funds to pay the costs of the undertaking or to reimburse funds loaned or advanced by or on the behalf of either the State or a municipality to pay the costs of the undertaking.

A revenue bond project shall be (i) owned or leased as lessee by the issuing unit or (ii) owned by one or more of the municipalities participating in an undertaking established pursuant to Part 1 of Article 20 of Chapter 160A of the General Statutes. If the revenue bond project is owned by one or more municipalities as provided in (ii) of this subdivision, any one or more of the participating municipalities may each be an issuing unit consistent with their agreement to establish a joint undertaking. In addition, any joint agency established by participating municipalities pursuant to Part 1 of

Article 20 of Chapter 160A of the General Statutes may be an issuing unit without owning the revenue bond project or leasing it as lessee.

The cost of an undertaking may include all property, both real and personal and improved and unimproved, plants, works, appurtenances, machinery, equipment, easements, water rights, air rights, franchises, and licenses used or useful in connection with the undertaking; the cost of demolishing or moving structures from land acquired and the cost of acquiring any lands to which the structures are to be moved; financing charges; the cost of plans, specifications, surveys, and estimates of cost and revenues; administrative and legal expenses; and any other expense necessary or incident to the project.

The following facilities or systems may be revenue bond projects under this subdivision:

…

(r.) In the case of the North Carolina Recovery Finance Authority, the financing of a deficit in the North Carolina Insurance Underwriting Association pursuant to G.S. 58-45-47 with the repayment thereof to come from catastrophe recovery charges pursuant to that section or other revenues of the North Carolina Recovery Finance Authority, including payments from the Association or its members."

SECTION 2.6. G.S. 159-83 is amended by adding a new subsection to read:

"(g) The North Carolina Recovery Finance Authority by the power to finance as a revenue project a deficit in the Association pursuant to G.S. 58-45-47 and for this purpose may contract for the charging of catastrophe recovery charges pursuant to G.S. 58-45-47, including covenanting to make such charges as necessary for the payment of revenue bonds, and shall have the power to pledge and assign its rights to the making, revising, receiving, and enforcing such changes as security for its revenue bonds."

SECTION 2.7. G.S. 159-89 is amended by adding a new subdivision to read:

"(15) With respect to revenue bonds issued by the North Carolina Recovery Finance Authority, any agreements with the North Carolina Insurance Underwriting Association to assign without recourse to the Recovery Finance Authority the Insurance Underwriting Association's obligation to pay claims with respect to insurance policies issued by the Insurance Underwriting Association in an amount estimated to be in excess of its losses and expenses that exceed available surplus, reinsurance, and other sources of funding of Insurance Underwriting Association losses, including permissible assessments on its members, and act as agent for the Recovery Finance Authority to collect catastrophe recovery charges imposed by it under G.S. 58-45-47 and direct amounts so collected to the Recovery Finance Authority."

SECTION 2.8. G.S. 159-90(a)(1) reads as rewritten:

"(1) The maturity dates may not exceed the maximum maturity periods prescribed by the Commission for general obligation bonds pursuant to ~~G.S. 159-122.~~G.S. 159-122, provided the maturity dates for revenue bonds issued by the North Carolina Recovery Finance Authority shall be related to the structuring of the repayment of the proceeds rather than the facilities paid for, subject to an overall limit of 40 years. For bonds issued in reimbursement of a loan or advance, the maximum maturity period to be used in determining the maturity dates of the bonds shall be the maximum permissible period prescribed by the Commission for the original project for which the loan or advance was expended, calculated from the date the original project is completed."

SECTION 2.9. G.S. 159-93 reads as rewritten:

"§ 159-93. Agreement of the State.

The State of North Carolina does pledge to and agree with the holders of any revenue bonds or revenue bond anticipation notes heretofore or hereafter issued by the State or any municipality in this State that so long as any such bonds or notes are outstanding and unpaid the State will not limit or alter the rights vested in the State or the municipality at the time of issuance of the bonds or notes to establish, maintain, revise, charge, and collect such rates, fees, rentals, tolls, catastrophe recovery charges, and other charges for the use, services, facilities, and commodities of or furnished by the revenue bond project in connection with which the bonds or notes, or bonds or notes refunded by the bonds or notes, were issued as shall produce revenues at least sufficient with other available funds to meet the expense of maintenance and operation of and renewal and replacements to such project, including reserves therefor, to pay when due the principal, interest, and redemption premiums (if any) of the bonds or notes, and to fulfill the terms of any agreements made with the bondholders or noteholders, nor will the State in any way impair the rights and remedies of the bondholders or noteholders until the bonds or notes and all costs and expenses in connection with any action or proceedings by or on behalf of the bondholders or noteholders, are fully paid, met, and discharged."

SECTION 2.10. G.S. 159-95 reads as rewritten:

"§ 159-95. Approval of State agencies.

The general design and plan of any revenue bond project undertaken for water systems or facilities or sewage disposal systems or facilities shall be subject to the approval of the Commission for Public Health or the State Environmental Management Commission to the same extent that such projects would be if they were not financed by revenue bonds, and the provisions of the revenue bond order shall be consistent with any requirements imposed on the project by the Commission for Public Health or the State Environmental Management Commission. No revenue bond project for the acquisition or construction of systems or facilities for the generation, production, or transmission of gas or electric power may be undertaken by the State or a municipality unless the State or municipality, as the case may be, shall first obtain a certificate of convenience and necessity from the North Carolina Utilities Commission. Bonds issued by the North Carolina Recovery Finance Authority do not require the approval of the Department of Insurance except to the extent catastrophe recovery charges therefore require action pursuant to G.S. 58-45-47."

SECTION 2.11. G.S. 159-96 is amended by adding a new subsection to read:

"(f) Notwithstanding the other provisions of this section, there is no geographic or territorial limitation on the use of proceeds of North Carolina Recovery Finance Authority revenue bonds other than for payment of a deficit related to a catastrophic event affecting property covered under insurance policies issued by the North Carolina Insurance Underwriting Association."

PART III. REFORM CONSENT TO RATE

SECTION 3.1. G.S. 56-36-30 reads as rewritten:

"§ 58-36-30. Deviations.

…

(b) This subsection applies only to insurance nonfleet private passenger motor vehicles coverage, with the exception of liability coverage. A rate in excess of that promulgated by the Bureau may be charged by an insurer on any specific risk if the higher rate is charged in accordance with rules adopted by the Commissioner and with the knowledge and written consent of the insured. 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 are greater than those rates 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. This subsection may be used to provide motor vehicle liability coverage limits above those required under Article 9A of Chapter 20 of the General Statutes and above those cedable to the Facility under Article 37 of this Chapter to persons whose personal excess liability insurance policies require that they maintain specific higher liability coverage limits. Any data obtained by the Commissioner under this subsection is proprietary and confidential and is not a public record under G.S. 132-1 or G.S. 58-2-100.

(b1) This subsection applies only to insurance against loss to residential real property with not more than four housing units. A rate in excess of that promulgated by the Bureau may be charged by an insurer on any specific risk if the higher rate is charged in accordance with rules adopted by the Commissioner and is charged with the knowledge and written consent of the insured. An insurer shall give reasonable notice to the insured by including the following language on the insured's written consent to rate form in at least 10 point type:

"NOTICE: THE PREMIUM USING NORTH CAROLINA RATE BUREAU'S MANUAL RATES FOR THE HOMEOWNER'S INSURANCE COVERAGE I APPLIED FOR IS $. THE PREMIUM FOR THIS COVERAGE IS $. THE TOTAL PERCENTAGE INCREASE ABOVE THE MANUAL RATES IS %, WHICH DOES NOT EXCEED 250% OF THE PREMIUM THAT I WOULD BE CHARGED USING NORTH CAROLINA RATE BUREAU MANUAL RATES FOR THE SAME COVERAGE."

The insurer shall provide the rate information on the disclosure statement above, as applicable, to the insured. The disclosure statement noted above in this subsection shall be included on any renewal of or endorsement to the policy for any subsequent rate increase above the manual rate following the initial written consent of an insured. However, once an initial written consent to rate is received, the insurer is not required to obtain the written consent of the insured on any renewal of or endorsement to the policy. The insurer shall give 30 days' notice to the insured for all written consents to rate and notices required under this subsection on all policy renewals and endorsements. 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. Any data obtained by the Commissioner under this subsection is proprietary and confidential and is not a public record under G.S. 132-1 or G.S. 58-2-100.

…."

PART IV. CATASTROPHIC MODELING

SECTION 4.1. G.S. 58-36-10 reads as rewritten:

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

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

(1) Rates or loss costs shall not be excessive, inadequate or unfairly discriminatory.

(2) Due consideration shall be given to actual loss and expense experience within this State for the most recent three-year period for which that information is available; to prospective loss and expense experience within this State; to the hazards of conflagration and catastrophe; to a reasonable margin for underwriting profit and to contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers; to investment income earned or realized by insurers from their unearned premium, loss, and loss expense reserve funds generated from business within this State; to past and prospective expenses specially applicable to this State; and to all other

relevant factors within this State: Provided, however, that countrywide expense and loss experience and other countrywide data may be considered only where credible North Carolina experience or data is not available.

(3) In the case of property insurance rates under this Article, consideration may be given to the experience of property insurance business during the most recent five-year period for which that experience is available. In the case of property insurance rates under this Article, consideration shall be given to the insurance public protection classifications of fire districts established by the Commissioner. The Commissioner shall establish and modify from time to time insurance public protection districts for all rural areas of the State and for cities with populations of 100,000 or fewer, according to the most recent annual population estimates certified by the State Budget Officer. In establishing and modifying these districts, the Commissioner shall use standards at least equivalent to those used by the Insurance Services Office, Inc., or any successor organization. The standards developed by the Commissioner are subject to Article 2A of Chapter 150B of the General Statutes. The insurance public protection classifications established by the Commissioner issued pursuant to the provisions of this Article shall be subject to appeal as provided in G.S. 58-2-75, et seq. The exceptions stated in G.S. 58-2-75(a) do not apply. <u>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, and the models shall be based on maximum load designs, such as maximum wind or rain loads, contained within the State Building Codes promulgated by the State Building Code Council.</u>

…."

PART V. STUDIES

SECTION 5.1.(a) LSC Study of Property Insurance Rate Making. – There is created the Joint Legislative Study Committee on Property Insurance Rate Making. The Committee shall consist of 10 members to be appointed as follows:

(1) Five members of the House of Representatives appointed by the Speaker of the House of Representatives.

(2) Five members of the Senate appointed by the President Pro Tempore of the Senate.

SECTION 5.1.(b) Study. – The Committee shall study the following:

(1) The structure, function, and operations of the Rate Bureau, with particular attention to the conditions and characteristics of the insurance market and the magnitude and type of insurable risks in North Carolina that require the existence of a body such as the Rate Bureau that no longer exists in any other state.

(2) The prevalence and geographic distribution of property insurance policies (including homeowners' insurance policies and separate policies of windstorm and hail insurance) issued with a rate in excess of that promulgated by the North Carolina Rate Bureau that is charged with the knowledge and written consent of the insured under G.S. 58-36-30(b) ("Consent to Rate policies").

(3) Any other subject the Committee finds germane to an understanding of and basis for legislative proposals to revise the property insurance rate making process in North Carolina.

SECTION 5.1.(c) Cochairs; Vacancies. – The Speaker of the House of Representatives shall designate one representative to serve as cochair, and the President Pro Tempore of the Senate shall designate one senator to serve as cochair. Vacancies on the Committee shall be filled by the same appointing authority making the initial appointment.

SECTION 5.1.(d) Powers. – The Committee, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4. The Committee may meet at any time upon the joint call of the cochairs. The Committee may meet in the Legislative Building or the Legislative Office Building.

SECTION 5.1.(e) Staffing. – The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. The Directors of Legislative Assistants of the Senate and of the House of Representatives shall assign clerical staff to the Committee, and the expenses relating to the clerical employees shall be borne by the Committee. Members of the Committee shall receive subsistence and travel expenses at the rates set forth in G.S. 120-3.1, 138-5, or 138-6, as appropriate.

SECTION 5.1.(f) Report. – The Committee shall submit an interim report to the 2015 General Assembly when it reconvenes in 2016. The Committee shall submit a final report, including findings and legislative recommendations, to the 2017 General Assembly. The Committee shall terminate upon filing its final report.

PART VI. REMOVE CERTAIN OBSOLETE REFERENCES TO THE COASTAL PROPERTY INSURANCE POOL

SECTION 6.1.(a) The title of Article 45 of Chapter 58 of the General Statutes reads as rewritten:

"Article 45.

"Essential Property Insurance for ~~Beach Area~~Coastal Property."

SECTION 6.1.(b) G.S. 58-45-5(2c) reads as rewritten:

"(2c) Coastal Property Insurance Pool. – The ~~name of which was formerly known as "the Beach Plan" and which is governed by the North Carolina Insurance Underwriting Association. All references to "the Beach Plan" shall mean the Coastal Property Insurance Pool, which is the~~ market of last resort which is governed by the North Carolina Insurance Underwriting Association, and is provided by the Association to the beach area and the coastal area."

PART VII. MISCELLANEOUS PROVISIONS

SECTION 7.1. If any section or provision of this act is declared unconstitutional or invalid by the courts, such action does not affect the validity of this act as a whole or any part other than the part so declared to be unconstitutional or invalid.

SECTION 7.2. Section 1 of this act is effective when it becomes law, and any current year requirements apply to the 2015 and subsequent calendar years. The remainder of this act becomes effective July 1, 2015.

HOUSE BILL 182: Property Insurance Fairness

2015-2016 General Assembly

Committee:	House Insurance, if favorable, Finance	**Date:**	April 20, 2015
Introduced by:	Reps. Millis, Lewis, Hager	**Prepared by:**	Tim Hovis Committee Counsel
Analysis of:	PCS to First Edition H182-CSRG-3		

BILL SUMMARY: **Section 1** of the proposed committee substitute for House Bill 182 would require the Rate Bureau to submit detailed information on losses related to homeowners insurance rate filings including the following:

- Direct incurred losses, house years, and statewide expenses for the most recent five years.
- Computations by territory where available.
- Wind and hail information if requested by the Department of Insurance based on a specific event.

The Department is required to post any information received on its website.

Section 2 of the bill creates the North Carolina Recovery Finance Authority housed within the Department. The Authority would be considered a municipality and would be allowed to issue bonds to pay claims with respect to insurance policies issued by the North Carolina Insurance Underwriting Association, often referred to as the Beach Plan. Bonds issued by the Authority would be exempt from taxation.

Section 3 makes changes to the consent to rate provisions with regard to residential real property insurance, G.S. 58-36-30, to require a 30 days written notice in 10 point type of the rate provided, the actual approved rate and the actual percentage above the approved rate. As under the current law, written consent of the insured would only be required for an initial consent to rate. However, the notice would be required on any homeowner's policy renewal if the rate is increased.

Section 4 requires the Rate Bureau to present more than one catastrophe model with a property insurance rate filing and would require the model to conform to maximum load designs contained in the State Building Codes.

Section 5 would establish a Legislative Services Commission Study on Property Insurance Rate Making and would require an interim report to the 2016 General Assembly in 2016 and a final report to the 2017 General Assembly.

Section 6 removes obsolete references to the "Beach Plan."

EFFECTIVE DATE: Section 1 of the proposed committee substitute for H182 is effective when it becomes law. The remaining sections become effective July 1, 2015.

EXHIBIT 15

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H **D**

HOUSE BILL 599
PROPOSED COMMITTEE SUBSTITUTE H599-CSTU-14 [v.2]
4/24/2015 12:23:19 PM

Short Title: Impounding Vehicles with Lapsed/No Insurance. (Public)

Sponsors:

Referred to:

April 9, 2015

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE VEHICLE BEING OPERATED BY A DRIVER WHO HAS FAILED TO MAINTAIN FINANCIAL RESPONSIBILITY TO BE SEIZED AND FORFEITED.

The General Assembly of North Carolina enacts:

SECTION 1. Article 2 of Chapter 20 of the General Statutes is amended by adding a new section to read:

"**§ 20-28.10. Seizure, impoundment, forfeiture of motor vehicles for driving without insurance.**

(a) Authority. – A vehicle driven by a person who commits a violation of G.S. 20-313 shall be subject to seizure, impoundment, and forfeiture.

(b) Exception. – A vehicle shall not become subject to an order of forfeiture under this section if the underlying violation is a violation of G.S. 20-313 and the defendant tenders proof of financial responsibility that satisfies the requirements of G.S. 20-7(c1) to the judge.

(c) Governing Law and Procedures. – The laws and procedures governing the seizure, impoundment, and forfeiture of vehicles under this section shall be the same as those set forth in G.S. 20-28.2 through G.S. 20-28.9. Wherever those statutes refer to a particular underlying offense, they shall, for purposes of this section, be construed to refer to the applicable violation of subsection (a) of this section. Furthermore, for purposes of this section, an innocent owner shall be a person who did not know and had no reason to know that the defendant was engaging in a violation of subsection (a) of this section."

SECTION 2. G.S. 20-313(a) reads as rewritten:

"(a) On or after July 1, 1963, any owner of a motor vehicle registered or required to be registered in this State who shall operate or permit such motor vehicle to be operated in this State without having in full force and effect the financial responsibility required by this Article shall be guilty of a Class 3 ~~misdemeanor.~~misdemeanor, and the motor vehicle that was operated in violation of this section becomes property subject to forfeiture in accordance with the laws and procedures set forth in G.S. 20-28.2 through G.S. 20-28.9."

SECTION 3. This act becomes effective December 1, 2015, and applies to offenses committed on or after that date.

EXHIBIT 16

HOUSE BILL 599: Impounding Vehicles with Lapsed/No Insurance

2015-2016 General Assembly

Committee:	House Insurance, if favorable, Judiciary I	**Date:**	April 28, 2015
Introduced by:	Rep. Cleveland	**Prepared by:**	Tim Hovis Kristen Harris Committee Counsel
Analysis of:	First Edition		

SUMMARY: House Bill 599 would allow for the seizure, impoundment, and forfeiture of a vehicle whose owner fails to maintain his or her liability insurance yet operates or allows the vehicle to be operated.

CURRENT LAW: G.S. 20-313 states that any owner of a motor vehicle registered or required to be registered who operates or allows such vehicle to be operated without financial responsibility is guilty of a Class 3 misdemeanor.

BILL ANALYSIS:

Section 1 would amend the law by stating that a vehicle driven by a person who commits a violation of G.S. 20-313 must be subject to seizure, impoundment, and forfeiture unless 1) the violation is a violation of G.S. 20-313 and 2) the person tenders proof of financial responsibility in accordance with G.S. 20-7(c1) to the judge.

To satisfy G.S. 20-7(c1), the person can provide proof of financial responsibility in one of the following forms:

- Documentation from any insurance carrier duly authorized to do business in the State certifying that there is a nonfleet private passenger liability policy in effect for the person.
- A binder for or policy of nonfleet private passenger liability insurance under which the person is insured.

Both forms need to include the effective dates of the policy.

The laws and procedures governing the seizure, impoundment, and forfeiture of the vehicle would be the same as those already in effect in Article 2 (Uniform Driver's License Act).

Section 2 would make conforming changes consistent with Section 1.

EFFECTIVE DATE: This act becomes effective December 1, 2015, and applies to offenses committed on or after that date.

O. Walker Reagan
Director

H599-SMTU-31 E1 -V3

Research Division
(919) 733-2578

EXHIBIT 17

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

INSURANCE COMMITTEE REPORT
Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

FAVORABLE COM SUB , UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

HB **182** Property Insurance Fairness.

Draft Number:	H182-PCS40445-RG-3
Serial Referral:	**FINANCE**
Recommended Referral:	None
Long Title Amended:	Yes
Floor Manager:	Millis

TOTAL REPORTED: 1

CMR302-V-1

EXHIBIT 18

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

INSURANCE COMMITTEE REPORT
Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

FAVORABLE

HB **196** DOI License Processing Fees.

Draft Number:	None
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Dollar

HB **361** Principle-Based Reserving.

Draft Number:	None
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Collins

FAVORABLE AND RE-REFERRED

HB **528** Establish Chiropractor Co-Pay Parity.

Draft Number:	None
Serial Referral:	**APPROPRIATIONS**
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Burr

TOTAL REPORTED: 3

CMR293-V-1

Cancelled Notice

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

You are hereby notified that the **House Committee on Insurance** will **NOT** meet as follows:

DAY & DATE: Tuesday, June 2, 2015
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**
COMMENTS: **Representative Mitchell S. Setzer will be presiding.**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 676	Autism Health Insurance Coverage.	Senator Apodaca Senator Krawiec

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 11:43 AM on Monday, June 01, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margaret Herring (Committee Assistant)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Tuesday, June 2, 2015
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**
COMMENTS: **Representative Mitchell S. Setzer will be presiding.**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 676	Autism Health Insurance Coverage.	Senator Apodaca Senator Krawiec

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 9:47 AM on Thursday, May 28, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margaret Herring (Committee Assistant)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Tuesday, June 30, 2015
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**
COMMENTS: **Representative Mitchell S. Setzer will be presiding.**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 676	Autism Health Insurance Coverage.	Senator Apodaca Senator Krawiec

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 9:47 AM on Thursday, October 08, 2015.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margaret Herring (Committee Assistant)

House Committee on Insurance
Tuesday, June 30, 2015, 1:00 PM
1228/1327 Legislative Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 676	Autism Health Insurance Coverage.	Senator Apodaca Senator Krawiec

Presentations

Other Business

Adjournment

House Committee on Insurance
Tuesday, June 30, 2015 at 1:00 PM
Room 1228/1327 of the Legislative Building

MINUTES

The House Committee on Insurance met at 1:00 PM on June 30, 2015 in Room 1228/1327 of the Legislative Building. Representatives Arp, Boles, Bumgardner, Burr, Collins, Dollar, Earle, Gill, Hanes, Holloway, Horn, Howard, Iler, Insko, Lambeth, Langdon, Lucas, Pierce, Setzer, Shepard, Tine, and Warren attended.

Chairman Mitchell S. Setzer called the meeting to order at 1:00 PM. He introduced the House Sergeant of Arms staff (Attachment I) and the House pages (Attachment II). Visitors Registration Sheet (Attachment III).

The following bills were considered:

SB 676 Autism Health Insurance Coverage. (Senators Apodaca, Krawiec)

After some discussion, Representative Howard motioned for a favorable report.

The meeting adjourned at 1:25 PM.

Mitchell S. Setzer
Representative Mitchell S. Setzer, Chairman

Margaret Herring
Margaret Herring, Committee Clerk

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S **2**

SENATE BILL 676
Insurance Committee Substitute Adopted 4/23/15

Short Title: Autism Health Insurance Coverage.	(Public)
Sponsors:	
Referred to:	

March 30, 2015

A BILL TO BE ENTITLED

AN ACT TO PROVIDE COVERAGE FOR THE TREATMENT OF AUTISM SPECTRUM DISORDER.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-220 reads as rewritten:

"**§ 58-3-220. Mental illness benefits coverage.**

(a) Mental Health Equity Requirement. – Except as provided in subsection (b), an insurer shall provide in each group health benefit plan benefits for the necessary care and treatment of mental illnesses that are no less favorable than benefits for physical illness generally, including application of the same limits. For purposes of this subsection, mental illnesses are as diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders, ~~DSM-IV,~~ DSM-5, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the ~~DSM-IV~~ DSM-5 or subsequent edition as autism spectrum disorder (299.00), substance-related disorders (291.0 through 292.2 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as "V" codes. For purposes of this subsection, "limits" includes deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b) Minimum Required Benefits. – Except as provided in subsection (c), a group health benefit plan may apply durational limits to mental illnesses that differ from durational limits that apply to physical illnesses. A group health benefit plan shall provide at least the following minimum number of office visits and combined inpatient and outpatient days for all mental illnesses and disorders not listed in subsection (c), as diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders, ~~DSM-IV,~~ DSM-5, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the ~~DSM-IV~~ DSM-5 or subsequent edition as autism spectrum disorder (299.00), substance-related disorders (291.0 through 292.2 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as "V" codes:

(1) Thirty combined inpatient and outpatient days per year.

(2) Thirty office visits per year.

…

(h) Definitions. – As used in this section:

(1) "Health benefit plan" has the same meaning as in G.S. 58-3-167.

(2) "Insurer" has the same meaning as in G.S. 58-3-167.

(3) "Mental illness" has the same meaning as in G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental

Disorders, ~~DSM-IV,~~ DSM-5, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the ~~DSM-IV~~ DSM-5 or subsequent editions as autism spectrum disorder (299.00), substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as "V" codes.

(i) Notwithstanding any other provisions of this section, a group health benefit plan that covers both medical and surgical benefits and mental health benefits shall, with respect to the mental health benefits, comply with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of ~~2008.~~2008, and the applicable regulations, as amended.

(j) Subsection (i) of this section applies only to a group health benefit plan covering a large employer as defined in G.S. 58-68-25(a)(10)."

SECTION 2. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-192. Coverage for autism spectrum disorder.**

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

(1) Adaptive behavior treatment. – Behavioral and developmental interventions that systematically manage instructional and environmental factors or the consequences of behavior that have been shown to be clinically effective through research published in peer reviewed scientific journals and based upon randomized, quasi-experimental, or single subject designs. Both of the following requirements must be met:

a. The intervention must be necessary to (i) increase appropriate or adaptive behaviors, (ii) decrease maladaptive behaviors, or (iii) develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

b. The treatment must be ordered by a licensed physician or licensed psychologist and the treatment must be provided or supervised by one of the following licensed professionals, so long as the services or supervision provided is commensurate with the licensed professional's training, experience, and scope of practice:

1. A licensed psychologist or psychological associate.
2. A licensed psychiatrist or developmental pediatrician.
3. A licensed speech and language pathologist.
4. A licensed occupational therapist.
5. A licensed clinical social worker.
6. A licensed professional counselor.
7. A licensed marriage and family therapist.

(2) Autism spectrum disorder. – As defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the most recent edition of the International Statistical Classification of Diseases and Related Health Problems. Autism spectrum disorder is not considered a mental illness as defined in G.S. 58-3-220, 58-51-55, 58-65-90, or 58-67-75.

(3) Diagnosis of autism spectrum disorder. – Any medically necessary assessments, evaluations, or tests to determine whether an individual has autism spectrum disorder.

(4) Health benefit plan. – As defined in G.S. 58-3-167.

(5) Pharmacy care. – Medications prescribed by a licensed health care provider.

(6) Psychiatric care. – Direct or consultative services provided by a licensed psychiatrist.

(7) Psychological care. – Direct or consultative services provided by a licensed psychologist or licensed psychological associate.

(8) Therapeutic care. – Direct or consultative services provided by a licensed speech therapist, licensed occupational therapist, licensed physical therapist, licensed clinical social worker, licensed professional counselor, or licensed marriage and family therapists.

(9) Treatment for autism spectrum disorder. – Any of the following care for an individual diagnosed with autism spectrum disorder, or equipment related to that care, ordered by a licensed physician or a licensed psychologist who determines the care to be medically necessary:

a. Adaptive behavior treatment.
b. Pharmacy care.
c. Psychiatric care.
d. Psychological care.
e. Therapeutic care.

(b) Except as provided in subsection (c) of this section, health benefit plans shall provide coverage for the screening, diagnosis, and treatment of autism spectrum disorder. No insurer shall terminate coverage or refuse to issue, amend, or renew coverage to an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder.

(c) Coverage for adaptive behavior treatment under this section may be subject to a maximum benefit of up to forty thousand dollars ($40,000) per year and may be limited to individuals 18 years of age or younger. Beginning in 2017 and for subsequent years, the amount shall be indexed using the Consumer Price Index for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of March of the year preceding the change divided by the index as of March 2015. This amount shall be posted by the Commissioner no later than April 1 of each year and shall apply to policies renewed or purchased the following calendar year.

(d) Coverage under this section may not be denied on the basis that the treatments are habilitative or educational in nature.

(e) Coverage under this section may be subject to co-payment, deductible, and coinsurance provisions of a health benefit plan that are not less favorable than the co-payment, deductible, and coinsurance provisions that apply to substantially all medical services covered by the health benefit plan.

(f) This section shall not be construed as limiting benefits that are otherwise available to an individual under a health benefit plan.

(g) Nothing in this section shall apply to non-grandfathered health plans in the individual and small group markets that are subject to the requirement to cover the essential health benefit package under 45 C.F.R. § 147.150(a). For purposes of this subsection, "non-grandfathered health plan" is a health benefit plan not included in the plans defined under G.S. 58-50-110(10a).

(h) This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan.

(i) Notwithstanding subsection (g) of this section, and except as provided in subsection (c) of this section, every health benefit plan shall provide coverage for the screening, diagnosis, and treatment of autism spectrum disorder in accordance with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and the applicable regulations, as amended."

SECTION 3. G.S. 58-51-55(a) reads as rewritten:

"(a) Definitions. – As used in this section, the term:

(1) "Mental illness" has the same meaning as defined in G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, ~~DSM-IV,~~ DSM-5, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the ~~DSM-IV~~ DSM-5 or subsequent editions as autism spectrum disorder (299.00), substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as "V" codes.

(2) "Chemical dependency" has the same meaning as defined in G.S. 58-51-50, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, ~~DSM-IV,~~ DSM-5, or subsequent editions published by the American Psychiatric Association."

SECTION 4. G.S. 58-67-75(a) reads as rewritten:

"(a) Definitions. – As used in this section, the term:

(1) "Mental illness" has the same meaning as defined in G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, ~~DSM-IV,~~ DSM-5, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the ~~DSM-IV~~ DSM-5 or subsequent editions as autism spectrum disorder (299.00), substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as "V" codes.

(2) "Chemical dependency" has the same meaning as defined in G.S. 58-67-70, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, ~~DSM-IV,~~ DSM-5 or subsequent editions published by the American Psychiatric Association."

SECTION 5. G.S. 58-65-90(a) reads as rewritten:

"(a) Definitions. – As used in this section, the term:

(1) "Mental illness" has the same meaning as defined in G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, ~~DSM-IV,~~ DSM-5, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the ~~DSM-IV~~ DSM-5 or subsequent editions as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as autism spectrum disorder (299.00), sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as "V" codes.

(2) "Chemical dependency" has the same meaning as defined in G.S. 58-65-75, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, ~~DSM-IV,~~ DSM-5, or subsequent editions published by the American Psychiatric Association."

SECTION 6. This act becomes effective January 1, 2016, and applies to insurance contracts issued, renewed, or amended on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S 2

SENATE BILL 676
Insurance Committee Substitute Adopted 4/23/15

Short Title: Autism Health Insurance Coverage. (Public)

Sponsors:

Referred to:

March 30, 2015

A BILL TO BE ENTITLED

AN ACT TO PROVIDE COVERAGE FOR THE TREATMENT OF AUTISM SPECTRUM DISORDER.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-220 reads as rewritten:

"**§ 58-3-220. Mental illness benefits coverage.**

(a) Mental Health Equity Requirement. – Except as provided in subsection (b), an insurer shall provide in each group health benefit plan benefits for the necessary care and treatment of mental illnesses that are no less favorable than benefits for physical illness generally, including application of the same limits. For purposes of this subsection, mental illnesses are as diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders, ~~DSM-IV,~~ DSM-5, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the ~~DSM-IV~~ DSM-5 or subsequent edition as autism spectrum disorder (299.00), substance-related disorders (291.0 through 292.2 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as "V" codes. For purposes of this subsection, "limits" includes deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b) Minimum Required Benefits. – Except as provided in subsection (c), a group health benefit plan may apply durational limits to mental illnesses that differ from durational limits that apply to physical illnesses. A group health benefit plan shall provide at least the following minimum number of office visits and combined inpatient and outpatient days for all mental illnesses and disorders not listed in subsection (c), as diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders, ~~DSM-IV,~~ DSM-5, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the ~~DSM-IV~~ DSM-5 or subsequent edition as autism spectrum disorder (299.00), substance-related disorders (291.0 through 292.2 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as "V" codes:

(1) Thirty combined inpatient and outpatient days per year.
(2) Thirty office visits per year.

…

(h) Definitions. – As used in this section:

(1) "Health benefit plan" has the same meaning as in G.S. 58-3-167.
(2) "Insurer" has the same meaning as in G.S. 58-3-167.
(3) "Mental illness" has the same meaning as in G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental

Disorders, ~~DSM-IV,~~ DSM-5, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the ~~DSM-IV~~ DSM-5 or subsequent editions as autism spectrum disorder (299.00), substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as "V" codes.

(i) Notwithstanding any other provisions of this section, a group health benefit plan that covers both medical and surgical benefits and mental health benefits shall, with respect to the mental health benefits, comply with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of ~~2008.~~ 2008, and the applicable regulations, as amended.

(j) Subsection (i) of this section applies only to a group health benefit plan covering a large employer as defined in G.S. 58-68-25(a)(10)."

SECTION 2. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-192. Coverage for autism spectrum disorder.**

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

(1) Adaptive behavior treatment. – Behavioral and developmental interventions that systematically manage instructional and environmental factors or the consequences of behavior that have been shown to be clinically effective through research published in peer reviewed scientific journals and based upon randomized, quasi-experimental, or single subject designs. Both of the following requirements must be met:

a. The intervention must be necessary to (i) increase appropriate or adaptive behaviors, (ii) decrease maladaptive behaviors, or (iii) develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

b. The treatment must be ordered by a licensed physician or licensed psychologist and the treatment must be provided or supervised by one of the following licensed professionals, so long as the services or supervision provided is commensurate with the licensed professional's training, experience, and scope of practice:

1. A licensed psychologist or psychological associate.
2. A licensed psychiatrist or developmental pediatrician.
3. A licensed speech and language pathologist.
4. A licensed occupational therapist.
5. A licensed clinical social worker.
6. A licensed professional counselor.
7. A licensed marriage and family therapist.

(2) Autism spectrum disorder. – As defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the most recent edition of the International Statistical Classification of Diseases and Related Health Problems. Autism spectrum disorder is not considered a mental illness as defined in G.S. 58-3-220, 58-51-55, 58-65-90, or 58-67-75.

(3) Diagnosis of autism spectrum disorder. – Any medically necessary assessments, evaluations, or tests to determine whether an individual has autism spectrum disorder.

(4) Health benefit plan. – As defined in G.S. 58-3-167.

(5) Pharmacy care. – Medications prescribed by a licensed health care provider.

(6) Psychiatric care. – Direct or consultative services provided by a licensed psychiatrist.

(7) Psychological care. – Direct or consultative services provided by a licensed psychologist or licensed psychological associate.

(8) Therapeutic care. – Direct or consultative services provided by a licensed speech therapist, licensed occupational therapist, licensed physical therapist, licensed clinical social worker, licensed professional counselor, or licensed marriage and family therapists.

(9) Treatment for autism spectrum disorder. – Any of the following care for an individual diagnosed with autism spectrum disorder, or equipment related to that care, ordered by a licensed physician or a licensed psychologist who determines the care to be medically necessary:

a. Adaptive behavior treatment.

b. Pharmacy care.

c. Psychiatric care.

d. Psychological care.

e. Therapeutic care.

(b) Except as provided in subsection (c) of this section, health benefit plans shall provide coverage for the screening, diagnosis, and treatment of autism spectrum disorder. No insurer shall terminate coverage or refuse to issue, amend, or renew coverage to an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder.

(c) Coverage for adaptive behavior treatment under this section may be subject to a maximum benefit of up to forty thousand dollars ($40,000) per year and may be limited to individuals 18 years of age or younger. Beginning in 2017 and for subsequent years, the amount shall be indexed using the Consumer Price Index for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of March of the year preceding the change divided by the index as of March 2015. This amount shall be posted by the Commissioner no later than April 1 of each year and shall apply to policies renewed or purchased the following calendar year.

(d) Coverage under this section may not be denied on the basis that the treatments are habilitative or educational in nature.

(e) Coverage under this section may be subject to co-payment, deductible, and coinsurance provisions of a health benefit plan that are not less favorable than the co-payment, deductible, and coinsurance provisions that apply to substantially all medical services covered by the health benefit plan.

(f) This section shall not be construed as limiting benefits that are otherwise available to an individual under a health benefit plan.

(g) Nothing in this section shall apply to non-grandfathered health plans in the individual and small group markets that are subject to the requirement to cover the essential health benefit package under 45 C.F.R. § 147.150(a). For purposes of this subsection, "non-grandfathered health plan" is a health benefit plan not included in the plans defined under G.S. 58-50-110(10a).

(h) This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan.

(i) Notwithstanding subsection (g) of this section, and except as provided in subsection (c) of this section, every health benefit plan shall provide coverage for the screening, diagnosis, and treatment of autism spectrum disorder in accordance with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and the applicable regulations, as amended."

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(2) "Chemical dependency" has the same meaning as defined in G.S. 58-51-50, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, ~~DSM-IV,~~ DSM-5, or subsequent editions published by the American Psychiatric Association."

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(2) "Chemical dependency" has the same meaning as defined in G.S. 58-67-70, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, ~~DSM-IV,~~ DSM-5 or subsequent editions published by the American Psychiatric Association."

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(2) "Chemical dependency" has the same meaning as defined in G.S. 58-65-75, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, ~~DSM-IV,~~ DSM-5, or subsequent editions published by the American Psychiatric Association."

SECTION 6. This act becomes effective January 1, 2016, and applies to insurance contracts issued, renewed, or amended on or after that date.

SENATE BILL 676:
Autism Health Insurance Coverage

2015-2016 General Assembly

Committee:	House Insurance	**Date:**	June 30, 2015
Introduced by:	Sens. Apodaca, Krawiec	**Prepared by:**	O. Walker Reagan Staff Attorney Kristen Harris Committee Counsel
Analysis of:	Second Edition		

***SUMMARY:** Senate Bill 676 creates a new section in Article 3 of Chapter 58 that addresses health benefit plan coverage for the screening, diagnosis and treatment of autism spectrum disorder.*

BILL ANALYSIS:

Section 2 of Senate Bill 676 adds a new section to Article 3 of Chapter 58 requiring certain health benefit plans to offer coverage for autism spectrum disorders. The bill defines autism spectrum disorder as "any of the pervasive developmental disorders or autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or the most recent edition of the International Statistical Classification of Diseases and Related Health Problems." Autism is expressly carved out from the definition of mental illness under Chapter 58 of the General Statutes. **Sections 1, 3, 4** and **5** make these conforming changes.

Section 2 of the bill requires certain health benefit plans to provide coverage for the screening, diagnosis and treatment of autism spectrum disorders. **Section 2** specifies that the requirement to provide coverage for autism spectrum disorder will not apply to plans that are non-grandfathered health plans in the individual market that are subject to the requirement to cover the essential health benefit package under 45 C.F.R. 147.150(a). These are plans whose coverage may be determined by the federal government to require the State to make payments for a state-required benefit that is in excess of the essential health benefits.

For plans that are required to provide coverage, coverage may not be denied because the treatments are habilitative or educational in nature. Coverage may be subject to co-payments, deductible, or coinsurance provisions which are no less favorable than the cost-sharing provisions that apply to substantially all other medical services covered by the health plan.

However, coverage for adaptive behavior treatment may be subject to a maximum benefit of up to $40,000 per year, under the bill and may be limited to individuals under 18 years of age. The bill defines adaptive behavioral treatment as "behavioral and developmental interventions that systematically manage instructional and environmental factors or the consequences of behavior that have been shown to be clinically effective through research published in peer reviewed scientific journals and based upon randomized, quasi-experimental, or single subject designs." Both of the following must be met to meet the definition of adaptive behavior treatment:

- The intervention must be necessary to (i) increase appropriate or adaptive behaviors, (ii) decrease maladaptive behaviors, or (iii) develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
- The treatment must be ordered by a licensed physician or licensed psychologist and the treatment must be provided or supervised by one of the specified licensed professionals, so

long as the services provided are commensurate with the licensed professional's training, experience, and scope of practice.

Although the diagnosis of autism spectrum disorder is removed from the mental illness benefits coverage parity provisions of G.S.58-3-220, the new G.S. 58-3-192 requires every health benefit plan to provide coverage for the screening, diagnosis, and treatment of autism spectrum disorder, with the exception of adaptive behavior treatment, in accordance with the standards set forth in the federal Paul Wellston and Pete Domenici Mental Health Parity and Addiction Equality Act of 2008.

EFFECTIVE DATE: This act becomes effective January 1, 2016, and applies to insurance contracts issued, renewed, or amended on or after that date.

* Former Staff Attorney Amy Jo Johnson substantially contributed to this summary.

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Autism Health Insurance Coverage

2015-2016 General Assembly

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For plans that are required to provide coverage, coverage may not be denied because the treatments are habilitative or educational in nature. Coverage may be subject to co-payments, deductible, or coinsurance provisions which are no less favorable than the cost-sharing provisions that apply to substantially all other medical services covered by the health plan.

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- The intervention must be necessary to (i) increase appropriate or adaptive behaviors, (ii) decrease maladaptive behaviors, or (iii) develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
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long as the services provided are commensurate with the licensed professional's training, experience, and scope of practice.

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EFFECTIVE DATE: This act becomes effective January 1, 2016, and applies to insurance contracts issued, renewed, or amended on or after that date.

* Former Staff Attorney Amy Jo Johnson substantially contributed to this summary.

attachment I

Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Insurence

DATE: 06/30/15 Room: 1228

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name: Will Crocker
5. Name:

Senate Sgt-At Arms:

1. Name:
2. Name:
3. Name:
4. Name:
5. Name:

Thursday, June 25	**Room**	**Time**
INSURANCE	1228/1327	1:00 pm

Name	County	Sponsor
Jackson Parker	Johnston	N. Leo Daughtry
Emily Perry	Pasquotank	Bob Steinburg
Kayla Powell	Rockingham	Rayne Brown
Andrew Weatherman	Cabarrus	Larry G. Pittman

Attachment III

VISITOR REGISTRATION SHEET

INSURANCE — June 30, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sally Cameron	NC Psychological Association
Robin Huffman	NC Psychiatric Association
Courtney Lakamy	Randolph Cloud & Assoc.
Suzanne Beasley	SEANC
Flint Benson	SEANC
Ken Melton	K.M.A.
Chris Hollis	[illegible]
Christopher Rivers	NC Dept of [illegible]
Lanier B. Hodgson	UNC Health Care
Kara Weishaar	SA
Sarah Preston	ACLU-NC

VISITOR REGISTRATION SHEET

INSURANCE — June 30, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
L C Penyon	CSS
[illegible]	BCBSNC
Susan Valauri	Friend of BBS
Joyce Peters	CSS
Jean Holliday	Insurance
Ben Popken	NCDOI
[illegible]	NMRS
Jon Carr	NCAMFT / NCPS
Jonathan Barbalin	Barbalin + Assoc
[illegible]	[illegible] & Assoc
[illegible]	ESUCP NC [illegible]

VISITOR REGISTRATION SHEET

INSURANCE — June 30, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Annaliese Dolph	DL
JOEL MAYNARD	GPM & ASSOC
Brett [illegible]	[illegible]
G. Lane	NCGA
Lindsay Cooper	Intern - DHHS
Andy Chase	KMA
David [illegible]	ASNC
Kristy White	ASNC

VISITOR REGISTRATION SHEET

INSURANCE — June 30, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Angel Sams	NCSP
Barbara Perryman	Citizen
Daniel Baum	Troutman Sanders
Harry Kaplan	AANC
Amber Cassady	ASNC
John Nash	The Arc of NC
Julia Adams Schweinsch	Arc NC, MAPP, ASNC, NCARF,
Tracey Sheriff	ASNC
Jennifer Mahan	ASNC
Robert PASchal	Young Moore
Tom Friedman	SHP

VISITOR REGISTRATION SHEET

INSURANCE — June 30, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Padraig Gibbons	CCS
Stephen Kouba	CCS
Hayden Burgess	FSP
[illegible]	BCI
Lorri Unumb	Autism Speaks
Jonathan Hill	CTNC
[illegible]	[illegible]
Gerry Cohen	Nelson Mullins
Bruce Thompson	Parker Poe
Grace Battle Thompson	Parker Poe
Selene Johnson	ABC of NC

VISITOR REGISTRATION SHEET

INSURANCE — **Name of Committee**

June 30, 2015 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sarah Wolfe	MWC
Fred Bone	Bone & Asso.
Erin Wynia	NCLM

Exhibit IV

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

INSURANCE COMMITTEE REPORT
Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

FAVORABLE

SB **676** **(CS#1)** Autism Health Insurance Coverage.

Draft Number:	None
Serial Referral:	None
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	McGrady

TOTAL REPORTED: 1

CMR486-V-1

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Wednesday, June 22, 2016
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 1048	Reduce Barriers to Improve NC Health & Safety.	Representative Lewis Representative Jackson Representative Murphy Representative Dobson

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 4:55 PM on Monday, June 20, 2016.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margie Penven (Committee Assistant)

House Committee on Insurance
Wednesday, June 22, 2016, 1:00 PM
1228/1327 Legislative Building
Representative Bumgardner Presiding

AGENDA

Welcome and Opening Remarks

Introduction of Pages and Sergeants-at Arms

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 1048	Reduce Barriers to Improve NC Health & Safety.	Representative Lewis Representative Jackson Representative Murphy Representative Dobson

Presentations

Persons wishing to speak on HB 1048 may sign up with the Committee Assistant.

Other Business

Adjournment

House Committee on Insurance
Wednesday, June 22, 2016 at 1:00 PM
Room 1228/1327 of the Legislative Building

MINUTES

The House Committee on Insurance met at 1:00 PM on June 22, 2016, in Room 1228/1327 of the Legislative Building. Representatives Boles, Brawley, Bumgardner, Burr, Collins, Conrad, Dixon, Dollar, Earle, K. Hall, Hamilton, Hanes, Hastings, Horn, Iler, Jackson, Langdon, Lucas, Murphy, Pendleton, W. Richardson, Setzer, Shepard, Tine, and Warren attended.

Representative Dana Bumgardner, Chair, presided. A copy of the Visitor Registration Sheet is attached as Exhibit 1. The agenda is attached as Exhibit 2.

The chair called the meeting to order and introduced the Pages and Assistant Sergeants-at-Arms serving the committee. Pages were: Nathan Graham from Moore County, sponsored by Rep. Jamie Boles; and Fin Landi from Wake County, sponsored by Speaker Tim Moore. Assistant Sergeant-at-Arms were: David Leighton, Warren Hawkins, Malachi McCullough, and Rex Foster.

The following bill was considered: **HB 1048 Reduce Barriers to Improve NC Health & Safety. (Representatives Lewis, Jackson, Murphy, Dobson)** A copy of the bill is attached as Exhibit 3. A copy of the bill summary, prepared by Kristen L. Harris, Committee Co-Counsel, is attached as Exhibit 4.

Chairman Bumgardner announced that the meeting was for discussion of HB 1048 only, and he recognized Representative Lewis to explain the bill. Representative Lewis deferred to co-sponsors Dobson and Murphy to explain HB 1048.

Committee members questioned Representative Murphy and commented on the bill. Representative Pendleton spoke in opposition to the bill.

Chairman Bumgardner opened up the meeting to public comment, and the following people made comments in opposition to HB 1048: Mr. Nathan Babcock, who represented the NC Chamber; Ms. Chris Evans, who represented Blue Cross/Blue Shield; Mr. Ben Twilley, who represented Express Scripts; and Ms. Abby Stoddard, who represented Prime Therapeutics.

There was no one else present who wished to be heard, and the meeting adjourned at 1:40 p.m.

Representative Dana Bumgardner, Chair
Presiding

Margie Penven
Margie Penven, Committee Clerk

Attachments:

1. Visitor Registration
2. Agenda
3. Copy of HB 1048
4. Summary of HB 1048

EXHIBIT 1

VISITOR REGISTRATION SHEET

House Committee on Insurance — 06/22/2016

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Evan Anderson	North Carolina Medical Society
Julia Adams Schaurich	Oak City GR
[illegible]	[illegible]
Butch Gunnells	NC Bev
Gabe Farris	NCGA Intern
Madeline Baker	SEANC
Lean Arthur	NCRMA
Daniel VanLiere	Vidant
Christina Craig	WakeMed
Cody Hand	NCHA
Scott Caster	SSGNC

VISITOR REGISTRATION SHEET

House Committee on Insurance — 06/22/2016

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sophie Sherman	Natl. MS Society
[illegible]	Natl. MS Society
Matt Grabowski	State Health Plan
Andy Chase	KMA
CS Hollis	CSH
[illegible]	NCDOI
Jean Holliday	NCDOJ
[illegible]	NMRS
Debbie Bowden	N/A
Mia [illegible]	NCC
[illegible]	NCC

VISITOR REGISTRATION SHEET

House Committee on Insurance — 06/22/2016

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mark Fleming	BCBSNC
Matt Bales	BCBSNC
DOUG HERON	DUKE
Chris Broughton	MWC

VISITOR REGISTRATION SHEET

House Committee on Insurance — 06/22/2016
Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
J Perry	CSS
Flint Benson	SEANC
Dana Simpson	SA
Kara Weishaar	SA
Tori Ludwig	Eckel & Vaughan
Courtney Lockamy	Randolph Cloud & Assoc.
Karen Kiriako	SAME
Randolph S. Cloud	R. Cloud & Assoc

VISITOR REGISTRATION SHEET

House Committee on Insurance 06/22/2016

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robert PASchal	Young Moore
Breeanna Zamore	USMC
Christine Weason	ACSCAN
[illegible]	MUC
Abigail Stoddard	Prime Therapeutics Minneapolis, MN
[illegible]	CSS
[illegible]	[illegible]
[illegible]	[illegible]
Meg O'Donnell	WS, Raleigh
Ben Twilley	Express Scripts
John McMillan	MF&S

VISITOR REGISTRATION SHEET

House Committee on Insurance — 06/22/2016

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Thomas Hardaway	PhRMA
John Hardin	MFS
Tom Fetzer	FSP
Hayden Burgess	FSP
John DelGiorno	Brubaker+Assoc.
Sarah Bales	" "
Jonathan Brubaker	" "
Chris [illegible]	BSP
Michele Frazier	MFS
Erin Frey	AstraZeneca
Amy McConkey	NC Beverage

VISITOR REGISTRATION SHEET

House Committee on Insurance — 06/22/2016

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mason Gruden	GSK
Rob Lehman	RLA
DAINA WORCESTER	DaunaMWor
Joyce Peters	CSS

EXHIBIT 2

House Committee on Insurance
Wednesday, June 22, 2016, 1:00 PM
1228/1327 Legislative Building
Representative Bumgardner Presiding

AGENDA

Welcome and Opening Remarks

Introduction of Pages and Sergeants-at Arms

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 1048	Reduce Barriers to Improve NC Health & Safety.	Representative Lewis Representative Jackson Representative Murphy Representative Dobson

Presentations

Persons wishing to speak on HB 1048 may sign up with the Committee Assistant.

Other Business

Adjournment

EXHIBIT 3

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 1

HOUSE BILL 1048

Short Title:	Reduce Barriers to Improve NC Health & Safety.	(Public)
Sponsors:	Representatives Lewis, Jackson, Murphy, and Dobson (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Insurance	

May 9, 2016

A BILL TO BE ENTITLED

AN ACT TO INCREASE ACCESS TO ABUSE-DETERRENT OPIOID ANALGESICS AND TO ENSURE THE PROPER ADMINISTRATION OF STEP THERAPY PROTOCOLS FOR PRESCRIPTION DRUGS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON STEP THERAPY.

Whereas, opioid-related deaths have doubled in North Carolina between 1999 and 2013; and

Whereas, a 2013 National Survey on Drug Use and Health found that over 63% of all people who abuse prescription drugs obtained the drugs from family and friends; and

Whereas, opioid abuse in North Carolina is a serious and severe problem that affects the health, social, and economic welfare of this State; and

Whereas, abuse-deterrent opioid analgesics have been labelled a top priority by the United States Food and Drug Administration; and

Whereas, patient access to abuse-deterrent opioid analgesics is an important step in addressing the opioid abuse epidemic; and

Whereas, health benefit plans are increasingly making use of step therapy protocols under which patients are required to try one or more prescription drugs before coverage is provided for a drug selected by the patient's health care provider; and

Whereas, when step therapy protocols are based on well-developed scientific standards and administered in a flexible manner that takes into account the individual needs of patients, the protocols can play an important role in controlling health care costs; and

Whereas, in some cases, requiring a patient to follow a step therapy protocol may have adverse and even dangerous consequences for the patient who may either not realize a benefit from taking a prescription drug or may suffer harm from taking an inappropriate drug; and

Whereas, without uniform policies in the State for step therapy protocols, patients may not receive the best and most appropriate treatment; and

Whereas, it is imperative that step therapy protocols preserve the health care provider's right to make treatment decisions in the best interest of the patient; and

Whereas, the General Assembly declares it a matter of public interest that it require health benefit plans base step therapy protocols on appropriate clinical practice guidelines developed by independent experts with knowledge of the condition or conditions under consideration; that patients be exempt from step therapy protocols when inappropriate or otherwise not in the best interest of the patients; and that patients have access to a fair, transparent, and independent process for requesting an exception to a step therapy protocol when appropriate; Now, therefore,

H1048-V-1

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:

"**§ 58-3-295. Coverage for abuse-deterrent opioid analgesics.**

(a) The following definitions apply in this section:

(1) Abuse-deterrent opioid analgesic drug product. – A brand or generic opioid analgesic drug product approved by the United States Food and Drug Administration with an abuse-deterrence labeling claim that indicates that the drug product is expected to deter abuse.

(2) Health benefit plan. – As defined in G.S. 58-3-167.

(3) Opioid analgesic drug product. – A drug product in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions in immediate-release, extended-release, or long-acting form, regardless of whether or not combined with other drug substances to form a single drug product or dosage form.

(b) Any health benefit plan that provides coverage for abuse-deterrent opioid analgesic drug products may impose a prior authorization requirement for an abuse-deterrent opioid analgesic drug product only if the health benefit plan imposes the same prior authorization requirement for each opioid analgesic drug product without an abuse-deterrence labeling claim.

(c) No health benefit plan that provides coverage for abuse-deterrent opioid analgesic drug products may require the use of an opioid analgesic drug product without an abuse-deterrence labeling claim before authorizing the use of an abuse-deterrent opioid analgesic drug product."

SECTION 2. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 8. Administration of Step Therapy Protocols.

"**§ 58-50-301. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the following definitions apply:

(1) Clinical practice guidelines. – A systematically developed statement to assist health care provider and patient decisions about appropriate health care for specific clinical circumstances and conditions.

(2) Clinical review criteria. – The written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by an insurer, health plan, or utilization review organization to determine the medical necessity and appropriateness of health care services.

(3) Step therapy override determination. – A determination as to whether a step therapy protocol should apply in a particular situation or whether the step therapy protocol should be overridden in favor of immediate coverage of the health care provider's selected prescription drug. This determination is based on a review of the patient's or prescriber's request for an override along with supporting rationale and documentation.

(4) Step therapy protocol. – A protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are medically appropriate for a particular patient and are covered by an insurer or health plan.

(5) Utilization review organization. – As defined in G.S. 58-50-61(a)(18).

"**§ 58-50-305. Clinical review criteria.**

Clinical review criteria used to establish a step therapy protocol shall be based on clinical practice guidelines that meet all the following requirements:

(1) Recommend that the prescription drugs be taken in the specific sequence required by the step therapy protocol.

(2) Are developed and endorsed by an independent, multidisciplinary panel of experts not affiliated with a health benefit plan or utilization review organization.

(3) Are based on high-quality studies, research, and medical practice.

(4) Are created by an explicit and transparent process that includes all of the following:

a. Minimizes biases and conflicts of interest.

b. Explains the relationship between treatment options and outcomes.

c. Rates the quality of the evidence supporting recommendations.

d. Considers relevant patient subgroups and preferences.

(5) Are continually updated through a review of new evidence and research.

"§ 58-50-310. Exceptions process transparency.

(a) Exceptions Process. – When coverage of a prescription drug for the treatment of any medical condition is restricted for use by a health benefit plan or utilization review organization through the use of a step therapy protocol, the patient and prescribing practitioner shall have access to a clear and convenient process to request a step therapy override determination. A health benefit plan or utilization review organization may use its existing medical exceptions process to satisfy this requirement. The process shall be made easily accessible on the health benefit plan's or utilization review organization's Web site.

(b) Exceptions. – A step therapy override determination request shall be expeditiously granted if any of the following apply:

(1) The required prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient.

(2) The required prescription drug is expected to be ineffective based on the known relevant physical or mental characteristics of the patient and the known characteristics of the prescription drug regimen.

(3) The patient has tried the required prescription drug while under their current or a previous health insurance or health benefit plan or another prescription drug in the same pharmacologic class or with the same mechanism of action and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

(4) The required prescription drug is not in the best interest of the patient, based on medical appropriateness.

(5) The patient is stable on a prescription drug selected by their health care provider for the medical condition under consideration.

(c) Effect of Exception. – Upon the granting of a step therapy override determination, the health benefit plan or utilization review organization shall authorize coverage for the prescription drug prescribed by the patient's treating health care provider, provided such prescription drug is a covered prescription drug under such policy or contract.

(d) Limitations. – This section shall not be construed to prevent any of the following:

(1) A health benefit plan or utilization review organization from requiring a patient to try an AB-rated generic equivalent prior to providing coverage for the equivalent branded prescription drug.

(2) A health care provider from prescribing a prescription drug that is determined to be medically appropriate.

"§ 58-50-315. Rules and limitation of Part.

(a) The Commissioner shall adopt rules to implement this Article.

(b) Nothing in this Part shall be construed to impact an insurer's ability to substitute a generic drug for a name brand drug."

SECTION 3. This act becomes effective October 1, 2016, and applies to insurance contracts issued, renewed, or amended on or after that date.

EXHIBIT 4

2016-2017 General Assembly

HOUSE BILL 1048: Reduce Barriers to Improve NC Health & Safety.

Committee:	House Insurance	**Date:**	June 22, 2016
Introduced by:	Reps. Lewis, Jackson, Murphy, Dobson	**Prepared by:**	Kristen L. Harris
Analysis of:	First Edition		Committee Co-Counsel

SUMMARY:* *House Bill 1048 would require health benefit plans to treat abuse-deterrent and non-abuse deterrent opioids the same in terms of prior authorization requirements and would prevent plans from requiring a person to use a non-abuse deterrent opioid before authorizing the use of an abuse-deterrent opioid. It would also require insurers utilizing step therapy to base their protocols upon clinical review criteria and to make a step therapy override determination process available to their patients and their patients' practitioners if coverage for a prescription drug is restricted for use by the plan under the step therapy protocol.

BACKGROUND: Step therapy is a type of prior authorization requirement used in health benefit plans. Step therapy requires the insured to try one or more prerequisite drugs that are generally less costly before more costly medication will be covered.

BILL ANALYSIS:

Section 1 would require a health benefit plan that provides coverage for abuse-deterrent opioids to treat abuse-deterrent and non-abuse deterrent opioids the same in terms of prior authorization requirements. Additionally, the health benefit plan would not be allowed to require a person to use a non-abuse deterrent opioid before authorizing the use of an abuse-deterrent opioid.

Section 2 would add a new Part 8 to Article 50 of Chapter 58 of the General Statues that would address the administration of step therapy protocols. A step therapy protocol would be defined as "a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are medically appropriate for a particular patient and are covered by an insurer or health plan." An insurer would be required to use written screening procedures, decision abstracts, clinical protocols, and practice guideless to establish a step therapy protocol. These clinical review criteria would be based on clinical practice guidelines that meet the following requirements:

- Recommend the drugs be taken in the specific sequence required by the step therapy protocol.
- Are developed and endorsed by an independent, multidisciplinary panel of experts not affiliated with a health benefit plan or utilization review organization.
- Are based on high quality studies, research, and medical practice.
- Are created by an explicit and transparent process that:
  - Minimizes biases and conflicts of interest;
  - Explains the relationship between treatment options and outcomes;
  - Rates the quality of the evidence supporting recommendations; and
  - Considers relevant patient subgroups and preferences.
- Are continually updated through a review of new evidence and research.

Karen Cochrane-Brown
Director

H1048-SMTU-89 E1 -V-5

Legislative Analysis
Division
919-733-2578

House Bill 1048 would also require that the patient and prescribing practitioner have access to a step therapy override determination process. A health benefit plan or utilization review organization would be able to use its existing medical exceptions process for this purpose. A step therapy override determination request would be granted if any of the following apply:

- The required prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient.
- The required prescription drug is expected to be ineffective based on the known relevant physical or mental characteristics of the patient and the known characteristics of the prescription drug regimen.
- The patient has tried the required prescription drug while under their current or a previous health insurance or health benefit plan or another prescription drug in the same pharmacologic class or with the same mechanism of action and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
- The required prescription drug is not in the best interest of the patient, based on medical appropriateness.
- The patient is stable on a prescription drug selected by their health care provider for the medical condition under consideration.

House Bill 1048 would indicate that nothing will be construed to prevent a health benefit plan or utilization review organization from requiring a patient to try an AB rated generic equivalent prior to providing coverage for the equivalent branded prescription drug or a health care provider from prescribing a prescription drug that is determined to be medically appropriate.

EFFECTIVE DATE: This act becomes effective October 1, 2016, and applies to health benefit contracts issued, renewed, or amended on or after that date.

*Staff Attorney Amy Jo Johnson substantially contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H **1**

HOUSE BILL 16

Short Title:	Repeal outdated reports.-AB	(Public)
Sponsors:	Representative Pendleton (Primary Sponsor). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Insurance.	

January 29, 2015

A BILL TO BE ENTITLED

AN ACT TO REPEAL OUTDATED AND UNNECESSARY INSURANCE REPORTING REQUIREMENTS, AS RECOMMENDED BY THE DEPARTMENT OF INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-2-165(b) reads as rewritten:

"(b) The Commissioner may require statements under this ~~section, G.S. 58-2-170,~~section and G.S. 58-2-190 to be filed in a format that can be read by electronic data processing equipment, provided that this subsection does not apply to an audited financial statement prepared by a certified public accountant that is submitted by a town or county mutual pursuant to subsection (a1) of this section."

SECTION 2. G.S. 58-2-170 is repealed.

SECTION 3. G.S. 58-3-191(a) and (b1) are repealed.

SECTION 4. G.S. 58-67-140(a)(7) is repealed.

SECTION 5. G.S. 58-36-3(c) is repealed.

SECTION 6. G.S. 58-40-130(e) is repealed.

SECTION 7. G.S. 58-50-95 is repealed.

SECTION 8. This act is effective when it becomes law and applies to reports otherwise required to be filed on or after July 1, 2015.

Margie Penven (Rep. Dana Bumgardner)

From:	Margaret Herring (Rep. Mitchell Setzer)
Sent:	Thursday, June 23, 2016 10:39 AM
To:	Rep. David Lewis; Rep. Darren Jackson; Rep. Josh Dobson; Rep. Gregory Murphy
Cc:	Grace Rogers (Rep. David Lewis); Angela McMillan (Rep. Darren Jackson); Julie Ryan (Rep. Josh Dobson); Theresa Lopez (Rep. Gregory Murphy)
Subject:	<NCGA> House Insurance Committee Meeting Notice for Tuesday, June 28, 2016 at 1:00 PM
Attachments:	Add Meeting to Calendar_LINC_.ics

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Tuesday, June 28, 2016
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**

The following bills will be considered:

BILL NO.	**SHORT TITLE**	**SPONSOR**
HB 1048	Reduce Barriers to Improve NC Health & Safety.	Representative Lewis Representative Jackson Representative Murphy Representative Dobson

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 10:37 AM on Thursday, June 23, 2016.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margaret Herring (Committee Assistant)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Tuesday, June 28, 2016
TIME: **1:00 PM**
LOCATION: **1228/1327 LB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 1048	Reduce Barriers to Improve NC Health & Safety.	Representative Lewis Representative Jackson Representative Murphy Representative Dobson

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 10:37 AM on Thursday, June 23, 2016.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margaret Herring (Committee Assistant)

House Committee on Insurance
Tuesday, June 28, 2016, 1:00 PM
1228/1327 Legislative Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 1048	Reduce Barriers to Improve NC Health & Safety.	Representative Lewis Representative Jackson Representative Murphy Representative Dobson

Presentations

Other Business

Adjournment

House Committee on Insurance
Tuesday, June 28, 2016 at 1:00 PM
Room 1228/1327 of the Legislative Building

MINUTES

The House Committee on Insurance met at 1:00 PM on June 28, 2016 in Room 1228/1327 of the Legislative Building. Representatives Boles, Bumgardner, Burr, Collins, Conrad, Dollar, Earle, K. Hall, Hamilton, Hanes, Hastings, Horn, Iler, Jackson, Langdon, Lucas, Murphy, Pendleton, W. Richardson, Setzer, Shepard, Tine, and Warren attended.

Chairman Mitchell S. Setzer, presided. He recognized the House Pages (Attachment I) and the House Sergeants at Arms (Attachment II). In addition, he welcomed the visitors (Attachment III).

The following bills were considered:

HB 1048 Reduce Barriers to Improve NC Health & Safety. (Representatives Lewis, Jackson, Murphy, Dobson) (Attachments IV and V).

Representative David Lewis explained the bill. Chairman Setzer recognized Christine Lassiter, National Arthritis Foundation for the bill and Gregg Thompson, State Director of National Federation of Independent Business against the bill for statements.

After the committee had discussion, Representative David Lewis pulled the bill.

The meeting adjourned at 1:35 PM.

Mitchell S. Setzer

Chairman Mitchell S. Setzer
Presiding

Margaret Herring

Margaret Herring, Committee Clerk

Attachment I

HOUSE PAGES
(INSURANCE)

Week of June 27-30, 2016

Name:	County:	Sponsor:
SUZANNA MOSLEY	NASH	REP. COLLINS
SARAH POPKIN	ORANGE	REP. SETZER
~~JOSHUA RAPER~~	WILSON	REP. MARTIN
MACKENZIE SILVER	MCDOWELL	REP. DOBSON

Everette Malchow

Honorary Pages: Aidan Stam

Gavin Stam

Attachment II

Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Insurance

DATE: 06/28/16 Room: 1228

House Sgt-At Arms:

1. Name: David Leighton
   MK
2. Name: Rey Cooke
3. Name: Dean Marshbourne
4. Name: Jonas Cherry
5. Name: Russell Salisbury

Senate Sgt-At Arms:

1. Name: ______
2. Name: ______
3. Name: ______
4. Name: ______
5. Name: ______

Attachment III

VISITOR REGISTRATION SHEET

INSURANCE	June 28,2016
Name of Committee	**Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Madeline Baker	SEANC
[illegible]	SEANC
Michelle Frazier	MFS
John McMillan	MFS
Michelle McArthur	AF
Candice Fuller	Arthritis Foundation
Amy McConkey	NC Beverage
Courtney Lockamy	Randolph Cloud & Assoc.

VISITOR REGISTRATION SHEET

INSURANCE — June 28,2016

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	[illegible]
Natalie Koziarski	NCSU
M. Jillian D Totman	MWC LLC
Tom West	NCICU
Jim Harrell	B+H
DOUG HERON	DUKE
John Del Giorno	[illegible]
SARAH BALES	" " "

VISITOR REGISTRATION SHEET

INSURANCE — June 28,2016

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Matt B[illegible]	BCBSNC
[illegible]	[illegible]
Chris Mc[illegible]	Brooks Pierce
Amanda Donovan	TSS
J Peters	CSS
[illegible]	[illegible]
[illegible] J. [illegible]	UHG
[illegible]	[illegible]
[illegible]	[illegible]

VISITOR REGISTRATION SHEET

INSURANCE — June 28,2016

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	CSS
Dave Horne	SA
Susan Valauri	NW
Mark Fleary	BCBSNC

VISITOR REGISTRATION SHEET

INSURANCE — June 28,2016

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Hayden Barguess	FSP
Debbie Bowden	FSP
Brianna Moragne	NCGA Intern- Rep Baskerville
Meghan Cook	NC DIT
Matt Grabowski	State Health Plan
[illegible]	SHP
Flint Benson	SEANC
Suzanne Beasley	SEANC

VISITOR REGISTRATION SHEET

INSURANCE — Name of Committee

June 28,2016 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cody Hand	NCHA
Elizabeth Dutten	Novant Health
Martha Ann McConnell	Carolinas HealthCare
Daniel VanLiere	Novant Health
Daniel Baum	Troutman Sanders
Julia Adams Schumacher	[illegible]
Joel Maynard	GRM ; Assoc
Steve Prokken	PSOC / Duke
Sarah Wolfe	MWC
[illegible]	NCAHP
Colin Campbell	N+O

VISITOR REGISTRATION SHEET

INSURANCE — June 28,2016

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dana Simpson	SA
[illegible]	NMRS
Ben Popkin	NCDOI

VISITOR REGISTRATION SHEET

INSURANCE — June 28,2016

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lori Ann Harris	LAHA
Meg Ryan O'Donnell	WS
Joe McClees	McClees Consulting
Gary Salamido	NC Chamber
Gregg Thompson	NFIB
Tim Fetzer	FSA
Anna Wilson	Eckel & Vaughan
Tori Ludwig	Eckel & Vaughan
Abby Stoddard	Prime Therapeutics, Minneapolis MN

VISITOR REGISTRATION SHEET

INSURANCE	June 28,2016
Name of Committee	**Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kelsey Byerly	Lorrie Orrino LLC
Jonathan Brubaker	BA
Kendall Bourdon	NC IC
Kara Weishaar	SA
Laura Gunter	NCBIO
Kella Hatcher	CFTF
[illegible]	[illegible]
[illegible]	[illegible]

VISITOR REGISTRATION SHEET

INSURANCE — June 28,2016

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
L C Bergman	CSS
[illegible]	[illegible]
Jake Cark	NCL
Meghan Lewis	NCL
Nathan Babcock	NCC
Robert PASchal	Young Moore
Andy Emanuels	NMSS
Sophie Sherman	NMSS
Felicia Gore Howey	public

Attachment IV

2016-2017 General Assembly

HOUSE BILL 1048: Reduce Barriers to Improve NC Health & Safety.

Committee:	House Insurance	**Date:**	June 28, 2016
Introduced by:	Reps. Lewis, Jackson, Murphy, Dobson	**Prepared by:**	Kristen L. Harris
Analysis of:	First Edition		Committee Co-Counsel

SUMMARY:* *House Bill 1048 would require health benefit plans to treat abuse-deterrent and non-abuse deterrent opioids the same in terms of prior authorization requirements and would prevent plans from requiring a person to use a non-abuse deterrent opioid before authorizing the use of an abuse-deterrent opioid. It would also require insurers utilizing step therapy to base their protocols upon clinical review criteria and to make a step therapy override determination process available to their patients and their patients' practitioners if coverage for a prescription drug is restricted for use by the plan under the step therapy protocol.

BACKGROUND: Step therapy is a type of prior authorization requirement used in health benefit plans. Step therapy requires the insured to try one or more prerequisite drugs that are generally less costly before more costly medication will be covered.

BILL ANALYSIS:

Section 1 would require a health benefit plan that provides coverage for abuse-deterrent opioids to treat abuse-deterrent and non-abuse deterrent opioids the same in terms of prior authorization requirements. Additionally, the health benefit plan would not be allowed to require a person to use a non-abuse deterrent opioid before authorizing the use of an abuse-deterrent opioid.

Section 2 would add a new Part 8 to Article 50 of Chapter 58 of the General Statues that would address the administration of step therapy protocols. A step therapy protocol would be defined as "a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are medically appropriate for a particular patient and are covered by an insurer or health plan." An insurer would be required to use written screening procedures, decision abstracts, clinical protocols, and practice guideless to establish a step therapy protocol. These clinical review criteria would be based on clinical practice guidelines that meet the following requirements:

- Recommend the drugs be taken in the specific sequence required by the step therapy protocol.
- Are developed and endorsed by an independent, multidisciplinary panel of experts not affiliated with a health benefit plan or utilization review organization.
- Are based on high quality studies, research, and medical practice.
- Are created by an explicit and transparent process that:
    - Minimizes biases and conflicts of interest;
    - Explains the relationship between treatment options and outcomes;
    - Rates the quality of the evidence supporting recommendations; and
    - Considers relevant patient subgroups and preferences.
- Are continually updated through a review of new evidence and research.

House Bill 1048 would also require that the patient and prescribing practitioner have access to a step therapy override determination process. A health benefit plan or utilization review organization would be able to use its existing medical exceptions process for this purpose. A step therapy override determination request would be granted if any of the following apply:

- The required prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient.
- The required prescription drug is expected to be ineffective based on the known relevant physical or mental characteristics of the patient and the known characteristics of the prescription drug regimen.
- The patient has tried the required prescription drug while under their current or a previous health insurance or health benefit plan or another prescription drug in the same pharmacologic class or with the same mechanism of action and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
- The required prescription drug is not in the best interest of the patient, based on medical appropriateness.
- The patient is stable on a prescription drug selected by their health care provider for the medical condition under consideration.

House Bill 1048 would indicate that nothing will be construed to prevent a health benefit plan or utilization review organization from requiring a patient to try an AB rated generic equivalent prior to providing coverage for the equivalent branded prescription drug or a health care provider from prescribing a prescription drug that is determined to be medically appropriate.

EFFECTIVE DATE: This act becomes effective October 1, 2016, and applies to health benefit contracts issued, renewed, or amended on or after that date.

*Staff Attorney Amy Jo Johnson substantially contributed to this summary.

Attachment V

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 1

HOUSE BILL 1048

Short Title:	Reduce Barriers to Improve NC Health & Safety.	(Public)
Sponsors:	Representatives Lewis, Jackson, Murphy, and Dobson (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Insurance	

May 9, 2016

A BILL TO BE ENTITLED

AN ACT TO INCREASE ACCESS TO ABUSE-DETERRENT OPIOID ANALGESICS AND TO ENSURE THE PROPER ADMINISTRATION OF STEP THERAPY PROTOCOLS FOR PRESCRIPTION DRUGS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON STEP THERAPY.

Whereas, opioid-related deaths have doubled in North Carolina between 1999 and 2013; and

Whereas, a 2013 National Survey on Drug Use and Health found that over 63% of all people who abuse prescription drugs obtained the drugs from family and friends; and

Whereas, opioid abuse in North Carolina is a serious and severe problem that affects the health, social, and economic welfare of this State; and

Whereas, abuse-deterrent opioid analgesics have been labelled a top priority by the United States Food and Drug Administration; and

Whereas, patient access to abuse-deterrent opioid analgesics is an important step in addressing the opioid abuse epidemic; and

Whereas, health benefit plans are increasingly making use of step therapy protocols under which patients are required to try one or more prescription drugs before coverage is provided for a drug selected by the patient's health care provider; and

Whereas, when step therapy protocols are based on well-developed scientific standards and administered in a flexible manner that takes into account the individual needs of patients, the protocols can play an important role in controlling health care costs; and

Whereas, in some cases, requiring a patient to follow a step therapy protocol may have adverse and even dangerous consequences for the patient who may either not realize a benefit from taking a prescription drug or may suffer harm from taking an inappropriate drug; and

Whereas, without uniform policies in the State for step therapy protocols, patients may not receive the best and most appropriate treatment; and

Whereas, it is imperative that step therapy protocols preserve the health care provider's right to make treatment decisions in the best interest of the patient; and

Whereas, the General Assembly declares it a matter of public interest that it require health benefit plans base step therapy protocols on appropriate clinical practice guidelines developed by independent experts with knowledge of the condition or conditions under consideration; that patients be exempt from step therapy protocols when inappropriate or otherwise not in the best interest of the patients; and that patients have access to a fair, transparent, and independent process for requesting an exception to a step therapy protocol when appropriate; Now, therefore, 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:

"**§ 58-3-295. Coverage for abuse-deterrent opioid analgesics.**

(a) The following definitions apply in this section:

(1) Abuse-deterrent opioid analgesic drug product. – A brand or generic opioid analgesic drug product approved by the United States Food and Drug Administration with an abuse-deterrence labeling claim that indicates that the drug product is expected to deter abuse.

(2) Health benefit plan. – As defined in G.S. 58-3-167.

(3) Opioid analgesic drug product. – A drug product in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions in immediate-release, extended-release, or long-acting form, regardless of whether or not combined with other drug substances to form a single drug product or dosage form.

(b) Any health benefit plan that provides coverage for abuse-deterrent opioid analgesic drug products may impose a prior authorization requirement for an abuse-deterrent opioid analgesic drug product only if the health benefit plan imposes the same prior authorization requirement for each opioid analgesic drug product without an abuse-deterrence labeling claim.

(c) No health benefit plan that provides coverage for abuse-deterrent opioid analgesic drug products may require the use of an opioid analgesic drug product without an abuse-deterrence labeling claim before authorizing the use of an abuse-deterrent opioid analgesic drug product."

SECTION 2. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 8. Administration of Step Therapy Protocols.

"**§ 58-50-301. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the following definitions apply:

(1) Clinical practice guidelines. – A systematically developed statement to assist health care provider and patient decisions about appropriate health care for specific clinical circumstances and conditions.

(2) Clinical review criteria. – The written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by an insurer, health plan, or utilization review organization to determine the medical necessity and appropriateness of health care services.

(3) Step therapy override determination. – A determination as to whether a step therapy protocol should apply in a particular situation or whether the step therapy protocol should be overridden in favor of immediate coverage of the health care provider's selected prescription drug. This determination is based on a review of the patient's or prescriber's request for an override along with supporting rationale and documentation.

(4) Step therapy protocol. – A protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are medically appropriate for a particular patient and are covered by an insurer or health plan.

(5) Utilization review organization. – As defined in G.S. 58-50-61(a)(18).

"**§ 58-50-305. Clinical review criteria.**

Clinical review criteria used to establish a step therapy protocol shall be based on clinical practice guidelines that meet all the following requirements:

(1) Recommend that the prescription drugs be taken in the specific sequence required by the step therapy protocol.

(2) Are developed and endorsed by an independent, multidisciplinary panel of experts not affiliated with a health benefit plan or utilization review organization.

(3) Are based on high-quality studies, research, and medical practice.

(4) Are created by an explicit and transparent process that includes all of the following:

a. Minimizes biases and conflicts of interest.

b. Explains the relationship between treatment options and outcomes.

c. Rates the quality of the evidence supporting recommendations.

d. Considers relevant patient subgroups and preferences.

(5) Are continually updated through a review of new evidence and research.

"**§ 58-50-310. Exceptions process transparency.**

(a) Exceptions Process. – When coverage of a prescription drug for the treatment of any medical condition is restricted for use by a health benefit plan or utilization review organization through the use of a step therapy protocol, the patient and prescribing practitioner shall have access to a clear and convenient process to request a step therapy override determination. A health benefit plan or utilization review organization may use its existing medical exceptions process to satisfy this requirement. The process shall be made easily accessible on the health benefit plan's or utilization review organization's Web site.

(b) Exceptions. – A step therapy override determination request shall be expeditiously granted if any of the following apply:

(1) The required prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient.

(2) The required prescription drug is expected to be ineffective based on the known relevant physical or mental characteristics of the patient and the known characteristics of the prescription drug regimen.

(3) The patient has tried the required prescription drug while under their current or a previous health insurance or health benefit plan or another prescription drug in the same pharmacologic class or with the same mechanism of action and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

(4) The required prescription drug is not in the best interest of the patient, based on medical appropriateness.

(5) The patient is stable on a prescription drug selected by their health care provider for the medical condition under consideration.

(c) Effect of Exception. – Upon the granting of a step therapy override determination, the health benefit plan or utilization review organization shall authorize coverage for the prescription drug prescribed by the patient's treating health care provider, provided such prescription drug is a covered prescription drug under such policy or contract.

(d) Limitations. – This section shall not be construed to prevent any of the following:

(1) A health benefit plan or utilization review organization from requiring a patient to try an AB-rated generic equivalent prior to providing coverage for the equivalent branded prescription drug.

(2) A health care provider from prescribing a prescription drug that is determined to be medically appropriate.

"**§ 58-50-315. Rules and limitation of Part.**

(a) The Commissioner shall adopt rules to implement this Article.

(b) Nothing in this Part shall be construed to impact an insurer's ability to substitute a generic drug for a name brand drug."

SECTION 3. This act becomes effective October 1, 2016, and applies to insurance contracts issued, renewed, or amended on or after that date.

Corrected #2: Time change again

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Wednesday, June 29, 2016
TIME: **15 Minutes After Rules Committee**
LOCATION: **1228/1327 LB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 865	State Health Plan/Admin Changes/Local Govts.	Senator Sanderson

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 11:39 AM on Thursday, July 07, 2016.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margie Penven (Committee Assistant)

Corrected #1: Note change of time

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Wednesday, June 29, 2016
TIME: **4:00 PM**
LOCATION: **1228/1327 LB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 865	State Health Plan/Admin Changes/Local Govts.	Senator Sanderson

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 11:19 AM on Wednesday, June 29, 2016.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margie Penven (Committee Assistant)

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2015-2016 SESSION

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

DAY & DATE: Wednesday, June 29, 2016
TIME: **12:00 PM**
LOCATION: **1228/1327 LB**

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 865	State Health Plan/Admin Changes/Local Govts.	Senator Sanderson

Respectfully,

Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 1:35 PM on Tuesday, June 28, 2016.

___ Principal Clerk
___ Reading Clerk – House Chamber

Margie Penven (Committee Assistant)

House Committee on Insurance
Wednesday, June 29, 2016, 4:45 p.m.
1228/1327 Legislative Building
Chairman Bumgardner Presiding

AGENDA

Welcome and Opening Remarks

Introduction of Pages and Sergeants-at-Arms

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 865	State Health Plan/Admin Changes/Local Govts.	Senator Sanderson

Presentations

Other Business

Adjournment

House Committee on Insurance
Wednesday, June 29, 2016 at 4:45 p.m.
Room 1228/1327 of the Legislative Building

MINUTES

The House Committee on Insurance met at 4:45 p.m. on June 29, 2016, in Room 1228/1327 of the Legislative Building. Representatives Arp, Boles, Bumgardner, Burr, Collins, Dixon, Dobson, C. Graham, K. Hall, Hanes, Hastings, Howard, Iler, Lucas, McElraft, Murphy, Pendleton, Setzer, Tine, Warren, and Wray attended.

Representative Dana Bumgardner, Chair, presided. A copy of the Visitor Registration is attached as Exhibit 1. The Agenda is attached as Exhibit 2.

The chair called the meeting to order and introduced the Assistant Sergeants-at-Arms serving the committee. They were: David Leighton, Jim Moran, and Russell Salisbury.

The following bill was considered:

SB 865 State Health Plan/Admin Changes/Local Govts. (Senator Sanderson). A copy of SB 865 is attached as Exhibit 3. Chairman Bumgardner said there was a proposed committee substitute for Senate Bill 865, and without objection, the substitute bill was placed before the committee for consideration. A copy of the committee substitute for Senate Bill 865 is attached at Exhibit 4.

The chair recognized Senator Sanderson to explain his bill, and he deferred to committee staff. Kristen Harris explained the committee substitute for Senate Bill 865, and a copy of the bill summary is attached as Exhibit 5.

There was committee discussion of the bill, and David Vanderweide from Fiscal Research Division was on hand to answer questions.

Following discussion, Representative Setzer moved for an unfavorable report as to the original bill, favorable as to the committee substitute bill, with a serial referral to Rules (with a recommendation to strike the serial referral). The motion carried. A copy of the committee report is attached as Exhibit 6.

The meeting adjourned at 5:00 p.m.

Representative Dana Bumgardner, Chair Presiding

Margie Penven, Committee Clerk

Attachments:
Exhibit 1: Visitor Registration

Exhibit 2: Agenda
Exhibit 3: SB 865
Exhibit 4: PCS for SB 865
Exhibit 5: Bill Summary for PCS for SB 865
Exhibit 6: Committee Report

Exhibit 1

VISITOR REGISTRATION SHEET

House Committee on Insurance 06/29/16

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Meghan Cook	NC DIT
[illegible]	SOS
Henri McClees	McClees Consulting
Joe McClees	McClees Consulting
S [illegible]	DST
[illegible]	[illegible]
L C [illegible]	CSS
L Harris	LAHA
Phoebe Landon	MCC
Katy Kingsbury	[illegible]
Daniel Valliere	Von Heach

VISITOR REGISTRATION SHEET

House Committee on Insurance 06/29/16

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Michelle Frazier	MFS
Marge Foreman	NCHE
Flint Benson	SEANC
Ben Popkin	NCDOI
Dalen A. Yancey	NCANP
Jim Harrell	B&H
Gerry Cohen	NN
Steven Mange	NCRLA
[illegible]	A&P
Lexi Arthur	NCRMA
Elizabeth Robinson	NCRMA

VISITOR REGISTRATION SHEET

House Committee on Insurance 06/29/16

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amanda Donovan	TSS
Andy Chase	KMA
Doug Heron	DUKE
[illegible]	NCHA
TJ Bugbee	NP
Ryan [illegible]	GM
Sue Ann Forrest	NCICU
[illegible]	Bar Assn.
Dodie Renfro	CCR
Jonathan Brubaker	BA
Hayden Bauguess	FSP

VISITOR REGISTRATION SHEET

House Committee on Insurance 06/29/16

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Gabriel Farris	House Intern
Hugh Johnson	NCACC
Johanna Reese	NCACC
Casandra Hoekstra	NCACC
Jingjing Guo	NCACC
Adam Pridemore	NCASA

House Committee on Insurance
Wednesday, June 29, 2016, 4:45 p.m.
1228/1327 Legislative Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 865	State Health Plan/Admin Changes/Local Govts.	Senator Sanderson

Presentations

Other Business

Adjournment

Exhibit 3

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S 2

SENATE BILL 865
Insurance Committee Substitute Adopted 6/23/16

Short Title: State Health Plan/Admin Changes/Local Govts. (Public)

Sponsors:

Referred to:

May 11, 2016

A BILL TO BE ENTITLED

AN ACT TO MAKE ADMINISTRATIVE CHANGES TO THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES STATUTES; TO INCREASE THE NUMBER OF LOCAL GOVERNMENTS ABLE TO PARTICIPATE IN THE STATE HEALTH PLAN; AND TO MAKE CHANGES TO STATE HEALTH PLAN PREMIUMS PAID BY LOCAL GOVERNMENT EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-48.47(b) reads as rewritten:

"(b) Participation Requirements. – A local government unit may elect to participate in the State Health Plan. Participation shall be governed by the following:

(1) In order to participate, a local government unit must do the following:
a. Pass a valid resolution expressing the local government's desire to participate in the Plan.
b. Enter into a memorandum of understanding with the Plan that acknowledges the conditions of this section and this Article.
c. Provide at least 90 days' notice to the Plan prior to entry and complete the requirements of this subdivision at least 60 days prior to entry.

(2) In order to participate, a local government unit and its employees must meet the federal requirements to participate in a governmental plan. The Plan may refuse participation to persons who would jeopardize the Plan's qualification as a governmental plan under federal law.

(2a) The Plan shall admit any local government unit that meets the administrative and legal requirements of this section, regardless of the claims experience of the local government unit group or the financial impact on the Plan.

(3) A local government unit shall determine the eligibility of its employees and employees' ~~dependents and what portion of the premiums employees with pay to the local governments unit.~~dependents.

(3a) The premiums employees pay to the local government unit for their own coverage shall conform to the premiums in the structure set by the Plan. The premiums employees pay to the local government unit for coverage of their dependents may be determined by the local government unit but may not exceed the premiums set by the Plan.

(4) Premiums for coverage and Plan options shall be the same as those offered to State employees and dependents on a fully contributory basis.

(5) The local government unit shall pay all premiums for all covered individuals directly to the Plan or the Plan's designee."

SECTION 2.(a) G.S. 135-48.47(c) reads as rewritten:

"(c) Enrollment Limitation. – Local governments may elect to participate until the number of employees and dependents of employees of local governments enrolled in the Plan reaches ~~10,000,~~ 16,000, after which time no additional local governments may join the Plan. Any local government electing to participate must have less than 1,000 employees and dependents enrolled in health coverage at the time the local government provides notice to the Plan of its desire to participate."

SECTION 2.(b) In admitting additional local governments as permitted by subsection (a) of this section, the Plan shall use the following transition schedule:

(1) Through June 30, 2017, the Plan may admit local governments until the number of employees and dependents of employees of local governments enrolled in the Plan reaches 13,500.

(2) Through January 31, 2018, the Plan may admit local governments until the number of employees and dependents of employees of local governments enrolled in the Plan, plus the estimated number of employees and dependents of employees of local governments that completed the Plan's Notice of Participation and Information Sheet prior to April 1, 2016, but that are not yet enrolled in the Plan reaches 16,000.

(3) After January 31, 2018, only the limitations of G.S. 135-48.47 will apply.

Notwithstanding the schedule above, the Plan may admit a local government that completed the Plan's Notice of Participation and Information Sheet prior to April 1, 2016, unless the limitation of 16,000 is reached.

SECTION 3. G.S. 135-48.47 is amended by adding a new subsection to read:

"(d) Local governments participating in the Plan as of April 1, 2016, may elect to withdraw from participating in the Plan effective January 1, 2017. Notice of withdrawal must be given by the local government to the Plan no later than September 15, 2016."

SECTION 4. Part 4 of Article 3B of Chapter 135 of the General Statutes is amended by adding a new section to read:

"**§ 135-48.49. IRC sections 6055 and 6056 regulatory reporting.**

The Plan shall be responsible for reporting coverage for retirees and coverage for direct bill members, except for individuals participating in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, as required by section 6055 of the Internal Revenue Code. The Plan shall provide employing units with access to Plan data necessary for employing units to meet filing requirements under sections 6055 and 6056 of the Internal Revenue Code. The Plan may facilitate the availability of a reporting solution; however, the employing unit is responsible for paying all costs associated with the use of any reporting solution made available by the Plan."

SECTION 5. G.S. 58-3-167 reads as rewritten:

"**§ 58-3-167. Applicability of acts of the General Assembly to health benefit plans.**

(a) As used in this section:

(1) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. "Health benefit plan" does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives. "Health benefit plan" does not mean any plan implemented or administered by the State Health Plan for Teachers and State Employees.

"Health benefit plan" does not mean any plan consisting of one or more of any combination of benefits described in G.S. 58-68-25(b).

...."

SECTION 6. Section 1 of this act becomes effective January 1, 2017, and applies to premiums paid on or after that date. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S **D**

SENATE BILL 865
Insurance Committee Substitute Adopted 6/23/16
PROPOSED HOUSE COMMITTEE SUBSTITUTE S865-CSTU-30 [v.2]
06/28/2016 03:11:23 PM

Short Title: State Health Plan/Admin Changes/Local Govts. (Public)

Sponsors:

Referred to:

May 11, 2016

A BILL TO BE ENTITLED

AN ACT TO MAKE ADMINISTRATIVE CHANGES TO THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES STATUTES; TO INCREASE THE NUMBER OF LOCAL GOVERNMENTS ABLE TO PARTICIPATE IN THE STATE HEALTH PLAN; AND TO MAKE CHANGES TO STATE HEALTH PLAN PREMIUMS PAID BY LOCAL GOVERNMENT EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-48.1 reads as rewritten:

"**§ 135-48.1. General definitions.**

As used in this Article unless the context clearly requires otherwise, the following definitions apply:

...

(2a) Claims Data Feed. – An electronic file provided by a Claims Processor that contains all claims processing data elements for every claim processed by the Claims Processor for the Plan, including Claim Payment Data for each claim.

(2b) Claim Payment Data. – Data fields within a Claims Data Feed that reflect the provider and the amount the provider billed for services provided to a Plan member, the allowed amount applied to the claim by the Claim Processor, and the amount paid by the Plan on the claim. The term "Claim Payment Data" includes any document, material, or other work, whether tangible or electronic, that is derived from, is based on, or reflects any of the foregoing data fields or information contained therein. If the Claim Processor designates Claim Payment Data as a trade secret, the Claim Payment Data shall be treated as a trade secret as defined in G.S. 66-152(3)

..."

SECTION 2. G.S. 135-48.10(a) reads as rewritten:

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

(a) Any information described in this section that is in the possession of the State Health Plan for Teachers and State Employees or its Claims Processor under the Plan or the Predecessor Plan shall be confidential and shall be exempt from the provisions of Chapter 132 of the General Statutes or any other provision requiring information and records held by State agencies to be made public or accessible to the public. This section shall apply to all information concerning individuals, including the fact of coverage or noncoverage, whether or not a claim has been filed, medical information, whether or not a claim has been paid, and any other information or materials concerning a plan ~~participant.~~participant, including Claim Payment Data and any documents or other materials derived from the Claim Payment Data. This information may, however, be released to the State Auditor or to the Attorney General in furtherance of their statutory duties and responsibilities, or to such persons or organizations as may be designated and approved by the State Treasurer. Any information so released shall remain confidential as stated above and any party obtaining such information shall assume the same level of responsibility for maintaining such confidentiality as that of the State Health Plan for Teachers and State Employees."

SECTION 3. G.S. 135-48.32 reads as rewritten:

"**§ 135-48.32. Contracts to provide benefits.**

(a) The Plan benefits shall be provided under contracts between the Plan and the claims processors selected by the Plan. ~~The State Treasurer may contract with a pharmacy benefits manager to administer pharmacy benefits under the Plan. Such contracts shall include the applicable provisions of 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. The Claims Processor shall provide all claims processing data elements to the Plan including the identification of providers and the allowed amounts paid. ~~If any of the provisions of 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 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.~~

(b) Unless otherwise directed by the Plan, each Claims Processor shall provide the Plan with a Claims Data Feed, which includes all Claim Payment Data, at a frequency agreed to by the Plan and the Claim Processor. The frequency shall be no less than monthly. The Claims Processor is not required to disclose Claim Payment Data that reflects rates negotiated with or agreed to by a non-contracted third party, but, upon request, shall provide to the Plan sufficient documentation to support the payment of claims for which Claim Payment Data is withheld on such basis.

(c) Any provision of any contract between a Claims Processor and a health care provider, subcontractor, or third party that would prevent or prohibit the Claims Processor from disclosing Claim Payment Data to the Plan in accordance with this section shall be void and unenforceable, but only to the extent the provision prevents and prohibits disclosure to the Plan.

(d) The Plan may use and disclose Claim Payment Data solely for the purpose of administering and operating the State Health Plan for Teachers and State Employees in accordance with G.S. 135-48.2 and the provisions of this Article. The Plan shall not make any use or disclosure of Claim Payment Data that would compromise the proprietary nature of the data or, as applicable, its status as a trade secret, or otherwise misappropriate the data.

(e) The Plan may not use a provider's Claim Payment Data to negotiate rates, fee schedules, or other master charges with that provider or any other provider.

(f) The Plan may disclose Claim Payment Data to a third party to use on the Plan's behalf as agreed upon between the Plan and the Claims Processor. The Plan must obtain the agreement of the Claims Processor for each third party to whom the Plan seeks to disclose Claim Payment Data and for each use the third party will make of the data. The Plan may not disclose Claim Payment Data to any third party without first entering into a contract with the third party that contains restrictions on the use and disclosure of the Claim Payment Data by the third party that are at least as restrictive as the provisions of this section.

(g) A Claims Processor who discloses Claim Payment Data in accordance with this section shall not incur any civil liability and shall not be subject to equitable relief in connection for the disclosure."

SECTION 4. G.S. 135-48.47(b) reads as rewritten:

"(b) Participation Requirements. – A local government unit may elect to participate in the State Health Plan. Participation shall be governed by the following:

(1) In order to participate, a local government unit must do the following:
   a. Pass a valid resolution expressing the local government's desire to participate in the Plan.
   b. Enter into a memorandum of understanding with the Plan that acknowledges the conditions of this section and this Article.
   c. Provide at least 90 days' notice to the Plan prior to entry and complete the requirements of this subdivision at least 60 days prior to entry.

(2) In order to participate, a local government unit and its employees must meet the federal requirements to participate in a governmental plan. The Plan may refuse participation to persons who would jeopardize the Plan's qualification as a governmental plan under federal law.

(2a) The Plan shall admit any local government unit that meets the administrative and legal requirements of this section, regardless of the claims experience of the local government unit group or the financial impact on the Plan.

(3) A local government unit shall determine the eligibility of its employees and employees' ~~dependents and what portion of the premiums employees with pay to the local governments unit.~~ dependents.

(3a) The premiums employees pay to the local government unit for their own coverage shall conform to the premiums in the structure set by the Plan. The premiums employees pay to the local government unit for coverage of their dependents may be determined by the local government unit but may not exceed the premiums set by the Plan.

(4) Premiums for coverage and Plan options shall be the same as those offered to State employees and dependents on a fully contributory basis.

(5) The local government unit shall pay all premiums for all covered individuals directly to the Plan or the Plan's designee."

SECTION 5.(a). G.S. 135-48.47(c) reads as rewritten:

"(c) Enrollment Limitation. – Local governments may elect to participate until the number of employees and dependents of employees of local governments enrolled in the Plan reaches ~~10,000,~~16,000, after which time no additional local governments may join the Plan. Any local government electing to participate must have less than 1,000 employees and dependents enrolled in health coverage at the time the local government provides notice to the Plan of its desire to participate."

SECTION 5.(b). In admitting additional local governments as permitted by subsection (a) of this section, the Plan shall use the following transition schedule:

(1) Through June 30, 2017, the Plan may admit local governments until the number of employees and dependents of employees of local governments enrolled in the Plan reaches 13,500.

(2) Through January 31, 2018, the Plan may admit local governments until the number of employees and dependents of employees of local governments enrolled in the Plan, plus the estimated number of employees and dependents of employees of local governments that completed the Plan's Notice of Participation and Information Sheet prior to April 1, 2016, but that are not yet enrolled in the Plan reaches 16,000.

(3) After January 31, 2018, only the limitations of G.S. 135-48.47 will apply.

Notwithstanding the schedule above, the Plan may admit a local government that completed the Plan's Notice of Participation and Information Sheet prior to April 1, 2016, unless the limitation of 16,000 is reached.

SECTION 6. G.S. 135-48.47 is amended by adding a new subsection to read:

"(d) Local governments participating in the Plan as of April 1, 2016, may elect to withdraw from participating in the Plan effective January 1, 2017. Notice of withdrawal must be given by the local government to the Plan no later than September 15, 2016."

SECTION 7. Part 4 of Article 3B of Chapter 135 of the General Statutes is amended by adding a new section to read:

"**§ 135-48.49. IRC sections 6055 and 6056 regulatory reporting.**

The Plan shall be responsible for reporting coverage for retirees and coverage for direct bill members, except for individuals participating in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, as required by section 6055 of the Internal Revenue Code. The Plan shall provide employing units with access to Plan data necessary for employing units to meet filing requirements under sections 6055 and 6056 of the Internal Revenue Code. The Plan may facilitate the availability of a reporting solution; however, the employing unit is responsible for paying all costs associated with the use of any reporting solution made available by the Plan."

SECTION 8. G.S. 58-3-167 reads as rewritten:

"**§ 58-3-167. Applicability of acts of the General Assembly to health benefit plans.**

(a) As used in this section:

(1) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. "Health benefit plan" does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives. "Health benefit plan" does not mean any plan implemented or administered by the State Health Plan for Teachers and State Employees. "Health benefit plan" does not mean any plan consisting of one or more of any combination of benefits described in G.S. 58-68-25(b).

..."

SECTION 9. Section 4 of this act becomes effective January 1, 2017, and applies to premiums paid on or after that date. The remainder of this act is effective when it becomes law and applies to contracts entered into on or after that date.

SENATE BILL 865: State Health Plan/Admin Changes/Local Govts.

2016-2017 General Assembly

Committee:	House Insurance	**Date:**	June 29, 2016
Introduced by:	Sen. Sanderson	**Prepared by:**	Kristen L. Harris
Analysis of:	PCS to Second Edition S865-CSTU-30		Jason Moran-Bates Committee Co-Counsel

SUMMARY: ***The Proposed Committee Substitute to Senate Bill 865 makes several changes to the statutes governing the State Health Plan for Teachers and State Employees. The changes in each section are described below.***

BILL ANALYSIS:

Section 1: Amends G.S. 135-48.1 to add definitions for "Claims Data Feed" and "Claim Payment Data."

Section 2: Amends G.S. 135-48.10(a) to clarify that Claims Payment Data and materials derived from Claims Payment Data are confidential and exempt from the provisions of Chapter 132 of the General Statutes.

Section 3: Amends G.S. 135-48.32 to require claims processors to provide the Claims Data Feed and all available claims data elements, including the identification of providers and the allowed amounts paid, to the Plan. Claims Processors are allowed to withhold information that reflects rates negotiated with or agreed to by a third party, so long as sufficient documentation to support the payment of claims is provided. Section 3 makes any section of a contract between a Claims Processor and medical provider, subcontractor, or third party void and unenforceable to the extent that it prohibits or prevents the Claims Processor from disclosing the required Claims Payment Data. The Plan may only use the Claims Payment Data for purposes of administering the Plan in accordance with G.S. 135-48.2 and the provisions of this Article. It may not use the Claims Payment Data to negotiate rates, fee schedules, or master charges with any medical provider, or if disclosure would compromise the proprietary nature of the Claims Payment Data, its status as a trade secret, or misappropriate the Claims Payment Data. The Plan may disclose Claims Payment Data to a third party to use on the Plan's behalf only if it first gets permission to do so from the Claim Processor and enters into a contract with the third party preventing the third party from disclosing the Claims Payment Data. Finally, Section 3 exempts a Claims Processor who discloses Claims Payment Data in accordance with this section from civil liability or equitable relief.

Section 4: Amends G.S. 135-48.47(b) to prohibit local government units that participate in the Plan from charging employees more for their coverage than allowed under the structure set by the Plan. It also prohibits local governments from charging premiums for employees' dependents which are greater than those set by the Plan.

Section 5.(a).: Amends G.S. 135-47(c) to increase the enrollment limitation on the number of employees and dependents of local governments from 10,000 to 16,000. Section 5.(b). sets forth a schedule for this increase.

Section 6: Amends G.S. 135-48.17 to allow local governments to withdraw from the Plan effective January 1, 2017, so long as notice is given to the Plan no later than September 15, 2016.

Section 7: Adds a new Part to Article 3B of Chapter 135 of the General Statutes to clarify that the Plan is responsible for federal filing requirements under sections 6055 and 6056 of the Internal Revenue Code for retirees and direct bill members, but employing units are responsible for those filings for all other individuals. The Plan shall provide employing units with access to the necessary data and may facilitate a reporting solution, but the employing unit is responsible for paying all costs of that solution. For 2015, the Plan provided and paid for a solution for all employing units. The filing requirements relate to the "individual mandate" and "employer mandate" under the federal Affordable Care Act.

Section 8: Amends G.S. 58-3-167(a)(1) to clarify that a "Health benefit plan" does not include any plan implemented or administered by the State Health Plan for Teachers and State Employees.

EFFECTIVE DATE: Section 4 becomes effective on January 1, 2017, and applies to premiums paid on or after that date. The remainder of the act becomes effective when it becomes law and applies to contracts entered into on or after that date.

David Vanderweide of the Fiscal Research Division substantially contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S **D**

SENATE BILL 865
Insurance Committee Substitute Adopted 6/23/16
~~PROPOSED~~ HOUSE COMMITTEE SUBSTITUTE S865-PCS15403-TU-30

Short Title: State Health Plan/Admin Changes/Local Govts. (Public)

Sponsors:

Referred to:

May 11, 2016

A BILL TO BE ENTITLED

AN ACT TO MAKE ADMINISTRATIVE CHANGES TO THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES STATUTES; TO INCREASE THE NUMBER OF LOCAL GOVERNMENTS ABLE TO PARTICIPATE IN THE STATE HEALTH PLAN; AND TO MAKE CHANGES TO STATE HEALTH PLAN PREMIUMS PAID BY LOCAL GOVERNMENT EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-48.1 reads as rewritten:

"**§ 135-48.1. General definitions.**

As used in this Article unless the context clearly requires otherwise, the following definitions apply:

…

(2a) Claims Data Feed. – An electronic file provided by a Claims Processor that contains all claims processing data elements for every claim processed by the Claims Processor for the Plan, including Claim Payment Data for each claim.

(2b) Claim Payment Data. – Data fields within a Claims Data Feed that reflect the provider and the amount the provider billed for services provided to a Plan member, the allowed amount applied to the claim by the Claims Processor, and the amount paid by the Plan on the claim. The term "Claim Payment Data" includes any document, material, or other work, whether tangible or electronic, that is derived from, is based on, or reflects any of the foregoing data fields or information contained therein. If the Claims Processor designates Claim Payment Data as a trade secret, the Claim Payment Data shall be treated as a trade secret as defined in G.S. 66-152(3)

…."

SECTION 2. G.S. 135-48.10(a) reads as rewritten:

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

(a) Any information described in this section that is in the possession of the State Health Plan for Teachers and State Employees or its Claims Processor under the Plan or the Predecessor Plan shall be confidential and shall be exempt from the provisions of Chapter 132 of the General Statutes or any other provision requiring information and records held by State agencies to be made public or accessible to the public. This section shall apply to all information concerning individuals, including the fact of coverage or noncoverage, whether or not a claim has been filed, medical information, whether or not a claim has been paid, and any other information or materials concerning a plan ~~participant.~~participant, including Claim Payment Data and any documents or other materials derived from the Claim Payment Data. This information may, however, be released to the State Auditor or to the Attorney General in furtherance of their statutory duties and responsibilities, or to such persons or organizations as may be designated and approved by the State Treasurer. Any information so released shall remain confidential as stated above and any party obtaining such information shall assume the same level of responsibility for maintaining such confidentiality as that of the State Health Plan for Teachers and State Employees."

SECTION 3. G.S. 135-48.32 reads as rewritten:

"**§ 135-48.32. Contracts to provide benefits.**

(a) The Plan benefits shall be provided under contracts between the Plan and the claims processors selected by the Plan. ~~The State Treasurer may contract with a pharmacy benefits manager to administer pharmacy benefits under the Plan. Such contracts shall include the applicable provisions of 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. The Claims Processor shall provide all claims processing data elements to the Plan including the identification of providers and the allowed amounts paid. ~~If any of the provisions of 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 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.~~

(b) Unless otherwise directed by the Plan, each Claims Processor shall provide the Plan with a Claims Data Feed, which includes all Claim Payment Data, at a frequency agreed to by the Plan and the Claims Processor. The frequency shall be no less than monthly. The Claims Processor is not required to disclose Claim Payment Data that reflects rates negotiated with or agreed to by a noncontracted third party but, upon request, shall provide to the Plan sufficient documentation to support the payment of claims for which Claim Payment Data is withheld on such basis.

(c) Any provision of any contract between a Claims Processor and a health care provider, subcontractor, or third party that would prevent or prohibit the Claims Processor from disclosing Claim Payment Data to the Plan, in accordance with this section, shall be void and unenforceable, but only to the extent the provision prevents and prohibits disclosure to the Plan.

(d) The Plan may use and disclose Claim Payment Data solely for the purpose of administering and operating the State Health Plan for Teachers and State Employees in accordance with G.S. 135-48.2 and the provisions of this Article. The Plan shall not make any use or disclosure of Claim Payment Data that would compromise the proprietary nature of the data or, as applicable, its status as a trade secret, or otherwise misappropriate the data.

(e) The Plan may not use a provider's Claim Payment Data to negotiate rates, fee schedules, or other master charges with that provider or any other provider.

(f) The Plan may disclose Claim Payment Data to a third party to use on the Plan's behalf as agreed upon between the Plan and the Claims Processor. The Plan must obtain the agreement of the Claims Processor for each third party to whom the Plan seeks to disclose Claim Payment Data and for each use the third party will make of the data. The Plan may not disclose Claim Payment Data to any third party without first entering into a contract with the third party that contains restrictions on the use and disclosure of the Claim Payment Data by the third party that are at least as restrictive as the provisions of this section.

(g) A Claims Processor who discloses Claim Payment Data in accordance with this section shall not incur any civil liability and shall not be subject to equitable relief in connection for the disclosure."

SECTION 4. G.S. 135-48.47(b) reads as rewritten:

"(b) Participation Requirements. – A local government unit may elect to participate in the State Health Plan. Participation shall be governed by the following:

(1) In order to participate, a local government unit must do the following:
   a. Pass a valid resolution expressing the local government's desire to participate in the Plan.
   b. Enter into a memorandum of understanding with the Plan that acknowledges the conditions of this section and this Article.
   c. Provide at least 90 days' notice to the Plan prior to entry and complete the requirements of this subdivision at least 60 days prior to entry.

(2) In order to participate, a local government unit and its employees must meet the federal requirements to participate in a governmental plan. The Plan may refuse participation to persons who would jeopardize the Plan's qualification as a governmental plan under federal law.

(2a) The Plan shall admit any local government unit that meets the administrative and legal requirements of this section, regardless of the claims experience of the local government unit group or the financial impact on the Plan.

(3) A local government unit shall determine the eligibility of its employees and employees' ~~dependents and what portion of the premiums employees with pay to the local governments unit.~~dependents.

(3a) The premiums employees pay to the local government unit for their own coverage shall conform to the premiums in the structure set by the Plan. The premiums employees pay to the local government unit for coverage of their dependents may be determined by the local government unit but may not exceed the premiums set by the Plan.

(4) Premiums for coverage and Plan options shall be the same as those offered to State employees and dependents on a fully contributory basis.

(5) The local government unit shall pay all premiums for all covered individuals directly to the Plan or the Plan's designee."

SECTION 5.(a) G.S. 135-48.47(c) reads as rewritten:

"(c) Enrollment Limitation. – Local governments may elect to participate until the number of employees and dependents of employees of local governments enrolled in the Plan reaches ~~10,000,~~16,000, after which time no additional local governments may join the Plan. Any local government electing to participate must have less than 1,000 employees and dependents enrolled in health coverage at the time the local government provides notice to the Plan of its desire to participate."

SECTION 5.(b) In admitting additional local governments as permitted by subsection (a) of this section, the Plan shall use the following transition schedule:

(1) Through June 30, 2017, the Plan may admit local governments until the number of employees and dependents of employees of local governments enrolled in the Plan reaches 13,500.

(2) Through January 31, 2018, the Plan may admit local governments until the number of employees and dependents of employees of local governments enrolled in the Plan, plus the estimated number of employees and dependents of employees of local governments that completed the Plan's Notice of Participation and Information Sheet prior to April 1, 2016, but that are not yet enrolled in the Plan reaches 16,000.

(3) After January 31, 2018, only the limitations of G.S. 135-48.47 will apply.

Notwithstanding the schedule above, the Plan may admit a local government that completed the Plan's Notice of Participation and Information Sheet prior to April 1, 2016, unless the limitation of 16,000 is reached.

SECTION 6. G.S. 135-48.47 is amended by adding a new subsection to read:

"(d) Local governments participating in the Plan as of April 1, 2016, may elect to withdraw from participating in the Plan effective January 1, 2017. Notice of withdrawal must be given by the local government to the Plan no later than September 15, 2016."

SECTION 7. Part 4 of Article 3B of Chapter 135 of the General Statutes is amended by adding a new section to read:

"**§ 135-48.49. IRC sections 6055 and 6056 regulatory reporting.**

The Plan shall be responsible for reporting coverage for retirees and coverage for direct bill members, except for individuals participating in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, as required by section 6055 of the Internal Revenue Code. The Plan shall provide employing units with access to Plan data necessary for employing units to meet filing requirements under sections 6055 and 6056 of the Internal Revenue Code. The Plan may facilitate the availability of a reporting solution; however, the employing unit is responsible for paying all costs associated with the use of any reporting solution made available by the Plan."

SECTION 8. G.S. 58-3-167 reads as rewritten:

"**§ 58-3-167. Applicability of acts of the General Assembly to health benefit plans.**

(a) As used in this section:

(1) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. "Health benefit plan" does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives. "Health benefit plan" does not mean any plan implemented or administered by the State Health Plan for Teachers and State Employees. "Health benefit plan" does not mean any plan consisting of one or more of any combination of benefits described in G.S. 58-68-25(b).

...."

SECTION 9. Section 4 of this act becomes effective January 1, 2017, and applies to premiums paid on or after that date. The remainder of this act is effective when it becomes law and applies to contracts entered into on or after that date.

Exhibit 6

NORTH CAROLINA GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

INSURANCE COMMITTEE REPORT
Representative Dana Bumgardner, Co-Chair
Representative Mitchell S. Setzer, Co-Chair

FAVORABLE HOUSE COM SUB, UNFAVORABLE SENATE COM SUB AND RE-REFERRED

SB **865** **(CS#1)** State Health Plan/Admin Changes/Local Govts.

Draft Number:	S865-PCS15403-TU-30
Serial Referral:	**RULES, CALENDAR, AND OPERATIONS OF THE HOUSE**
Recommended Referral:	None
Long Title Amended:	No
Floor Manager:	Dobson

TOTAL REPORTED: 1

CMR832-V-1