2015-2016

SENATE
INSURANCE

MINUTES

INSURANCE SENATE COMMITTEE

2015 - 2016

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Wesley Meredith
Co-Chair

Norman Sanderson
Vice-Chair

Dan Blue

Jim Davis

Joel Ford

Rick Gunn

Ralph Hise

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North Carolina General Assembly
Through Senate Committee on
Insurance

2015-2016 Biennium

Date: 08/06/2(

Bill	Introducer	Short Title		Latest Action	Date In	Date Out
H 16	Pendleton	Repeal Outdated Reports.-AB	*R	Ch. SL 2015-92	05/05/2015	06/03/2015
H 20	Graham	Reegan's Rule/Enforce Pharm. Ben. Mgt.	*S	Re-ref Com On Insurance	07/21/2015	
H 56	Holloway	State Health Plan/Rehired Retiree Eligibility.	*S	Re-ref Com On Insurance	05/05/2015	
H 122	Presnell	Add Counties/Towns/Cities-State Health Plan.	*S	Re-ref Com On Insurance	05/07/2015	
H 148	Shepard	Insurance Required for Mopeds.	*R	Ch. SL 2015-125	04/30/2015	06/11/2015
H 154	Iler	Local Governments in State Health Plan.	*R	Ch. SL 2015-112	04/23/2015	06/11/2015
H 163	Johnson	Captive Insurance Amendments.	*R	Ch. SL 2015-99	05/07/2015	06/03/2015
H 182	Millis	Property Insurance Fairness.	*S	Ref To Com On Insurance	05/14/2015	
H 190	Pendleton	State Health Plan Modifications.-AB	*R	Ch. SL 2015-100	05/07/2015	06/03/2015
H 262	Pendleton	Surplus Lines Amendments.	*R	Ch. SL 2015-101	05/22/2015	06/03/2015
H 288	Setzer	Insurance Technical Changes.-AB	*R	Ch. SL 2015-146	04/16/2015	06/15/2015
H 361	Collins	Principle-Based Reserving.	S	Re-ref Com On Insurance	07/16/2015	
H 809	Avila	Third-Party Premium Payments.	*S	Re-ref Com On Insurance	07/21/2015	
S 120	Hartsell	DOI License Processing Fees.	H	Re-ref Com On Judiciary IV	03/02/2015	04/23/2015
S 136	Tarte	Charter School in State Health Plan.	S	Re-ref Com On Insurance	04/20/2015	
S 208	Cook	Property Insurance Fairness.	S	Re-ref Com On Insurance	04/21/2015	
S 290	Curtis	Allow Early Refills of Prescription Eye Drops.	S	Re-ref Com On Insurance	04/06/2015	
S 385	Curtis	Payroll Processor Surety Bonds.	S	Re-ref to Insurance. If fav, re-ref to Finance	03/26/2015	
S 423	Barringer	Foster Care Family Act.	*R	Ch. SL 2015-135	04/16/2015	04/23/2015
S 428	Brock	Surcharge Transparency.	S	Re-ref Com On Insurance	03/30/2015	
S 479	Brown	Local Governments in State Health Plan.	S	Re-ref Com On Insurance	03/30/2015	
S 637	Tarte	After Tax Benefit Plan Efficiency.	S	Re-ref Com On Insurance	04/09/2015	
S 665	Apodaca	Unclaimed Life Insurance Benefits.	*H	Ref to the Com on Judiciary I, if favorable, Insurance	03/30/2015	04/23/2015
S 667	Apodaca	Principle-Based Reserving.	H	Ref to the Com on Judiciary I, if favorable, Insurance	04/09/2015	04/23/2015
S 668	Apodaca	Auto Insurance/Allow Optional Enhancements.	H	Re-ref Com On Insurance	03/30/2015	04/23/2015
S 676	Apodaca	Autism Health Insurance Coverage.	*H	Re-ref Com On Rules, Calendar, and Operations of the House	03/30/2015	04/20/2015

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

North Carolina General Assembly
Through Senate Committee on
Insurance

S 676	Apodaca	Autism Health Insurance Coverage.	*H	Re-ref Com On Rules, Calendar, and Operations of the House	04/21/2015	04/23/2015
S 683	Lee	Abolish Consent to Rate for Property Ins.	S	Ref To Com On Insurance	03/30/2015	

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

Senate Committee on Insurance
Thursday, April 23, 2015 at 9:15 AM
Room 1027/1128 of the Legislative Building

MINUTES

The Senate Committee on Insurance met at 9:15 AM on April 23, 2015 in Room 1027/1128 of the Legislative Building. Eleven members were present.

Senator Wesley Meredith, Chair, presided.

Esme Merritt-Dorosin from Carrboro, Alec Johnson from Canton and Olivia Robertson from Swansboro served as pages.

Senator Meredith changed the order of the bills during the committee. The order of the bills are reflected below.

SB 676 Autism Health Insurance Coverage. (Senators Apodaca, Krawiec)
Senator Gunn moved to adopt the proposed committee substitute (PCS) to the committee for discussion and it was carried. Sen. Apodaca was introduced to speak on the bill. Amy Jo Johnson an attorney from the Research Division shared the highpoints of the bill. Sen. Krawiec spoke on the bill and encouraged the support of the committee. Questions were responded to by Ms. Johnson and Sen. Apodaca. Senator McKissick moved unfavorable to the bill – favorable to the PCS and it carried.

SB 423 Foster Care Family Act. (Senators Barringer, Harrington, Tucker)
Senator Sanderson moved to adopt the proposed committee substitute (PCS) to the committee for discussion and it was carried. Sen. Barringer was introduced to speak on the bill. Questions asked by the members were responded to by Sen. Barringer. Sen. Meredith asked R. Michel Strickland an attorney from Young Moore & Henderson, P.A. to speak on the bill. Sen. Ford moved unfavorable to the bill – favorable to the PCS and it carried.

SB 120 DOI License Processing Fees. (Senator Hartsell)
Sen Hartsell was introduced to speak on the bill. He brought a handout and it was shared with the members. There were no questions from the members. Sen. Gunn made a favorable report and it carried.

SB 665 Unclaimed Life Insurance Benefits. (Senator Apodaca)
Sen. Apodaca was introduced to speak on the bill. Kristen Harris an attorney from the Research Division was asked to explain the bill. Questions asked by the members were responded to by Ms. Harris. Anthony Solari from the Treasurer's Department spoke in favor of the bill. Sen. Hise moved for a favorable report and it carried.

SB 667 Principle-Based Reserving. (Senator Apodaca)
Senator Apodaca was introduced to speak on the bill. No questions were asked by the members. Sen. Ford moved for a favorable report and it carried.

SB 668 Auto Insurance/Allow Optional Enhancements. (Senator Apodaca)
Sen. Apodaca was introduced to speak on the bill. Sen. Meredith asked M. Benjamin Popkin, JD, MPH/ Director of Government Affairs for the NC Department of Insurance to speak in favor of the bill. Sen. Ford moved for a favorable report and it carried.

The meeting adjourned at 9:56 AM.

Senator Wesley Meredith, Chair
Presiding

Debbie Lown, Committee Clerk

Senate Committee on Insurance
Thursday, April 23, 2015, 9:15 AM
1027/1128 Legislative Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 120	DOI License Processing Fees.	Senator Hartsell
SB 423	Foster Care Family Act.	Senator Barringer Senator Harrington Senator Tucker
SB 665	Unclaimed Life Insurance Benefits.	Senator Apodaca
SB 667	Principle-Based Reserving.	Senator Apodaca
SB 668	Auto Insurance/Allow Optional Enhancements.	Senator Apodaca
SB 676	Autism Health Insurance Coverage.	Senator Apodaca Senator Krawiec

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Apodaca, Co-Chair
Senator Meredith, Co-Chair

Thursday, April 23, 2015

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

FAVORABLE

SB **120** DOI License Processing Fees.

Draft Number:	None
Sequential Referral:	Finance
Recommended Referral:	None
Long Title Amended:	No

SB **665** Unclaimed Life Insurance Benefits.

Draft Number:	None
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

SB **667** Principle-Based Reserving.

Draft Number:	None
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

SB **668** Auto Insurance/Allow Optional Enhancements.

Draft Number:	None
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 4

Senator Fletcher Hartsell will handle SB 120
Senator Tom Apodaca will handle SB 665
Senator Tom Apodaca will handle SB 667
Senator Tom Apodaca will handle SB 668

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Apodaca, Co-Chair
Senator Meredith, Co-Chair

Thursday, April 23, 2015

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

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

SB **676** Autism Health Insurance Coverage.

Draft Number:	S676-PCS35270-TK-34
Sequential Referral:	Health Care
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Senator Tom Apodaca will handle SB 676

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Apodaca, Co-Chair
Senator Meredith, Co-Chair

Thursday, April 23, 2015

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

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 2

SB **423** **(CS#1)** Foster Care Family Act.

Draft Number:	S423-PCS45358-TU-13
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Senator Tamara Barringer will handle SB 423

SENATE BILL 120:
DOI License Processing Fees

2015-2016 General Assembly

Committee:	Senate Re-ref to Insurance. If fav, re-ref to Finance	**Date:**	April 22, 2015
Introduced by:	Sen. Hartsell	**Prepared by:**	Tim Hovis Committee Counsel
Analysis of:	First Edition		

[As introduced, this bill was identical to H196, as introduced by Reps. Dollar, Lucas, which is currently in House Insurance.]

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.

Senate Bill 120 is a recommendation of the Joint Legislative Program Evaluation Oversight Committee.

EFFECTIVE DATE: Senate Bill 120 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

S120-SMRG-10 E1 -V1

Research Division
(919) 733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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SENATE BILL 120*

Short Title:	DOI License Processing Fees.	(Public)
Sponsors:	Senator Hartsell (Primary Sponsor).	
Referred to:	Rules and Operations of the Senate.	

February 27, 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, AS RECOMMENDED BY THE JOINT LEGISLATIVE PROGRAM EVALUATION OVERSIGHT COMMITTEE.

The General Assembly of North Carolina enacts:

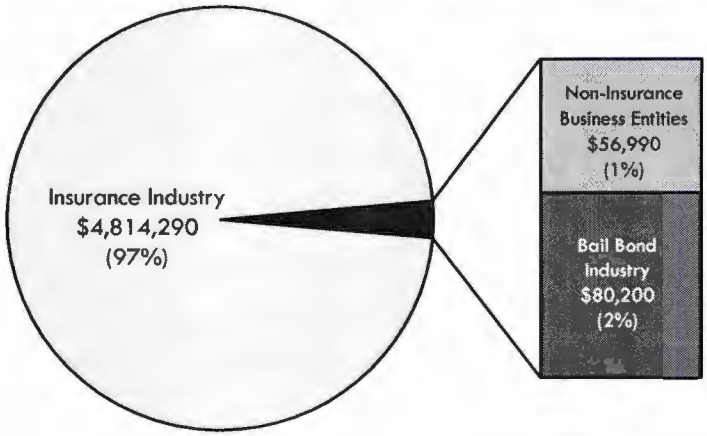
SECTION 1. G.S. 58-2-69(g) reads as rewritten:

"(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 5

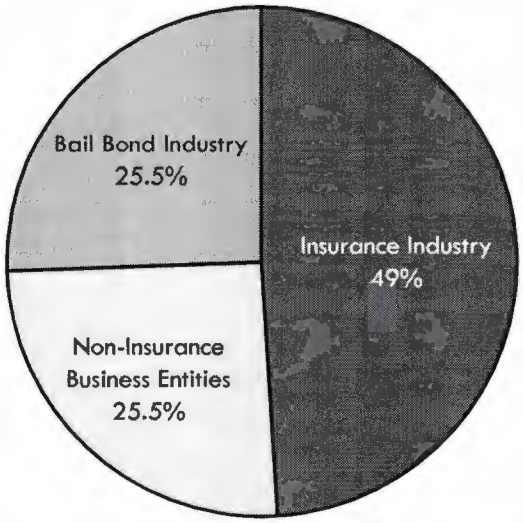
The Majority of Pearson VUE's Revenue Comes from the Insurance Industry



Source: Program Evaluation Division based on license processing fee information from the Agent Services Division of the Department of Insurance.

Exhibit 6

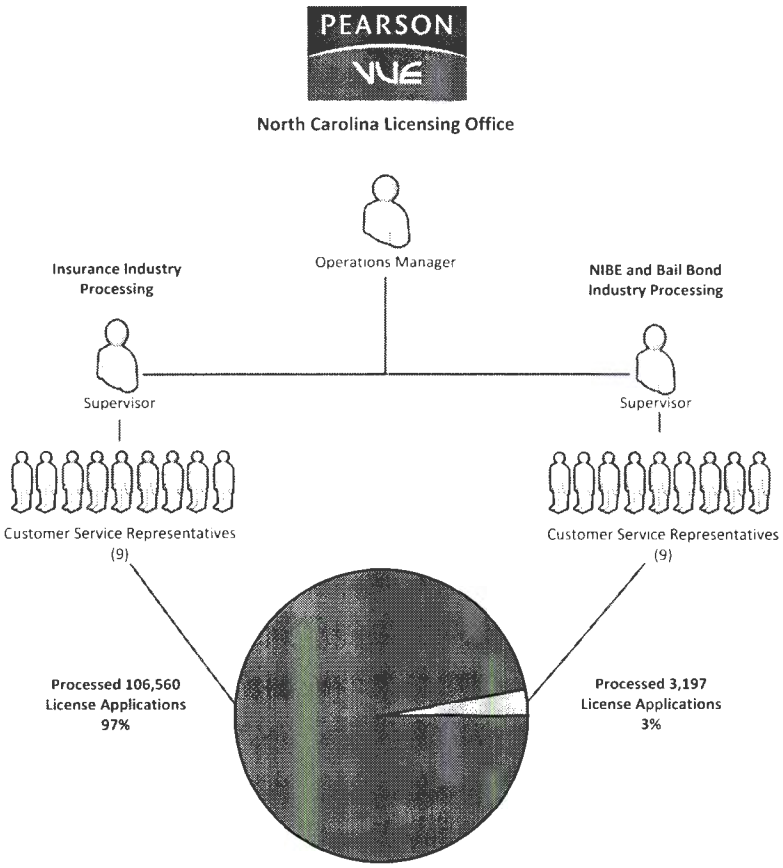
Over 50% of Pearson VUE's Operating Expenses for the 2012–14 Time Period Were Related to Collectively Processing Licenses for the Bail Bond Industry and Non-Insurance Business Entities



Note: The Program Evaluation Division requested that Pearson VUE provide actual operating cost information for processing licenses, but Pearson VUE did not provide operating expense information due to competitive concerns. Pearson VUE instead provided the percentage of operating expenses associated with processing licenses for the insurance industry, non-insurance business entities, and the bail bond industry.

Source: Program Evaluation Division based on 2012–2014 cost information from Pearson VUE.

Exhibit 7: Half of Pearson VUE's Customer Service Representatives Were Needed to Process 3% of License Applications During Fiscal Year 2013–14



Note: NIBE is the acronym for non-insurance business entity.

Source: Program Evaluation Division based on information from Pearson VUE.

Exhibit 8

Pearson VUE Can Process Several Initial Insurance License Applications in the Time Required to Process One Initial Surety Bail Bondsman or Collection Agency License Application

Source: Program Evaluation Division based on information from Pearson VUE.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S D

SENATE BILL 423
Health Care Committee Substitute Adopted 4/15/15
PROPOSED COMMITTEE SUBSTITUTE S423-CSTU-13 [v.5]
4/22/2015 6:59:49 PM

Short Title: Foster Care Family Act. (Public)

Sponsors:

Referred to:

March 26, 2015

A BILL TO BE ENTITLED

AN ACT TO ALIGN STATE LAW WITH FEDERAL LAW BY PROVIDING FOR THE SUPPORT OF HEALTHY DEVELOPMENT OF YOUTH IN FOSTER CARE THROUGH IMPLEMENTATION OF A REASONABLE AND PRUDENT PARENTING STANDARD FOR DECISIONS MADE BY A FOSTER PARENT OR A DESIGNATED OFFICIAL FOR A CHILD CARE INSTITUTION AND REVISING THE LAWS PERTAINING TO ABUSE, NEGLECT, AND DEPENDENCY REGARDING JUVENILE PLACEMENT UNDER THE JUVENILE CODE; TO PROVIDE LIABILITY INSURANCE FOR FOSTER PARENTS; TO REDUCE BARRIERS TO OBTAINING A DRIVERS LICENSE FOR FOSTER CHILDREN BY PROVIDING THAT MINORS AGED SIXTEEN AND OVER IN THE CUSTODY OF THE COUNTY DEPARTMENT OF SOCIAL SERVICES ARE COMPETENT TO CONTRACT FOR AUTOMOBILE INSURANCE, BY SPECIFYING PERSONS OTHER THAN THE FOSTER PARENT WHO MAY SIGN FOR A FOSTER CHILD TO OBTAIN A LEARNER'S PERMIT OR PROVISIONAL DRIVERS LICENSE, AND BY CLARIFYING THAT FOSTER PARENT'S DO NOT VIOLATE FINANCIAL RESPONSIBILITY REQUIREMENTS BY ALLOWING FOSTER CHILDREN WITH THEIR OWN INSURANCE COVERAGE TO OPERATE A VEHICLE OWNED BY THE FOSTER PARENT; AND TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY A MEDICAID WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE.

The General Assembly of North Carolina enacts:

PART I. SHORT TITLE

SECTION 1.1. This act shall be known and may be cited as the "Foster Care Family Act."

PART II. REASONABLE AND PRUDENT PARENTING STANDARD IN FOSTER CARE

SECTION 2.1. Part 1 of Article 1A of Chapter 131D of the General Statutes is amended by adding a new section to read:

"**§ 131D-10.2A. Reasonable and prudent parenting standard.**

(a) The reasonable and prudent parenting standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while encouraging the child's emotional and developmental growth.

(b) Every child care institution shall designate an on-site official who is authorized to apply the reasonable and prudent parenting standard pursuant to this section.

(c) A caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the county department of social services, must use the reasonable and prudent parenting standard when determining whether to allow a child in foster care to participate in extracurricular, enrichment, and social activities.

(d) A caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the county department of social services, or the Department of Health and Human Services with custody of or placement authority over a child in foster care shall not be held liable for an act or omission of the child if the caregiver or county department of social services is acting in accordance with the reasonable and prudent parenting standard under this section.

(e) Unless otherwise ordered by a court with jurisdiction pursuant to G.S. 7B-200, a caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, exercising the reasonable and prudent parenting standard has the authority to provide or withhold permission, without prior approval of the court or a county department of social services, allowing a child in foster care, in the custody of a county department of social services or under the placement authority of a county department of social services through a voluntary placement agreement, to participate in normal childhood activities. Normal childhood activities shall include, but are not limited to, extracurricular, enrichment, and social activities, and may include overnight activities outside the direct supervision of the caregiver for periods of over 24 hours and up to 72 hours.

(f) The caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the county department of social services, or the Department of Health and Human Services, shall not be liable for injuries to the child that occur as a result of the reasonable and prudent parenting standard. The burden of proof with respect to a breach of the reasonable and prudent parenting standard shall be by clear and convincing evidence.

(g) The caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the county department of social services or the Department of Health and Human Services, shall be liable for any action or inaction of gross negligence, willful and wanton conduct, or intentional wrongdoing that results in the injury to the child."

SECTION 2.2. G.S. 7B-505(b) reads as rewritten:

"(b) The court shall order the Department to make diligent efforts to notify relatives and any custodial parents of the juvenile's siblings that the juvenile is in nonsecure custody and of any hearings scheduled to occur pursuant to G.S. 7B-506, unless the court finds such notification would be contrary to the best interests of the juvenile. In placing a juvenile in nonsecure custody under this section, the court shall first consider whether a relative of the juvenile is willing and able to provide proper care and supervision of the juvenile in a safe home. If the court finds that the relative is willing and able to provide proper care and supervision in a safe home, then the court shall order placement of the juvenile with the relative unless the court finds that placement with the relative would be contrary to the best interests of the juvenile."

SECTION 2.3. G.S. 7B-800.1(a)(4) reads as rewritten:

"(a) Prior to the adjudicatory hearing, the court shall consider the following:

...

(4) Whether relatives or parents with custody of a sibling of the juvenile have been identified and notified as potential resources for placement or support."

SECTION 2.4. G.S. 7B-901 reads as rewritten:

"**§ 7B-901. Dispositional hearing.**

The dispositional hearing shall take place immediately following the adjudicatory hearing and shall be concluded within 30 days of the conclusion of the adjudicatory hearing. The dispositional hearing may be informal and the court may consider written reports or other evidence concerning the needs of the juvenile. The juvenile and the juvenile's parent, guardian, or custodian shall have the right to present evidence, and they may advise the court concerning the disposition they believe to be in the best interests of the juvenile. The court may consider any evidence, including hearsay evidence as defined in G.S. 8C-1, Rule 801, including testimony or evidence from any person who is not a party, that the court finds to be relevant, reliable, and necessary to determine the needs of the juvenile and the most appropriate disposition. The court may exclude the public from the hearing unless the juvenile moves that the hearing be open, which motion shall be granted.

At the dispositional hearing, the court shall inquire as to the identity and location of any missing parent and whether paternity is at issue. The court shall include findings of the efforts undertaken to locate the missing parent and to serve that parent and efforts undertaken to establish paternity when paternity is an issue. The order may provide for specific efforts in determining the identity and location of any missing parent and specific efforts in establishing paternity. The court shall also inquire about efforts made to identify and notify ~~relatives~~ relatives or parents with custody of a sibling of the juvenile, as potential resources for placement or support."

SECTION 2.5. Article 9 of Chapter 7B of the General Statutes is amended by adding the following new sections to read:

"**§ 7B-903.1. Juvenile placed in custody of a county department of social services.**

(a) To the extent authorized by federal law, a county department of social services with custody of a juvenile is authorized to make decisions about matters not addressed in this section that are generally made by a juvenile's custodian, including, but not limited to, educational decisions and consenting to the sharing of the juvenile's information. The county department of social services may delegate any part of this authority to the juvenile's parent, foster parent, or another individual.

(b) When a juvenile is in the custody or placement responsibility of a county department of social services, the placement provider may, in accordance with G.S. 131D-10.2A, provide or withhold permission, without prior approval of the court or county department of social services, allowing a juvenile to participate in normal childhood activities. If such authorization is not in the juvenile's best interest, the court shall set forth alternative parameters for approving normal childhood activities.

"**§ 7B-912. Juveniles 14 years of age and older; Another Planned Permanent Living Arrangement.**

(a) In addition to the permanency planning requirements under G.S. 7B-906.1, at every permanency planning hearing for a juvenile in the custody of a county department of social services who has attained the age of 14 years, the court shall inquire and make written findings regarding each of the following:

(1) The services provided to assist the juvenile in making a transition to adulthood.

(2) The steps the county department of social services is taking to ensure that the foster family or other licensed placement provider follows the reasonable and prudent parenting standard as provided in G.S. 131D-10.2A.

(3) Whether the juvenile has regular opportunities to engage in age- or developmentally appropriate activities.

(b) At or before the last scheduled permanency planning hearing, but at least 90 days before a juvenile attains 18 years of age, the court shall (i) inquire as to whether the juvenile

has a copy of the juvenile's birth certificate, Social Security card, health insurance information, drivers license or other identification card, and any educational or medical records the juvenile requests and (ii) determine the person or entity that should assist the juvenile in obtaining these documents before the juvenile attains the age of 18 years.

(c) If the court finds each of the following conditions applies, the court shall approve Another Planned Permanent Living Arrangement (APPLA) as the juvenile's primary permanent plan:

(1) The juvenile is 16 or 17 years old.

(2) The county department of social services has made diligent efforts to place the juvenile permanently with a parent or relative or in a guardianship or adoptive placement.

(3) Compelling reasons exist that it is not in the best interest of the juvenile to be placed permanently with a parent or relative or in a guardianship or adoptive placement.

(4) APPLA is the best permanency plan for the juvenile.

(d) If the court approves APPLA as the juvenile's permanent plan, the court shall, after questioning the juvenile, make written findings addressing the juvenile's desired permanency outcome."

PART III. LIABILITY INSURANCE FOR FOSTER PARENTS

SECTION 3.1. Article 36 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-36-44. Development of policy form or endorsement for personal liability insurance for foster parents.**

(a) The Rate Bureau shall develop an optional policy form or endorsement to be filed with the Commissioner for approval no later than May 1, 2016, that provides liability insurance for foster parents licensed under Article 1A of Chapter 131D of the General Statutes to provide foster care in a family foster home or therapeutic foster home. The policy form or endorsement shall provide coverage for acts or omissions of the foster parent while the parent is acting in his or her capacity as a foster parent in a licensed family foster home or therapeutic foster home licensed under Article 1A of Chapter 131D of the General Statutes.

(b) Nothing in this section is intended to require that the liability insurance policy or endorsement required by this section cover an act or omission that results from any action or inaction of gross negligence, willful and wanton conduct, or intentional wrongdoing that results in injury to the child."

PART IV. REDUCE DRIVING BARRIERS FOR FOSTER CHILDREN

SECTION 4.1. Article 1 of Chapter 48A of the General Statutes is amended by adding a new section to read:

"**§ 48A-4. Certain minors competent to contract.**

A minor who is 16 years of age or older and who is in the legal custody of the county department of social services, shall be qualified and competent to contract for the purchase of an automobile insurance policy with the consent of the court with continuing jurisdiction over the minor's placement under G.S. 7B-1000(b). The minor shall be responsible for paying the costs of the insurance premiums and shall be liable for damages caused by the minor's negligent operation of a motor vehicle. No State or local government agency, foster parent, or entity providing services to the minor under contract or at the direction of a State or local government agency shall be responsible for paying any insurance premiums or liable for damages of any kind as a result of the operation of a motor vehicle by the minor."

SECTION 4.2. G.S. 20-11(i) reads as rewritten:

"(i) Application. — An application for a permit or license authorized by this section must be signed by both the applicant and another person. That person must be:

(1) The applicant's parent or guardian;

(2) A person approved by the applicant's parent or guardian; or

(3) A person approved by the Division.

(4) With respect to minors in the legal custody of the county department of social services, any of the following:

a. A guardian ad litem or attorney advocate appointed to advocate for the minor.

b. The director or his or her designee or other type of caseworker assigned to work with the minor.

c. If no person listed in sub-subdivision a. or b. of this subdivision is available, the court with continuing jurisdiction over the minor's placement under G.S. 7B-1000(b)."

SECTION 4.3. G.S. 20-309 is amended by adding a new subsection to read:

"(a2) Notwithstanding any other provision of this Chapter, an owner's policy of liability insurance issued to a foster parent or parents, which policy includes an endorsement excluding coverage for one or more foster children residing in the foster parent's or parents' household, may be certified as proof of financial responsibility, provided that each foster child for whom coverage is excluded is insured in an amount equal to or greater than the minimum limits required by G.S. 20-279.21 under some other owner's policy of liability insurance or a named non-owner's policy of liability insurance. The North Carolina Rate Bureau shall establish, with the approval of the Commissioner of Insurance, a named driver exclusion endorsement or endorsements for foster children as described herein."

SECTION 4.4. G.S. 20-279.21(b) reads as rewritten:

"(b) Except as provided in G.S. 20-309(a2), such owner's policy of liability insurance:

..."

PART V. STUDY MEDICAID WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SED)

SECTION 5.1.(a) The Department of Health and Human Services, Division of Medical Assistance, shall design and draft, but not submit, a 1915(c) Medicaid waiver to serve children with Serious Emotional Disturbance (SED) in home and community-based settings. The Department may submit drafts of the waiver to the Centers for Medicare and Medicaid Services (CMS) to solicit feedback but shall not submit the waiver for CMS approval until authorized by the General Assembly.

SECTION 5.1.(b) The Department shall report the draft waiver, other findings, and any other options or recommendations to best serve children with SED to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2015. Specifically, the report shall provide an in-depth analysis of the cost per slot, including an analysis of the estimated number of waiver recipients who would be transitioned from a facility to a home and community-based setting and the estimated number of waiver recipients who would avoid placement in a facility.

PART VI. EFFECTIVE DATE

SECTION 6.1. Parts 2 and 4 of this act become effective October 1, 2015. The remainder of this act is effective when it becomes law.

SENATE BILL 423:
Foster Care Family Act

2015-2016 General Assembly

Committee:	Senate Insurance	**Date:**	April 23, 2015
Introduced by:	Sens. Barringer, Harrington, Tucker	**Prepared by:**	Kristen Harris
Analysis of:	PCS to Second Edition S423-CSTU-13		Committee Counsel

SUMMARY:

[As introduced, this bill was identical to H407, as introduced by Reps. Stevens, Glazier, which is currently in House Appropriations.]

The Proposed Committee Substitute for Senate Bill 423 would amend the law applying to foster care families through: 1) the implementation of a reasonable and prudent parent standard; 2) providing liability insurance for foster parents; 3) reducing barriers to obtaining a driver's license for foster children; and 4) requiring the Department of Health and Human Services (DHHS) to study a Medicaid waiver for children with serious emotional disturbance.

BILL ANALYSIS:

Section 2.1 would establish the reasonable and prudent parenting standard for foster care caregivers. A caregiver must apply the standard when determining if a child can participate in extracurricular, enrichment, or social activities. A caregiver has the authority to provide or withhold permission to participate in normal childhood activities, which includes sleepovers, without prior approval of the court or a county department of social services.

Under the new section, a caregiver would not be liable for 1) an act or omission of a foster child if the caregiver or county department of social services acted in accordance with the reasonable and prudent parenting standard or 2) for injuries to the child that occur as a result of reasonable and prudent parenting standard. The burden of proof for a breach of the reasonable and prudent parenting standard would be by clear and convincing evidence.

The caregiver would be liable for any action or inaction of gross negligence, willful and wanton conduct, or intentional wrongdoing that results in injury.

Section 2.2 would require DHHS to make diligent efforts to notify relatives and any custodial parents of the juvenile's siblings that the juvenile is in nonsecure custody and of nonsecure custody hearings.

Section 2.3 would require the court to consider, prior to the adjudicatory hearing, whether parents with custody of a sibling of the juvenile have been identified and notified as potential resources for placement and support.

Section 2.4 would require the court to inquire, at dispositional hearings, about efforts made to identify and notify parents with custody of a sibling of the juvenile as potential resources for placement or support.

Section 2.5 would first authorize a county department of social services (DSS) with custody of a juvenile to make decisions about matters generally made by a juvenile's custodian and to provide or withhold permission to allow a juvenile to participate in normal childhood activities.

Second, it would add requirements for every permanency planning hearing for a juvenile in the custody of DSS who has reached the age of 14, including that the court inquire and make written findings regarding the child's transition to adulthood and whether Another Planned Permanent Living Arrangement (APPLA) would be an appropriate plan for the juvenile.

Section 3.1 would require the Rate Bureau to develop an optional policy form or endorsement to be filed with the Commissioner of Insurance for approval no later than May 1, 2016 that provides liability insurance to licensed foster parents.

Section 4.1 would declare minors 16 years or older in the legal custody of DSS qualified and competent to contract for the purchase of an automobile insurance policy with the consent of the court. The minor would be responsible for paying for the insurance and be liable for damages caused by his or her negligent operation of a vehicle.

Section 4.2 would state who must sign an application for a learner's permit or provisional driver's license for a minor in the legal custody of the DSS.

Section 4.3 would allow a foster parent to meet the financial responsibility requirements for vehicle registration, even if a foster child residing in the household is excluded under the parent's policy, as long as the child is insured under some other policy of liability insurance or a named non-owner's liability policy. The Rate Bureau would establish, with the Commissioner's approval, a named driver exclusion endorsement for foster children.

Section 4.4 would make confirming changes to G.S. 20-279.21(b) ("Motor vehicle liability policy" defined) consistent with Section 4.3.

Section 5.1(a) would require the DHHS, Division of Medical Assistance to design and draft, but not submit, a 1915 (c) Medicaid waiver to serve children with Serious Emotional Disturbance (SED) in home and community-based settings.

Section 5.1(b) would require the DHHS to report the draft waiver, other findings, and any other options or recommendations to best serve children with SED to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2015.

EFFECTIVE DATE: Parts 2 and 4 of this act would become effective on October 1, 2015. The remainder of this act is effective when it becomes law.

Staff Attorney Tawanda Foster substantially contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S 2

SENATE BILL 423
Health Care Committee Substitute Adopted 4/15/15

Short Title: Foster Care Family Act. (Public)

Sponsors:

Referred to:

March 26, 2015

A BILL TO BE ENTITLED

AN ACT TO ALIGN STATE LAW WITH FEDERAL LAW BY PROVIDING FOR THE SUPPORT OF HEALTHY DEVELOPMENT OF YOUTH IN FOSTER CARE THROUGH IMPLEMENTATION OF A REASONABLE AND PRUDENT PARENT STANDARD FOR DECISIONS MADE BY A FOSTER PARENT OR A DESIGNATED OFFICIAL FOR A CHILD CARE INSTITUTION AND REVISING TO THE JUVENILE CODE UNDER THE LAWS PERTAINING TO ABUSE, NEGLECT, AND DEPENDENCY REGARDING JUVENILE PLACEMENT; TO PROVIDE LIABILITY INSURANCE FOR FOSTER PARENTS; TO REDUCE BARRIERS TO OBTAINING A DRIVERS LICENSE FOR FOSTER CHILDREN BY PROVIDING THAT MINORS AGED SIXTEEN AND OVER IN THE CUSTODY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ARE COMPETENT TO CONTRACT FOR AUTOMOBILE INSURANCE, BY SPECIFYING PERSONS OTHER THAN THE FOSTER PARENT WHO MAY SIGN FOR A FOSTER CHILD TO OBTAIN A LEARNER'S PERMIT OR PROVISIONAL DRIVERS LICENSE, AND BY CLARIFYING THAT FOSTER PARENTS DO NOT VIOLATE FINANCIAL RESPONSIBILITY REQUIREMENTS BY ALLOWING FOSTER CHILDREN WITH THEIR OWN INSURANCE COVERAGE TO OPERATE A VEHICLE OWNED BY THE FOSTER PARENT; AND TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY A MEDICAID WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE.

The General Assembly of North Carolina enacts:

PART I. SHORT TITLE

SECTION 1.1. This act shall be known and may be cited as the "Foster Care Family Act."

PART II. REASONABLE AND PRUDENT PARENTING STANDARD IN FOSTER CARE

SECTION 2.1. Part 1 of Article 1A of Chapter 131D of the General Statutes is amended by adding a new section to read:

"**§ 131D-10.2A. Reasonable and prudent parenting standard.**

(a) The reasonable and prudent parenting standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while encouraging the child's emotional and developmental growth.

(b) Every child care institution shall designate an on-site official who is authorized to apply the reasonable and prudent parenting standard pursuant to this section.

(c) A caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the Department of Health and Human Services must use the reasonable and prudent parenting standard when determining whether to allow a child in foster care to participate in extracurricular, enrichment, and social activities.

(d) A caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the county department of social services, or the Department of Health and Human Services with custody of or placement authority over a child in foster care shall not be held liable for an act or omission of the child if the caregiver or county department of social services is acting in accordance with the reasonable and prudent parenting standard under this section.

(e) Unless otherwise ordered by a court with jurisdiction pursuant to G.S. 7B-200, a caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, exercising the reasonable and prudent parenting standard has the authority to provide or withhold permission, without prior approval of the court or a county department of social services, allowing a child in foster care, in the custody of a county department of social services or under the placement authority of a county department of social services through a voluntary placement agreement, to participate in normal childhood activities. Normal childhood activities shall include, but are not limited to, extracurricular, enrichment, and social activities, and may include overnight activities outside the direct supervision of the caregiver for periods of over 24 hours and up to 72 hours.

(f) The caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the county department of social services, or the Department of Health and Human Services, shall not be liable for injuries to the child that occur as a result of the reasonable and prudent parenting standard. The caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the county department of social services or the Department of Health and Human Services, shall be liable for any action or inaction of gross negligence, willful and wanton conduct, or intentional wrongdoing that results in the injury to the child."

SECTION 2.2. G.S. 7B-505(b) reads as rewritten:

"(b) The court shall order the Department to make diligent efforts to notify relatives and any custodial parents of the juvenile's siblings that the juvenile is in nonsecure custody and of any hearings scheduled to occur pursuant to G.S. 7B-506, unless the court finds such notification would be contrary to the best interests of the juvenile. In placing a juvenile in nonsecure custody under this section, the court shall first consider whether a relative of the juvenile is willing and able to provide proper care and supervision of the juvenile in a safe home. If the court finds that the relative is willing and able to provide proper care and supervision in a safe home, then the court shall order placement of the juvenile with the relative unless the court finds that placement with the relative would be contrary to the best interests of the juvenile."

SECTION 2.3. G.S. 7B-800.1(a)(4) reads as rewritten:

"(a) Prior to the adjudicatory hearing, the court shall consider the following:

...

(4) Whether relatives or parents with custody of a sibling of the juvenile have been identified and notified as potential resources for placement or support."

SECTION 2.4. G.S. 7B-901 reads as rewritten:

"**§ 7B-901. Dispositional hearing.**

The dispositional hearing shall take place immediately following the adjudicatory hearing and shall be concluded within 30 days of the conclusion of the adjudicatory hearing. The dispositional hearing may be informal and the court may consider written reports or other evidence concerning the needs of the juvenile. The juvenile and the juvenile's parent, guardian, or custodian shall have the right to present evidence, and they may advise the court concerning the disposition they believe to be in the best interests of the juvenile. The court may consider any evidence, including hearsay evidence as defined in G.S. 8C-1, Rule 801, including testimony or evidence from any person who is not a party, that the court finds to be relevant, reliable, and necessary to determine the needs of the juvenile and the most appropriate disposition. The court may exclude the public from the hearing unless the juvenile moves that the hearing be open, which motion shall be granted.

At the dispositional hearing, the court shall inquire as to the identity and location of any missing parent and whether paternity is at issue. The court shall include findings of the efforts undertaken to locate the missing parent and to serve that parent and efforts undertaken to establish paternity when paternity is an issue. The order may provide for specific efforts in determining the identity and location of any missing parent and specific efforts in establishing paternity. The court shall also inquire about efforts made to identify and notify ~~relatives~~ relatives, including parents with custody of a sibling of the juvenile, as potential resources for placement or support."

SECTION 2.5. Article 9 of Chapter 7B of the General Statutes is amended by adding the following new sections to read:

"**§ 7B-903.1. Juvenile placed in custody of a county department of social services.**

(a) To the extent authorized by federal law, a county department of social services with custody of a juvenile is authorized to make decisions about matters not addressed in this section that are generally made by a juvenile's custodian, including, but not limited to, educational decisions and consenting to the sharing of the juvenile's information. The county department of social services may delegate any part of this authority to the juvenile's parent, foster parent, or another individual.

(b) When a juvenile is in the custody or placement responsibility of a county department of social services, the placement provider may, in accordance with G.S. 131D-10.2A, provide or withhold permission, without prior approval of the court or county department of social services, allowing a juvenile to participate in normal childhood activities. If such authorization is not in the juvenile's best interest, the court shall set forth alternative parameters for approving normal childhood activities.

"**§ 7B-912. Juveniles 14 years of age and older; Another Planned Permanent Living Arrangement.**

(a) In addition to the permanency planning requirements under G.S. 7B-906.1, at every permanency planning hearing for a juvenile in the custody of a county department of social services who has attained the age of 14 years, the court shall inquire and make written findings regarding each of the following:

(1) The services provided to assist the juvenile in making a transition to adulthood.

(2) The steps the county department of social services is taking to ensure that the foster family or other licensed placement provider follows the reasonable and prudent parenting standard as provided in G.S. 131D-10.2A.

(3) Whether the juvenile has regular opportunities to engage in age- or developmentally appropriate activities.

(b) At or before the last scheduled permanency planning hearing, but at least 90 days before a juvenile attains 18 years of age, the court shall (i) inquire as to whether the juvenile has a copy of the juvenile's birth certificate, Social Security card, health insurance information,

drivers license or other identification card, and any educational or medical records the juvenile requests and (ii) determine the person or entity that should assist the juvenile in obtaining these documents before the juvenile attains the age of 18 years.

(c) If the court finds each of the following conditions applies, the court shall approve Another Planned Permanent Living Arrangement (APPLA) as the juvenile's primary permanent plan:

(1) The juvenile is 16 or 17 years old.

(2) The county department of social services has made diligent efforts to place the juvenile permanently with a parent or relative or in a guardianship or adoptive placement.

(3) Compelling reasons exist that it is not in the best interest of the juvenile to be placed permanently with a parent or relative or in a guardianship or adoptive placement.

(4) APPLA is the best permanency plan for the juvenile.

(d) If the court approves APPLA as the juvenile's permanent plan, the court shall, after questioning the juvenile, make written findings addressing the juvenile's desired permanency outcome."

PART III. LIABILITY INSURANCE FOR FOSTER PARENTS

SECTION 3.1. Article 36 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-36-43. Development of policy form or endorsement for personal liability insurance for foster parents.**

(a) The Rate Bureau shall develop an optional policy form or endorsement to be filed with the Commissioner for approval no later than May 1, 2016, that provides liability insurance for foster parents licensed under Article 1A of Chapter 131D of the General Statutes to provide foster care in a family foster home or therapeutic foster home. The policy form or endorsement shall provide coverage for acts or omissions of the foster parent while the parent is acting in his or her capacity as a foster parent in a licensed family foster home or therapeutic foster home licensed under Article 1A of Chapter 131D of the General Statutes.

(b) Nothing in this section is intended to require that the liability insurance policy or endorsement required by this section cover an act or omission that results from any action or inaction of gross negligence, willful and wanton conduct, or intentional wrongdoing that results in injury to the child."

PART IV. REDUCE DRIVING BARRIERS FOR FOSTER CHILDREN

SECTION 4.1. Article 1 of Chapter 48A of the General Statutes is amended by adding a new section to read:

"**§ 48A-4. Certain minors competent to contract.**

A minor who is 16 years of age or older and who is in the legal custody of the Department of Health and Human Services, Division of Social Services, shall be qualified and competent to contract for the purchase of an automobile insurance policy with the consent of the court with continuing jurisdiction over the minor's placement under G.S. 7B-1000(b). The minor shall be responsible for paying the costs of the insurance premiums and shall be liable for damages caused by the minor's negligent operation of a motor vehicle. No State or local government agency, foster parent, or entity providing services to the minor under contract or at the direction of a State or local government agency shall be responsible for paying any insurance premiums or liable for damages of any kind as a result of the operation of a motor vehicle by the minor."

SECTION 4.2. G.S. 20-11(i) reads as rewritten:

"(i) Application. — An application for a permit or license authorized by this section must be signed by both the applicant and another person. That person must be:

(1) The applicant's parent or guardian;
(2) A person approved by the applicant's parent or guardian; or
(3) A person approved by the Division.
(4) With respect to minors in the legal custody of the Department of Health and Human Services, Division of Social Services, any of the following:
a. A guardian ad litem or attorney advocate appointed to advocate for the minor.
b. A case manager or other type of caseworker assigned to work with the minor.
c. If no person listed in sub-subdivision a. or b. of this subdivision is available, the court with continuing jurisdiction over the minor's placement under G.S. 7B-1000(b)."

SECTION 4.3. G.S. 20-309 is amended by adding a new subsection to read:

"(a2) The owner of a motor vehicle who is a foster parent providing foster care to a person between the ages of 16 and 21 shall not violate the requirements of this Article by allowing the motor vehicle to be operated by the person if the person is covered by a non-owner motor vehicle insurance policy issued by the North Carolina Reinsurance Facility as authorized by G.S. 58-37-35(g)(13). Nothing in this section is intended to prevent a foster parent from including a foster child on the parent's own motor vehicle insurance policy."

PART V. STUDY MEDICAID WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SED)

SECTION 5.1.(a) The Department of Health and Human Services, Division of Medical Assistance, shall design and draft, but not submit, a 1915(c) Medicaid waiver to serve children with Serious Emotional Disturbance (SED) in home and community-based settings. The Department may submit drafts of the waiver to the Centers for Medicare and Medicaid Services (CMS) to solicit feedback but shall not submit the waiver for CMS approval until authorized by the General Assembly.

SECTION 5.1.(b) The Department shall report the draft waiver, other findings, and any other options or recommendations to best serve children with SED to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2015. Specifically, the report shall provide an in-depth analysis of the cost per slot, including an analysis of the estimated number of waiver recipients who would be transitioned from a facility to a home and community-based setting and the estimated number of waiver recipients who would avoid placement in a facility.

PART VI. EFFECTIVE DATE

SECTION 6.1. Parts 2 and 4 of this act become effective October 1, 2015. The remainder of this act is effective when it becomes law.

SENATE BILL 665:
Unclaimed Life Insurance Benefits

2015-2016 General Assembly

Committee:	Senate Insurance	**Date:**	April 23, 2015
Introduced by:	Sen. Apodaca	**Prepared by:**	Kristen Harris
Analysis of:	First Edition		Committee Counsel

SUMMARY: Senate Bill 665 would create the North Carolina Unclaimed Life Insurance Benefits Act which would require insurers, unless it would result in hardship, to inquire on a semi-annual basis if benefits were due under their in-force policies.

CURRENT LAW AND BACKGROUND: The North Carolina Unclaimed Property Act is found in Article 4 of Chapter 116B of the General Statutes. An amount due and payable under a life insurance policy is considered property under the Act. The Act addresses when property is presumed abandoned, rules for taking custody, and notification and reporting requirements. All property escheated or abandoned under the provisions of Chapter 116B shall be paid into the Escheat Fund which is administered by the State Treasurer.

The North Carolina Department of Insurance has a "Lost life Insurance and Annuity Inquiry Service" to help consumers locate benefits from life insurance policies or annuity contracts purchased in the State. According to the Department's website, possible beneficiaries, as well as executors and legal representatives, may submit an inquiry form that will be forwarded to North Carolina-licensed life insurance companies which will then contact the individual if a policy is located.[1]

BILL ANALYSIS:

Section 1 would provide that nothing in the act would amend, modify, or supersede the North Carolina Unclaimed Property Act. An insurer of life insurance policies would be required to compare semi-annually its policies with the death master file (DMF) from the U.S. Social Security Administration to determine potential matches. If the insurer learned of a possible death, the insurer would be required within 90 days to complete a good-faith effort to confirm the death and determine what benefits may be due and to locate and instruct the beneficiaries on how to submit a claim. An insurer would not be allowed to charge a beneficiary for any fees or costs associated with a DMF search or match. If beneficiaries could not be found, the benefits would escheat to the State as unclaimed property. The Commissioner of Insurance would be able to exempt an insurer from DMF comparison requirements if the insurer demonstrated, to the Commissioner's satisfaction, that compliance would result in hardship to the insurer. A pattern of failures to meet the requirements of the act may constitute an unfair claims settlement practice under Chapter 58.

Section 2 would authorize the Commissioner to adopt rules to implement the act.

EFFECTIVE DATE: Section 2 of this act is effective when it becomes law. The remainder of this act becomes effective July 1, 2015.

[1] http://www.ncdoi.com/consumer/Consumer_Life_Lost_Policy.aspx

SENATE BILL 665

Short Title:	Unclaimed Life Insurance Benefits.	(Public)
Sponsors:	Senator Apodaca (Primary Sponsor).	
Referred to:	Insurance.	

March 30, 2015

A BILL TO BE ENTITLED

AN ACT TO ENACT THE NORTH CAROLINA UNCLAIMED LIFE INSURANCE BENEFITS ACT.

The General Assembly of North Carolina enacts:

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

"Part 7. Unclaimed Life Insurance Benefits.

"**§ 58-58-360. Purpose.**

(a) This part shall be known as the "Unclaimed Life Insurance Benefits Act".

"**§ 58-58-370. No preemption of Unclaimed Property Act.**

Nothing in this part shall be construed to amend, modify, or supersede the North Carolina Unclaimed Property Act, Article 4 of Chapter 116B of the General Statutes.

"**§ 58-58-380. Definitions.**

The following definitions apply in this part:

(1) Account owner. – The owner of a retained asset account opened by a resident of this State.

(2) Annuity. – Any active annuity contract issued in this State, other than an annuity used to fund an employment-based retirement plan or program where the insurer is not committed by terms of the annuity contract to pay death benefits to the beneficiaries of specific plan participants or that is used to fund a preneed funeral contract as defined in G.S. 90-210.60.

(3) Asymmetric conduct. – An insurer's use of the DMF prior to July 1, 2015, to provide information regarding deceased annuitants under the insurer's annuity contracts, but not to provide information regarding deceased insureds under the insurer's insurance contracts.

(4) Beneficiary. – An individual or other entity entitled to benefits under a policy or annuity.

(5) Death master file or DMF. – The death master file from the United States social security administration or any other database or service that an insurer may determine is substantially as inclusive as the death master file for determining that a person has reportedly died.

(6) Death master file match or DMF match. – A search of a DMF that results in a match of a person's social security number or name and date of birth.

(7) Insurer. – Any insurance company authorized to transact life insurance business in this State.

(8) Person. – The policy insured, annuity owner, annuitant, or account owner, as applicable under the policy, annuity, or retained asset account subject to this part.

(9) Policy. – any policy or certificate of life insurance issued in this State, but does not include any policy or certificate of life insurance that provides a death benefit under any of the following:

a. An employee benefit plan subject to the Employee Retirement Income Security Act of 1974, as periodically amended, compiled at 29 U.S.C. § 1002 et seq.

b. Any federal employee benefit program.

c. Government plans or church plans as defined in the Employee Retirement Income Security Act of 1974, as periodically amended, 29 U.S.C. § 1002 et seq.

d. A policy or certificate of life insurance that is used to fund a preneed funeral contract as defined in G.S. 90-210.60.

e. A policy or certificate of credit, life, or accident and health insurance.

f. A policy of industrial life insurance as defined in G.S. 58-58.5.

(10) Record keeping services. – Those circumstances under which the insurer has agreed with a group life insurance policyholder to be responsible for obtaining, maintaining, and administering in its own systems information about each individual insured under the policyholder's group life insurance contract that includes at least the following items:

a. Individual insured's social security number or name and date of birth;

b. Beneficiary designation information;

c. Coverage eligibility;

d. Benefit amount; and

e. Premium payment status.

"**§ 58-58-390. Requirements for insurers.**

(a) To the extent that an insurer's records of its in-force policies, annuities, and account owners are available electronically, an insurer shall perform a comparison of such in-force policies, annuities, and account owners against a death master file, on a semi-annual basis, to identify potential death master file matches. To the extent that an insurer's records of its in-force policies, annuities, and account owners are not available electronically, an insurer shall perform a comparison of such in-force policies, annuities, and account owners against a death master file, on a semi-annual basis, to identify potential death master file matches, using the records most easily accessible by the insurer.

(1) This section shall not apply to policies or annuities for which the insurer has received premiums from outside the policy value, by check, bank draft, payroll deduction, or any other similar method of active premium payment, within the 18 months immediately preceding the death master file comparison.

(2) An insurer may comply with the requirements of this section by using the full death master file once and thereafter using the death master file update files for future comparisons.

(3) An insurer that has not engaged in asymmetric conduct prior to July 1, 2015, shall not be required to comply with the requirements of this section with respect to any policies, annuities, or retained asset accounts issued or delivered prior to July 1, 2015. An insurer exempted under this subdivision shall comply with the requirements of this section for all policies, annuities, or retained asset accounts issued after July 1, 2015.

(4) The comparison required by this section shall not be applicable to group life insurance policies for which the insurer does not perform record keeping services.

(b) If an insurer learns of the possible death of a person, through a DMF match or otherwise, then the insurer shall within 90 days complete a good-faith effort, which shall be documented by the insurer, do all of the following:

(1) Confirm the death of such person against other available records and information.

(2) Review its records to determine whether such deceased person had purchased any other products with the insurer.

(3) Determine whether benefits may be due in accordance with any applicable policy, annuity, or retained asset account.

(4) Locate the beneficiary or beneficiaries.

(5) Provide the appropriate claims forms or instructions to the beneficiary to make a claim and notify the beneficiary of the actions necessary to submit a valid claim.

(c) Except as prohibited by law, an insurer may disclose only the minimum necessary identifying personal information about such an insured, annuitant, account owner or beneficiary to a person who the insurer reasonably believes may be able to assist the insurer in locating the beneficiary or a person otherwise entitled to payment of the claims proceeds.

(d) In the event an insurer is unable to confirm the death of a person following a DMF match, an insurer may determine that no further good-faith efforts, as described in subsection (b) of this section, are required of it with respect to such policy, annuity, or retained asset account.

(e) An insurer or its service provider shall not charge any beneficiary or other person who may be entitled to benefits any fees or costs associated with a DMF search or the verification of a DMF match conducted pursuant to this section.

(f) The benefits from life insurance policies, annuities, or retained asset accounts, any applicable accrued contractual interest, and interest payable under G.S. 58-58-110 shall first be payable to the beneficiaries or account owners as provided for in such policies, annuities, or retained asset accounts. In the event the beneficiaries or account owners cannot be found, the benefits and any associated interest shall escheat to the State as unclaimed property as set forth in Article 4 of Chapter 116B of the General Statutes.

(g) The Commissioner may exempt an insurer from the DMF comparisons required under subsection (a) of this section if the insurer demonstrates to the Commissioner's satisfaction that compliance would result in hardship to the insurer.

(h) Nothing in this section limits an insurer from requiring a valid death certificate as part of any claims validation process or otherwise requiring compliance with the terms and conditions of the policy or annuity relative to filing and payment of claims.

"**§ 58-58-400. Noncompliance may constitute unfair claims settlement practice.**

A pattern of failures to meet the requirements of this part may constitute an unfair claims settlement practice under G.S. 58-3-100(a)(5) and G.S. 58-63-15. Nothing in this part shall be construed to create or imply a private cause of action for a violation of this part."

SECTION 2. The Commissioner of Insurance is authorized to promulgate rules under Article 2A of Chapter 150B of the General Statutes to implement this act, provided such rules shall not impose any duty or requirements not stated in this act.

SECTION 3. Section 2 of this act is effective when it becomes law. The remainder of this act becomes effective July 1, 2015.

SENATE BILL 667:
Principle-Based Reserving

2015-2016 General Assembly

Committee:	Senate Insurance	**Date:**	April 23, 2015
Introduced by:	Sen. Apodaca	**Prepared by:**	Kristen Harris
Analysis of:	First Edition		Committee Counsel

SUMMARY: Senate Bill 667 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 was identical to H361, as introduced by Reps. Collins, Tine, Setzer, which is currently in House 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.

[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.

SENATE BILL 667*

Short Title:	Principle-Based Reserving.	(Public)
Sponsors:	Senator Apodaca (Primary Sponsor).	
Referred to:	Rules and Operations of the Senate.	

March 30, 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.

~~(d1)~~(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), ~~(d1),~~(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

date of the valuation manual. 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.

(m) The valuation manual shall apply as described in this subsection.

(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.

(2) The operative date of the valuation manual is specified in G.S. 58-58-51(b).

(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:

a. At least three-fourths of the members of the NAIC voting, but not less than a majority of the total membership.

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.

(4) The valuation manual must specify all of the following:

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:

1. The Commissioner's reserve valuation method for life insurance contracts subject to subsections (b2) and (b3) of this section.

2. The Commissioner's annuity reserve valuation method for annuity contracts subject to subsections (b2) and (b3) of this section.

3. Minimum reserves for all other policies or contracts subject to subsections (b2) and (b3) of this section.

b. The policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation as

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.

SENATE BILL 667: Principle-Based Reserving

2015-2016 General Assembly

Committee:	Senate Insurance	**Date:**	April 23, 2015
Introduced by:	Sen. Apodaca	**Prepared by:**	Kristen Harris
Analysis of:	First Edition		Committee Counsel

SUMMARY: ***Senate Bill 667 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 was identical to H361, as introduced by Reps. Collins, Tine, Setzer, which is currently in House 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.

[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.

SENATE BILL 667*

Short Title:	Principle-Based Reserving.	(Public)
Sponsors:	Senator Apodaca (Primary Sponsor).	
Referred to:	Rules and Operations of the Senate.	

March 30, 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 ~~(e)~~(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

date of the valuation manual. 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.

(m) The valuation manual shall apply as described in this subsection.

(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.

(2) The operative date of the valuation manual is specified in G.S. 58-58-51(b).

(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:

a. At least three-fourths of the members of the NAIC voting, but not less than a majority of the total membership.

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.

(4) The valuation manual must specify all of the following:

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:

1. The Commissioner's reserve valuation method for life insurance contracts subject to subsections (b2) and (b3) of this section.

2. The Commissioner's annuity reserve valuation method for annuity contracts subject to subsections (b2) and (b3) of this section.

3. Minimum reserves for all other policies or contracts subject to subsections (b2) and (b3) of this section.

b. The policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation as

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.

SENATE BILL 668:
Auto Insurance/Allow Optional Enhancements

2015-2016 General Assembly

Committee:	Senate Insurance	**Date:**	April 22, 2015
Introduced by:	Sen. Apodaca	**Prepared by:**	Tim Hovis
Analysis of:	First Edition		Committee Counsel

SUMMARY: Senate Bill 668 would allow automobile and homeowners' insurers to file individually with the Commissioner for approval optional enhancements to their policies. The enhancements could then be offered as an endorsement to the policy. Any additional premium resulting from the enhancement must be included with the proposed enhancement filed with the Commissioner.

Optional enhancements would be outside the jurisdiction of the Rate Bureau.

CURRENT LAW: Article 36 of Chapter 58 requires the N.C. Rate Bureau to file jointly with the Commissioner for approval the rates, rating plans, and policy forms for nonfleet private passenger motor vehicle and homeowners' insurers. Optional endorsements filed by individual companies are not authorized under current law.

BILL ANALYSIS: Senate Bill 668 would create a new section allowing automobile and homeowners' insurers to file individually with the Commissioner for approval optional enhancements to their policies. These enhancements could then be offered as an endorsement to the 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.

The bill 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.

EFFECTIVE DATE: Senate Bill 668 would become effective July 1, 2015.

O. Walker Reagan
Director

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Research Division
(919) 733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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SENATE BILL 668

Short Title:	Auto Insurance/Allow Optional Enhancements.	(Public)
Sponsors:	Senator Apodaca (Primary Sponsor).	
Referred to:	Insurance.	

March 30, 2015

A BILL TO BE ENTITLED

AN ACT TO ALLOW INSURANCE COMPANIES WRITING PRIVATE AUTOMOBILE INSURANCE IN NORTH CAROLINA TO OFFER OPTIONAL PROGRAM ENHANCEMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. 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."

SECTION 2. This act becomes effective July 1, 2015, and applies to optional enhancements filed and approved on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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SENATE BILL 676
PROPOSED COMMITTEE SUBSTITUTE S676-CSTK-34 [v.1]

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.

SENATE BILL 676:
Autism Health Insurance Coverage

2015-2016 General Assembly

Committee:	Senate Re-ref to Insurance. If fav, re-ref to Health Care	**Date:**	April 22, 2015
Introduced by:	Sens. Apodaca, Krawiec	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	PCS to First Edition S676-CSTK-34		

SUMMARY: The PCS to Senate bill 676 exempts the diagnosis of autism spectrum disorder from the North Carolina mental illness benefit coverage statutes and creates a new G.S. 58-3-192 that addresses health benefit plan coverage for the diagnosis of autism spectrum disorder specifically.

BILL ANALYSIS:

Section 2 of the PCS to 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 of 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 PCS would require certain health benefits 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 increase appropriate or adaptive behaviors, decrease maladaptive behaviors, 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.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

SENATE BILL 676

Short Title:	Autism Health Insurance Coverage.	(Public)
Sponsors:	Senators Apodaca, Krawiec (Primary Sponsors); Brock, Ford, Hise, B. Jackson, Lee, Lowe, Pate, Tarte, Van Duyn, and Woodard.	
Referred to:	Insurance.	

March 30, 2015

A BILL TO BE ENTITLED

AN ACT TO PROVIDE COVERAGE FOR THE TREATMENT OF AUTISM SPECTRUM DISORDERS.

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-V, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the ~~DSM-IV~~ DSM-V or subsequent edition as autism spectrum disorders (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-V, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the ~~DSM-IV~~ DSM-V or subsequent edition as autism spectrum disorders (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-V, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the ~~DSM-IV~~ DSM-V or subsequent editions as autism spectrum disorders (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 disorders.**

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

(1) Adaptive behavior treatment. – The systematic management of 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 subjection designs. Both of the following requirements must be met to meet the definition of behavioral and developmental interventions:

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 provided are 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.

(2) Autism spectrum disorder. – 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 (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, or licensed professional counselor.

(9) Treatment for autism spectrum disorders. – 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 (d), health benefit plans shall provide coverage for the screening, diagnosis, and treatment of autism spectrum disorder for individuals 18 years of age or younger. 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 under this section may not be subject to any limits on the number of visits an individual may have for treatment of autism spectrum disorder.

(d) Coverage for adaptive behavior treatments under this section may be subject to a maximum benefit of up to forty thousand dollars ($40,000) per year.

(e) Coverage under this section may not be denied on the basis that the treatments are habilitative or educational in nature.

(f) 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.

(g) This section shall not be construed as limiting benefits that are otherwise available to an individual under a health benefit plan.

(h) 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).

(i) 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.

(j) Except as provided in subsection (d), 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-V, or a subsequent edition published by the

American Psychiatric Association, except those mental disorders coded in the ~~DSM-IV~~ DSM-V or subsequent editions as autism spectrum disorders (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-V, 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-V, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the ~~DSM-IV~~ DSM-V or subsequent editions as autism spectrum disorders (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-V 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-V, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the ~~DSM-IV~~ DSM-V or subsequent editions as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as autism spectrum disorders (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-V, or subsequent editions published by the American Psychiatric Association."

SECTION 6. This act becomes effective October 1, 2015, and applies to insurance contracts issued, renewed, or amended on or after that date.

SENATE PAGES ATTENDING

COMMITTEE: Insurance ROOM: 1027

DATE: 4-23 TIME: 9:15

PLEASE PRINT LEGIBILY!!!!!!!!!!!!!....*or else!*

Page Name	Hometown	Sponsoring Senator
1. Esmé Merritt-Dorosin	Carrboro	Foushee
2. Alec Johnson	Canton	Van Duyn
3. Olivia Robertson	Swansboro	Brown
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Do not add names below the grid.

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

VISITOR REGISTRATION SHEET

SENATE INSURANCE — April 23, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DEBBIE LOWN

NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Mahan	ASNC
LC Rengan	CBS
RAY EVANS	NCRB
Mike Strickland	NCRB-Council
Fred Fuller	NCDOI
Bob MACK	NCDOI
John Palumbo	NCAHIP
Robert Pasichal	Young Moore
Sarah Wolfe	MWC
Mandy Ableidinger	Benchmarks NC
Kay Castillo	NASW-NC

VISITOR REGISTRATION SHEET

SENATE INSURANCE — April 23, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DEBBIE LOWN

NAME	FIRM OR AGENCY AND ADDRESS
John McMillan	AFLS
Brenda Williams	DST
Kelly Chambers	AG's Office for DST
Stgrnes	Treasurer
Polari	DST
Maths	DST
[illegible]	NMRS
[illegible]	Smith Anderson
Michael Arnold	SOS
[illegible]	mwc
Sam Blanton	Rep. Chuck McGrady

VISITOR REGISTRATION SHEET

SENATE INSURANCE — April 23, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DEBBIE LOWN

NAME	FIRM OR AGENCY AND ADDRESS
Kevin Kelley	DHHS - DSS
Angie Stephenson	NC DOJ for NC DSS
Donna B Clarke	UNC Dept Grad.
Tim Lucas	NC Rate Bureau
Michelle Frazier	MFTS
John Hardin	MFTS
Robin Huffman	NC Psychiatric Assn
Sally Cameron	NC Psychological Assoc
[illegible]	[illegible]
Chris Ewan	BIDSNC
Julia Adams-Schmidt	ASNC

VISITOR REGISTRATION SHEET

SENATE INSURANCE — April 23, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DEBBIE LOWN

NAME	FIRM OR AGENCY AND ADDRESS
Stephen Kouba	CCS
[illegible]	R. [illegible] Insurance.
Jonathan Babbaker	Babbaker + Assoc
Angel Sams	WCSR
Jimmy Broughton	Gov. Office
Flint Benson	SEANC
Dana Sipe	SA
Annalise Dolph	DL
Cory Dunn	DRNC

VISITOR REGISTRATION SHEET

SENATE INSURANCE — April 23, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DEBBIE LOWN

NAME	FIRM OR AGENCY AND ADDRESS
J Rodc	BAH
[illegible]	NCGA
Ben Popkin	DOI
Jean Holliday	NCDOI
Tracy Kimbrell	Parker Poe

VISITOR REGISTRATION SHEET

SENATE INSURANCE — April 23, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DEBBIE LOWN

NAME	FIRM OR AGENCY AND ADDRESS
Sonny Watts	AT LARGE
Kara Weishaar	JA
Allison Stewart	Cardinal Innovations
Steven Veres	NCHBA
Mike Carpenter	NCHBA
Jake Cash	NCCI
David Stallen	Stone Farm.
Adam Shular	DHHS
Trent Womble	DHHS
Jake Parker	NCFB
CS Hollis	CSH

Senate Committee on Insurance
Wednesday, June 3, 2015 at 10:15 AM
Room 1027/1128 of the Legislative Building

MINUTES

The Senate Committee on Insurance met at 10:15 AM on June 3, 2015 in Room 1027/1128 of the Legislative Building. Eight members were present.

Select Vice Chair Sen. Norman Sanderson, presided.

Tafari Bailery from Raleigh, Hanna Lunsford from Leasburg, Claire Lewis from Reidsville, India Tisdale from Reidsville, Emily Cheston from Rocky Mount, Robin Braswell from Clayton, Charles Van Dyke from Raleigh and Daniel Kunath from Apex served as pages.

HB 288 Insurance Technical Changes.-AB (Representatives Setzer, Bumgardner)
Sen. Sanderson removed this bill from today's calendar.

Sen. Sanderson chose to take the bills out of order. The order in which they were heard is reflected below.

HB 163 Captive Insurance Amendments. (Representatives L. Johnson, Collins, Tine)
Rep. Tine was introduced to speak on the bill. He asked that M. Benjamin Popkin, JD, MPH/Director of Government Affairs for the North Carolina Department of Insurance to assist with the responses from the members. Rep. Tine also responded to member questions. R. Lane Brown III/vice President of Government Affairs for the NC Captive Insurance Association was asked by the committee to speak. Sen. Ford moved for a favorable report and it carried. Sen. Jim Davis was asked to manage the bill when heard in session.

HB 16 Repeal Outdated Reports.-AB (Representative Pendleton)
Representative Tine was introduced to speak on the bill. Sen. Sanderson sponsored an amendment and brought it before the committee. Sen. McKissick moved to allow the amendment to be brought before the members and it carried. He requested that M. Benjamin Popkin, JD, MPH/Director of Government Affairs for the North Carolina Department of Insurance, explain the amendment and the bill. Mr. Popkin responded to questions from the members. Sen. Ford moved unfavorable to the committee substitute bill no. 1 bill – favorable to the bill as amended to Senate Committee substitute bill and it carried. Sen. Apodaca was asked to manage the bill when heard in session.

HB 190 State Health Plan Modifications.-AB (Representative Pendleton)
Rep. Pendleton was introduced to speak on the bill. Questions from the members were responded to by Lotta Crabtree/Deputy Executive Administrator and Legal Counsel for the State Health Plan and Anthony Solari/Director of Government Relations for the North Carolina

Department of the State Treasurer. Sen. Ford moved for a favorable report and it carried. Sen. Sanderson was asked to manage the bill when heard in session.

HB 262 Surplus Lines Amendments. (Representatives Pendleton, Tine, Setzer)
Rep. Tine was asked to speak on the bill. Sen. Ford moved for a favorable report and it carried. Sen. Jim Davis was asked to manage the bill when heard in session.

The meeting adjourned at 10:40 AM.

Norman Sanderson

Senator Norman Sanderson Vice Chair Presiding

Debbie Lown, Committee Clerk

Senate Committee on Insurance
Wednesday, June 3, 2015, 10:15 AM
1027/1128 Legislative Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 288	Insurance Technical Changes.-AB	Representative Setzer Representative Bumgardner
HB 16	Repeal Outdated Reports.-AB	Representative Pendleton
HB 163	Captive Insurance Amendments.	Representative L. Johnson Representative Collins Representative Tine
HB 262	Surplus Lines Amendments.	Representative Pendleton Representative Tine Representative Setzer
HB 190	State Health Plan Modifications.-AB	Representative Pendleton

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Apodaca, Co-Chair
Senator Meredith, Co-Chair

Wednesday, June 03, 2015

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

FAVORABLE

HB **163** **(CS#1)** Captive Insurance Amendments.

Draft Number:	None
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

HB **190** **(CS#1)** State Health Plan Modifications.-AB

Draft Number:	None
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

HB **262** **(CS#1)** Surplus Lines Amendments.

Draft Number:	None
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 3

Senator James Davis will handle HB 163
Senator Norman Sanderson will handle HB 190
Senator James Davis will handle HB 262

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Apodaca, Co-Chair
Senator Meredith, Co-Chair

Wednesday, June 03, 2015

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

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

HB **16** **(CS#1)** Repeal Outdated Reports.-AB

Draft Number:	H16-PCS10390-TU-20
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Tom Apodaca will handle HB 16

HOUSE BILL 16:
Repeal Outdated Reports.-AB

2015-2016 General Assembly

Committee:	Senate Insurance	**Date:**	June 3, 2015
Introduced by:	Rep. Pendleton	**Prepared by:**	Tim Hovis
Analysis of:	Second Edition		Kristen Harris
			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. 58-36-3(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 4 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 5 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.

HOUSE BILL 16
Committee Substitute Favorable 3/24/15

Short Title: Repeal Outdated Reports.-AB (Public)

Sponsors:

Referred to:

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. 58-36-3(c) is repealed.

SECTION 4. G.S. 58-40-130(e) is repealed.

SECTION 5. G.S. 58-50-95 is repealed.

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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 16

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

H16-ATU-17 [v.3]

Amends Title [NO]
Second Edition

Date _____,2015

Senator _____

moves to amend the bill on page 1, line 15, by rewriting the line to read:

"**SECTION 6.** G.S. 58-3-191(a) and (b1) are repealed.
SECTION 7. G.S. 58-67-140(a)(7) is repealed.
SECTION 8. This act is effective when it becomes law.".

SIGNED Norman Sanderson
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 163:
Captive Insurance Amendments

2015-2016 General Assembly

Committee:	Senate Insurance	**Date:**	June 3, 2015
Introduced by:	Reps. L. Johnson, Collins, Tine	**Prepared by:**	Tim Hovis
Analysis of:	Second Edition		Kristen Harris
			Committee Counsel

SUMMARY: 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.

HOUSE BILL 163
Committee Substitute Favorable 4/15/15

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~~

~~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.

...

~~(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.~~

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

...

(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 ~~insolvent~~impaired, 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,~~ Commissioner 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~~ minimize the likelihood that 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~~ minimize the likelihood that the investments are not 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~~ ascertain 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.

...

"§ 58-10-655. Commissioner to share information with Department of Revenue.

Notwithstanding any other provisions of Chapter 58 of the General Statutes, 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."

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.

HOUSE BILL 262:
Surplus Lines Amendments

2015-2016 General Assembly

Committee:	Senate Insurance	**Date:**	June 2, 2015
Introduced by:	Reps. Pendleton, Tine, Setzer	**Prepared by:**	Tim Hovis
Analysis of:	Second Edition		Committee Counsel

SUMMARY: 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: House Bill 262 is effective when it becomes law.

O. Walker Reagan
Director

H262-SMRG-16 E2 -V1

Research Division
(919) 733-2578

HOUSE BILL 262
Committee Substitute Favorable 4/22/15

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 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. 58-21-35(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 or the stamping office, as appropriate, 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:~~to carry out the following functions:

(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;~~insurance.

(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 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.~~"

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.

HOUSE BILL 190:
State Health Plan Modifications.-AB

2015-2016 General Assembly

Committee:	Senate Insurance	**Date:**	June 2, 2015
Introduced by:	Rep. Pendleton	**Prepared by:**	Tim Hovis
Analysis of:	Second Edition		Kristen Harris
			Committee Counsel

SUMMARY: House Bill 190 makes a number of modifications to the State Health Plan.

BILL ANALYSIS:

Section 1 of House Bill 190 amends G.S. 135-48.42(e) pertaining to enrollment to allow retirees and surviving spouses to dis-enroll from the Plan during the Plan year without a qualifying event. It also allows retirees and surviving spouses to dis-enroll their dependents from the Plan without a qualifying event.

Section 2 amends G.S. 135-48.44(a) specifying that coverage will cease on the earliest of the last day of the month, or as soon thereafter as administratively feasible, in which the Plan approves cancellation of coverage for an employee or retired employee. This section also adds new language in the PCS to clarify that coverage will be terminated for failure to pay premiums. Termination for failure to pay will take place on the last day of the month for which a premium is paid.

Section 3 amends G.S. 135-48.40(b)(8) pertaining to partially contributory coverage to add "employees eligible for coverage on a noncontributory basis" to the section. According to the State Health Plan this change is needed to clarify treatment for Reduced in Force (RIF) employees.

Section 4(a) amends G.S. 135-48.40(d) regarding fully contributory coverage to allow surviving spouses of Disability Income Plan beneficiaries to be eligible for coverage under the Plan on a fully contributory basis.

Section 4(b) amends G.S. 135-48.41(g) pertaining to additional eligibility provisions to remove references to preexisting conditions and waiting periods.

Section 5 of the PCS amends G.S. 135-48.42(a) to add "other contributory basis" to enrollment language pertaining to new employees that must be given the opportunity to enroll or decline enrollment for themselves and their dependents within 30 days from the date of employment or from first becoming eligible on a partially contributory or other contributory basis.

EFFECTIVE DATE: House Bill 190 would become effective July 1, 2015.

Staff Analyst Theresa Matula substantially contributed to this summary.

HOUSE BILL 190
Committee Substitute Favorable 4/16/15

Short Title: State Health Plan Modifications.-AB (Public)

Sponsors:

Referred to:

March 11, 2015

A BILL TO BE ENTITLED

AN ACT TO MAKE MODIFICATIONS TO THE STATE HEALTH PLAN FOR PUBLIC EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-48.42(e) reads as rewritten:

"(e) Eligible employees and retirees may only change their elections, including adding or removing dependents, during the Plan year due to a qualifying event as defined under federal law. Notwithstanding the preceding sentence, retirees and surviving spouses may disenroll from the Plan during the Plan year without a qualifying event. Retirees and surviving spouses may also disenroll their dependents from the Plan during the Plan year without a qualifying event."

SECTION 2. G.S. 135-48.44(a) reads as rewritten:

"(a) Coverage under this Plan of an employee and his or her surviving spouse or eligible dependent children or of a retired employee and his or her surviving spouse or eligible dependent children shall cease on the earliest of the following dates:

...

(4) The last day of the ~~month~~month, or as soon thereafter as administratively feasible, in which the Plan approves cancellation of coverage for an employee or retired ~~employee requests cancellation of coverage.~~employee.

...

(9) The last day of the month for which a premium is paid in full."

SECTION 3. G.S. 135-48.40(b) reads as rewritten:

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

...

(8) Notwithstanding the provisions of G.S. 135-48.44, employees formerly covered by the provisions of this section, other than retired ~~employees,~~employees eligible for coverage on a noncontributory basis, who have been employed for 12 or more months by an employing unit, or who have completed a contract term of employment of 10 or 11 months and whose employing unit is a local school administrative unit, and whose jobs are eliminated because of a reduction, in total or in part, in the funds used to support the job or its responsibilities, provided the employees were covered by the Plan at the time of separation from service resulting from a job elimination. Employees covered by this subsection shall be covered for a period of up to 12 months following a separation from service because of a

job elimination. An employee formerly covered by the provisions of this section shall not be eligible for coverage under this subdivision if the employee is provided health benefit coverage on a non-contributory basis by a subsequent employer.

...."

SECTION 4.(a) G.S. 135-48.40(d) reads as rewritten:

"(d) Fully Contributory Coverage. – The following persons shall be eligible for coverage under the Plan, on a fully contributory basis, subject to the provisions of G.S. 135-48.43:

...

(9) Surviving spouses of deceased retirees and surviving spouses of deceased teachers, State employees, Disability Income Plan beneficiaries, and members of the General Assembly provided the death of the former Plan member occurred after September 30, 1986, and the surviving spouse was covered under the Plan at the time of death.

...."

SECTION 4.(b) G.S. 135-48.41(g) reads as rewritten:

"(g) An eligible surviving spouse and any eligible surviving dependent child of a deceased retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary shall be eligible for group benefits under this section ~~without waiting periods for preexisting conditions~~ provided coverage is elected within 90 days after the death of the former plan member. Coverage may be elected at a later ~~time,~~time during an annual enrollment ~~period, but members 19 years of age and older may be subject to the 12-month waiting period for preexisting conditions and will be effective the first day of the month following receipt of the application.~~period."

SECTION 5. G.S. 135-48.42(a) reads as rewritten:

"(a) Except as otherwise required by applicable federal law, new employees must be given the opportunity to enroll or decline enrollment for themselves and their dependents within 30 days from the date of employment or from first becoming eligible on a partially contributory or other contributory basis. Coverage may become effective on the first day of the month following date of entry on payroll or on the first day of the following month. New employees age 19 and older not enrolling themselves and their dependents age 19 and older within 30 days, or not adding dependents when first eligible as provided herein may enroll during annual enrollment, but may be subject to a 12-month waiting period for preexisting health conditions, except for employees who elect to change their coverage in accordance with rules established by the State Treasurer for optional or alternative plans available under the Plan. Children born to covered employees having coverage type (2) or (3), as outlined in G.S. 135-48.43(d) shall be automatically covered at the time of birth without any waiting period for preexisting health conditions. Children born to covered employees having coverage type (1) shall be automatically covered at birth without any waiting period for preexisting health conditions so long as the claims processor receives notification within 30 days of the date of birth that the employee desires to change from coverage (1) to coverage type (2) or (3), provided that the employee pays any additional premium required by the coverage type selected retroactive to the first day of the month in which the child was born."

SECTION 6. This act becomes effective July 1, 2015.

SENATE PAGES ATTENDING

COMMITTEE: Insurance **ROOM:** 1027

DATE: 6-3 **TIME:** 10:15

PLEASE PRINT LEGIBLY!!!!!!!!!!!!!....*or else!*

	Page Name	Hometown	Sponsoring Senator
1.	Tafari Bailey	Raleigh	Blue
2.	Hannah Lunsford	Leasburg	Woodard
3.	Claire Lewis	Reidsville	Berger
4.	India Tisdale	Reidsville	Phil Berger
5.	Emily Cheston	Rocky Mount	Buck Newton
6.	Robin Braswell	Clayton	Sen. Brent Jackson
7.	Charles Van Dyke	Raleigh	Berger
8.	Daniel Kunath	Apex	Barringer
9.			
10.			

Do not add names below the grid.

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

Senate Insurance Committee Meeting

June 3, 2015

Senate Sergeant at Arms

Terry Barnhardt

Larry Hancock

VISITOR REGISTRATION SHEET

SENATE INSURANCE — June 3, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DEBBIE LOWN

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	[illegible]
Lotta Crabtree	State Health Plan
Tom Friedmann	SHP/DST
Solari	DST
Geoff Allen	NCSLA
Steve Allen	NCSLA
Lane Brown	NCCIA
[illegible]	MWC
[illegible]	[illegible]
[illegible]	[illegible]
Starnes	Treasurer
Emily Ellis	DST
Dana Sipes	SIA
Robert PA School	Young Moore

VISITOR REGISTRATION SHEET

SENATE INSURANCE — June 3, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DEBBIE LOWN

NAME	FIRM OR AGENCY AND ADDRESS
David Collins	SEANC
Flint Benson	SEANC
Tracy Kimbrell	Parker Poe
David Stollen	State Farm
John McMillan	MFOS
Michelle Frazier	MFOS
John Handi-	MFOS
Tonya Hoatin	TSS
Daniel Bayne	TSS
Jim Hamm	NCDTSFA
John Bode	BVA

VISITOR REGISTRATION SHEET

SENATE INSURANCE — June 3, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DEBBIE LOWN

NAME	FIRM OR AGENCY AND ADDRESS
Mark Fleming	BCBSNC
Amy Fulk	30 PR
Evan Miller	NMRS
[illegible]	NMRS
[illegible]	Nelson Mullins
Christopher [illegible]	[illegible]
Bob Mack	NCDOI
Ed [illegible]	BP
Brooks Rayford	NCTA
R Rogers	NCRGEA
M Bocock	Prime Therapeutics

VISITOR REGISTRATION SHEET

SENATE INSURANCE — June 3, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DEBBIE LOWN

NAME	FIRM OR AGENCY AND ADDRESS
Sarah Bales	Brubaker Assoc
Chris Evans	BCBSNC
JAKE PARKER	NCFB
Josh Berdie	Insurance
SONNY WATTS	—
Chris Agee	DOJ
Doug Holbrook	NCBSIA
Brooks Rainford	NCTA
Jud Doss	Core 1550.
Matthew Eisley	SA
Susan Valaurie	Nationwide

VISITOR REGISTRATION SHEET

SENATE INSURANCE — June 3, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DEBBIE LOWN

NAME	FIRM OR AGENCY AND ADDRESS
Jonathan Barbaker	Barbaker + Assoc

Senate Committee on Insurance
Thursday, June 11, 2015 at 9:30 AM
Room 1027/1128 of the Legislative Building

MINUTES

The Senate Committee on Insurance met at 9:30 AM on June 11, 2015 in Room 1027/1128 of the Legislative Building. Nine members were present.

Senator Tom Apodaca, Chair, presided.

Hankins Feichter from Raleigh, Clara Booker from Raleigh, Warren Breden from Wilkesboro, Rebecca Lepore from Fuquay-Varina, Gray Keith from Wilmington, Larry Lepore from Fuquay-Varina, Taylor Payne from Burlington, and Campbell Fowler from Raleigh served as pages.

Sen. Apodaca chose to hear the bills out of order. The order in which they were heard is reflected below.

HB 288 Insurance Technical Changes.-AB (Representatives Setzer, Bumgardner)
Sen. Sanderson moved to adopt the proposed committee substitute (PCS) to the committee for discussion and it carried. Sen. Apodaca asked M. Benjamin Popkin, JD, MPH/Director of Government Affairs for the North Carolina Department of Insurance to comment on the bill. Sen. McKissick moved unfavorable to the bill – favorable to the PCS and it carried. Sen. Apodaca will manage the bill during session.

HB 148 Insurance Required for Mopeds. (Representatives Shepard, R. Brown, Waddell, Adams)
Rep. Shepard was introduced to speak on the bill. Rep Shepard responded to questions from the members. Sen. Ford moved for a favorable report and it carried. Sen. Apodaca will manage the bill during session.

HB 154 City, Towns, & Authority - State Health Plan. (Representative Iler)
Sen. Sanderson moved to adopt the proposed committee substitute (PCS) to the committee for discussion and it carried. Sen. Brown was asked to speak on the bill. Sen. Brown responded to questions from the members. Tim Hovis pointed out a typographical error on the bill summary; $100 should have been $1000. Tom Freeman/Director of the NC State Health Plan, and David Vanderweide an attorney from the Fiscal Research Division were asked to assist with responses to the members. Sen. McKissick moved unfavorable to the bill – favorable to the PCS and it carried. Sen. Brown will manage the bill during session.

The meeting adjourned at 10:08 AM.

Senator Tom Apodaca, Chair
Presiding

Debbie Lown, Committee Clerk

Senate Committee on Insurance
Thursday, June 11, 2015, 9:30 AM
1027/1128 Legislative Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 288	Insurance Technical Changes.-AB	Representative Setzer Representative Bumgardner
HB 154	City, Towns, & Authority - State Health Plan.	Representative Iler
HB 148	Insurance Required for Mopeds.	Representative Shepard Representative R. Brown Representative Waddell Representative Adams

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Apodaca, Co-Chair
Senator Meredith, Co-Chair

Thursday, June 11, 2015

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

FAVORABLE

HB **148** **(CS#1)** Insurance Required for Mopeds.

Draft Number:	None
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Tom Apodaca will handle HB 148

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Apodaca, Co-Chair
Senator Meredith, Co-Chair

Thursday, June 11, 2015

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

FAVORABLE

HB **148** **(CS#1)** Insurance Required for Mopeds.

Draft Number:	None
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Tom Apodaca will handle HB 148

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Apodaca, Co-Chair
Senator Meredith, Co-Chair

Monday, June 15, 2015

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

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

HB **288** **(CS#1)** Insurance Technical Changes.-AB

Draft Number:	H288-PCS10398-TU-19
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Senator Tom Apodaca will handle HB 288

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 288
Committee Substitute Favorable 4/15/15
PROPOSED SENATE COMMITTEE SUBSTITUTE H288-CSTU-19 [v.3]
6/10/2015 1:18:34 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; AND TO MAKE CONFORMING AND CLARIFYING CHANGES TO THE LAWS GOVERNING MOTOR VEHICLE FINANCIAL RESPONSIBILITY AND AUTO AND HOMEOWNERS' INSURANCE OPTIONAL PROGRAM ENHANCEMENTS, 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 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)(2), 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 "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. CONFORMING AND CLARIFYING CHANGES

SECTION 4. 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 5. 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."

PART V. EFFECTIVE DATE

SECTION 6. Sections 1 and 3 of this act become effective July 1, 2015. Section 2 of this act becomes effective January 1, 2017. Section 5 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.

HOUSE BILL 288:
Insurance Technical Changes.-AB

2015-2016 General Assembly

Committee:	Senate Insurance	**Date:**	June 11, 2015
Introduced by:	Reps. Setzer, Bumgardner	**Prepared by:**	Tim Hovis
Analysis of:	PCS to Second Edition		Kristen Harris
	H288-CSTU-19		Committee Counsel

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 and makes various statutory changes recommended by the Department.***

[The PCS makes a technical change to Section 1.4 and returns the language in Subsection (j)(1) of that section to how it appeared in the First Edition of the bill. The PCS also incorporates language from House Bill 287 relating to electronic proof of insurance and optional program enhancements.]

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.

PART VI

Section 4:

Adds a new subsection to The Vehicle Financial Responsibility Act which would allow proof of financial responsibility (auto liability insurance) for registration to be demonstrated in a physical and electronic format.

Section 5:

Creates a new section allowing automobile insurers to file individually with the Commissioner for approval of optional enhancements to their automobile or homeowners' 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.

EFFECTIVE DATE: Sections 1 and 3 of this act become effective July 1, 2015. Section 2 of this act becomes effective January 1, 2017. Section 5 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.

The Department of Insurance substantially contributed to this summary.

HOUSE BILL 288
Committee Substitute Favorable 4/15/15

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

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.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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HOUSE BILL 154
Committee Substitute Favorable 4/16/15
PROPOSED SENATE COMMITTEE SUBSTITUTE H154-CSRO-15 [v.3]

6/10/2015 4:11:33 PM

Short Title: Local Governments in State Health Plan. (Public)

Sponsors:

Referred to:

March 5, 2015

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE UNITS OF LOCAL GOVERNMENT TO ENROLL THEIR EMPLOYEES AND DEPENDENTS IN THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES, AND TO AUTHORIZE PIONEER SPRINGS COMMUNITY SCHOOL TO ELECT TO PARTICIPATE IN THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-48.8(b) reads as rewritten:

"(b) The State of North Carolina deems it to be in the public interest for ~~certain~~ local government units to be allowed to join the State Health Plan for Teachers and State Employees and to participate in the Plan."

SECTION 2. G.S. 135-48.47 reads as rewritten:

"**§ 135-48.47. Participation in State Health Plan by ~~certain~~ local government employees and dependents.**

(a) Eligibility. – The employees and dependents of employees of ~~the following~~ local government units are eligible to participate in the State Health ~~Plan:~~Plan, as provided in this section.

~~(1) Montgomery County.~~

~~(2) Towns of Elizabethtown and Matthews.~~

Employees and dependents participating under this section are not guaranteed participation in the Plan, and participation is contingent on their respective local government units (i) electing to participate in the Plan and (ii) complying with the provisions of this section and this Article, as well as any policies adopted by the Plan.

(b) Participation Requirements. – ~~The participation of a local government unit listed in subsection (a) of this section in the State Health Plan~~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, at least 60 days prior to joining the Plan, enter~~ 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) ~~The~~ 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) ~~The~~ A local government unit shall determine the eligibility of its employees and employees' dependents and what portion of the premiums employees will pay to the local government unit.

(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.

(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, 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 3. Notwithstanding any prior session law, any action taken by a Board of Trustees of the State Health Plan for Teachers and State Employees or of the predecessor plan to the current State Health Plan, or any other law, any local government unit that participates in the State Health Plan as of the effective date of this act may elect to be subject to the new requirements in G.S. 135-48.47, as enacted by this act. Local government units electing to participate in the Plan under G.S. 135-48.47 shall cease monthly contributions to the Retiree Health Benefit Fund in the month in which coverage begins under G.S. 135-48.47. Local government units shall not be entitled to a refund of any prior contributions to the Retiree Health Benefit Fund. Nothing in this section, nor an election to participate in the State Health Plan under G.S. 135-48.47, shall impact any existing debt to the Retiree Health Benefit Fund owed by any local government unit.

SECTION 4. Notwithstanding the time limitation contained in G.S. 135-48.54, the Board of Directors of Pioneer Springs Community School, a charter school located in Charlotte, may elect to become a participating employing unit in the State Health Plan for Teachers and State Employees in accordance with Article 3B of Chapter 135 of the General Statutes. The election authorized by this act shall be made no later than 30 days after the effective date of this act and shall be made in accordance with all other requirements of G.S. 135-48.54.

SECTION 5. This act is effective when it becomes law.

HOUSE BILL 154:
City, Towns, & Authority - State Health Plan

2015-2016 General Assembly

Committee:	Senate Ref to Insurance. If fav, re-ref to Pensions & Retirement and Aging	**Date:**	June 10, 2015
Introduced by:	Rep. Iler	**Prepared by:**	Tim Hovis Committee Counsel
Analysis of:	PCS to Second Edition H154-CSRO-15		

BACKGROUND:

18 local governments participate in the State Health Plan for Teachers and State Employees (the State Health Plan). These local governments were added in various laws passed since 2004 and there has been no consistent set of policies that local governments are subject to with regards to participation in the State Health Plan.

BILL ANALYSIS:

House Bill 154 would make local governments eligible to have their employees participate in the State Health Plan for Teachers and State Employees (State Health Plan) under specified conditions.

- The local government unit must pass a valid resolution expressing the local government's desire to participate in the State Health Plan.
- The local government unit must enter into a memorandum of understanding with the State Health Plan.
- The local government unit must provide at least 90 days' notice to the State Health Plan prior to entry and complete the requirements outlined in the bill at least sixty days prior to entry into the State Health Plan.
- The local government unit and its employees must meet the federal requirements to enter into a governmental plan and the State Health Plan has the right to refuse participation of the local government unit if its qualification as a governmental plan would be jeopardized.
- The Plan would be required to admit any local government unit that meet the qualifications outlined in the bill regardless of past claims experience or the financial impact to the State Health Plan.
- A local government unit must determine the eligibility of its employees and their dependents and what portion of the premiums employees will pay to the local government unit. Premiums for coverage and State Health Plan options will be the same as those offered to State employees and their dependents on a

fully contributory basis. The local government unit must pay all premiums for covered individuals directly to the State Health Plan or its designee.

Enrollment in the State Health by local government units is capped – no additional local governments will be allowed to join the State Health Plan after the number of employees and dependents of employees enrolled reaches 10,000, no additional local governments will be allowed to join. Any local government electing to participate must have less than 1,00 employees and dependents enrolled at the time of notice to the Plan.

Local governments currently participating in the State Health Plan would be given an option to elect to participate under the specified conditions outlined in the bill. Local government units electing to participate would also cease monthly contributions to the Retiree Health Benefit Fund. The Retiree Health Benefit Fund is a fund in which accumulated contributions from employers and any earnings on those contributions shall be used to provide health benefits to retired and disabled employees and their applicable beneficiaries.

The bill also authorizes Board of Directors of the Pioneer Springs Community School, a charter school, to elect to become a participating unit in the State Health Plan.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2015

Legislative Actuarial Note
Health Benefits

BILL NUMBER: Proposed Committee Substitute to House Bill 154 (H154-CSRO-15 [v.3])

SHORT TITLE: Local Governments in State Health Plan.

SPONSOR(S):

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

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

BILL SUMMARY:

Sections 1-3 (Local Governments)

The proposed legislation would add local governments to the list of employers eligible to have their employees participate in the Plan under the following conditions:

- The local government must meet certain administrative and legal requirements.
- The Plan is required to admit any local government meeting those requirements, regardless of claims experience. Participation is optional for the local government.
- The local government shall determine which employees and dependents are eligible and what portion of the premium they will pay. Retirees are not eligible to participate.
- The total premiums paid to the Plan will be the same as the fully contributory premiums for State employees and cannot vary by claims experience.
- The Plan may charge 1.5% interest per month for late payment of premiums.

Once the number of employees and dependents of employees of local governments enrolled in the Plan reaches 10,000, no additional local governments will be allowed to join. However, the total count of employees and dependents can exceed 10,000 depending on the size of the final local government admitted and due to growth in the number of members at the local governments that participate.

The proposed legislation only allows local governments with less than 1,000 employees and dependents to participate.

18 local governments already participate in the Plan, covering 2,118 employees, 980 dependents and roughly 500 retirees. These local governments were added in several different laws passed between 2004 and 2007, as well as Session Laws 2014-75 and 2014-105. These local governments participate under different, sometimes ambiguous policies and the bill gives these governments an option to elect to participate under the clarified policies contained in the bill.

Section 4 (Pioneer Springs Community School)

Section 4 of the proposed legislation permits the Board of Directors of Pioneer Springs Community School, a public charter school, to become a participating employer under the Plan within 30 days after the act becomes law. Under G.S. 135-48.54, an election to join the Plan by the board of a charter school is irrevocable and shall require all eligible employees of the charter school to participate.

EFFECTIVE DATE: The Proposed Committee Substitute is effective when it becomes law.

ESTIMATED IMPACT ON STATE:

Sections 1-3 (Local Governments)

Both The Segal Company, the actuary for the Plan, and Hartman & Associates, the actuary for the General Assembly, state that the cost of adding local governments cannot be determined due to a lack of demographic data and claims experience for the workforce of the local governments that might wish to join.

However, both actuaries note the possibility of a cost due to adverse selection. Adverse selection occurs when local governments and/or employees with higher-than-average claims cost are more likely to join the Plan than those with lower-than-average claims costs and those higher costs cannot be recovered through adjustments to premiums. The following aspects of the bill contribute to the potential for adverse selection:

- Participation is optional for local governments and the Plan cannot deny participation to any local unit. It is possible that local governments with higher-than-average claims costs will be more likely to choose to join.
- Local governments can determine eligibility. Local governments could choose to set eligibility rules that encourage employees with higher-than-average claims costs to enroll.
- Premiums cannot vary with the experienced claims for a particular local government, so the Plan cannot charge a higher premium to a local government whose employees incur higher-than-average claims.

Finally, both actuaries noted that the claims experience of the local units that participated in 2014 was favorable. Hartman & Associates calculated that claims costs were roughly 6% lower in 2014 for local government employees and dependents than for other comparable Plan members. The Segal Company calculated that claims and expenses for local government employees and dependents were roughly 4.3% lower than premiums. Thus, for the 2014 Plan Year, local government participation in the Plan reduced the amount the State would otherwise have to contribute to the Plan.

Section 4 (Pioneer Springs Community School)

The consulting actuary for the Plan, The Segal Company, estimates a financial loss to the Plan of $43,000 for FY 2015-2016 if Pioneer Springs Community School elects to participate in the Plan. Given the small size of the School, Segal estimates the projected costs would have a negligible impact on the Plan.

Hartman & Associates, consulting actuary for the General Assembly, estimates that the financial impact on the Plan would not be material upon Pioneer Springs Community School electing to participate in the Plan.

The additional cost impact of the bill, projected by either consulting actuary, would be expected to impact total claims growth by approximately two thousandths of one percent (0.002%) for the 2015-2016 fiscal year based on the highest estimate of additional cost (i.e., $43,000).

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

Authorized Charter Schools: As of January, 2015, there were 81 charter schools with 5,446 enrolled active employees and dependents participating in the Plan.

Data submitted by Pioneer Springs Community School: The Segal Company and Hartman & Associates based their respective analyses in part on a Distribution of Participants schedule submitted by the School. The schedule below reflects the age and sex demographic data for employees and dependents of the School. Complete claims experience data is usually unavailable on a group this size. However, the School did note that it currently pays total medical premiums of $8,152 per month and provided details on the benefits in its current program, which include:

- In-network office visit and therapy co-pay: $25 Primary Care; $50 Specialist
- Preventive care: $0
- Deductible: $1,000 (individual, in-network)
- Out-of-pocket maximum: $6,000 (individual, in-network)
- Inpatient and outpatient hospital: 20% coinsurance after deductible (in-network)
- Prescription drug co-pays: $10 generic; $35 preferred brand

Distribution of Participants - Pioneer Springs Community School

	Active Employees			Dependents of Active Employees		
Ages	Male	Female	Total	Male	Female	Total
0-4			0			0
5-9			0			0
10-14			0			0
15-19			0			0
20-24			0			0
25-29		5	5			0
30-34			0			0
35-39		4	4			0
40-44		5	5			0
45-49		2	2			0
50-54		1	1			0
55-59			0			0
60-64		1	1			0
65-69			0			0
70-74			0			0
75-79			0			0
>79			0			0
Unknown			0			0
TOTAL	0	18	18	0	0	0

Summary Information and Data about the Plan

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

The State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement, with the exception of many Medicare-eligible retirees who are in fully-insured Medicare Advantage plans. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who participate in a plan with a non-zero premium or who elect dependent coverage. Starting in 2014, benefit and premium changes are typically effective at January 1. The Plan's PPO benefit design includes three alternative benefit levels listed below:

1) The "Traditional" 70/30 plan that offers higher out-of pocket requirements in return for lower employee and retiree premiums without needing to complete wellness activities,

2) The "Enhanced" 80/20 plan that offers lower out-of-pocket requirements with higher employee and retiree premiums, which can be lowered by completing wellness activities, and

3) The Consumer-Directed Health Plan (CDHP) that applies deductibles and co-insurance to all services and offers lower employee and retiree premiums if one completes wellness activities

Medicare-eligible retirees are offered three alternative plans:

1) The "Traditional" 70/30 plan as coverage secondary to Medicare for medical services plus a pharmacy benefit plan,

2) "Base" Medicare Advantage Prescription Drug Plans (MA-PDPs) from a choice of two carriers, Humana or United Healthcare, that are actuarially equivalent to the "Enhanced" 80/20 Plan and apply in-network out-of-pocket requirements at out-of-network providers

3) "Enhanced" MA-PDPs, identical to the "Base" MA-PDPs, except with lower co-pays and higher retiree premiums

The following tables provide a summary of the most common monthly premium rates for the Plan in 2015:

Active Employees and Non-Medicare Retirees

Wellness Plans

	Employer Share	Employee/Retiree Share	
		Complete All Wellness Activities *	Complete No Wellness Activities
Enhanced 80/20 Plan	$448.12	$13.56	$63.56
Consumer-Directed Health Plan	$448.12	$0.00	$40.00

Alternate Plan

	Employer Share	Employee/Retiree Share
Traditional 70/30 Plan	$448.12	$0.00

* Members receive credits for each activity. We have shown all or none for simplicity.

Medicare Retirees

Medicare Advantage Plans

	Employer Share	Employee/Retiree Share
MA-PDP Base Plan	$348.24	$0.00
MA-PDP Enhanced Plan	$348.24	$33.00

Alternate Plan

	Employer Share	Employee/Retiree Share
Traditional 70/30 Plan	$348.24	$0.00

Dependents (paid by employee/retiree in addition to premiums above)

	All Dependents are Non-Medicare			One or More Medicare Dependents		
	Enhanced 80/20	CDHP	Traditional 70/30	MA-PDP Base	MA-PDP Enhanced	Traditional 70/30
Employee/Retiree + Children	$272.79	$184.60	$205.12	$114.50	$147.50	$145.94
Employee/Retiree + Spouse	$628.54	$475.68	$528.52	$114.50	$147.50	$383.72
Employee/Retiree + Family	$666.38	$506.64	$562.94	$229.00	$295.00	$418.10

The employer share of premiums for retirees is paid from the Retiree Health Benefit Fund. During FY 2014-15, employers contribute 5.49% of active employee payroll into the Fund. Total contributions for the year are projected to be approximately $848 million.

Financial Condition

Projected Results for CY 2015 and CY 2016 – The following summarizes projected financial results for 2015 and 2016, based on financial experience through December, 2014 and enrollments for January, 2015. The projection assumes a 7.0% annual claims growth trend for medical claims, an 8.5% trend for pharmacy claims, benefit provisions and member-paid premiums as currently adopted by the Board, and assumed premium increases in 2016 based on the Board's recommendation.

	($ millions) Projected CY 2015	Projected CY 2016
Beginning Cash Balance	$1,014.8	$863.2
Receipts:		
Net Premium Collections	$2,946.7	$3,063.9

Medicare Part D / EGWP Subsidies	$63.2	$14.3
Investment Earnings	$3.9	$3.0
Total	$3,013.8	$3,081.2
Disbursements:		
Net Medical Claim Payment Expenses	$2,099.3	$2,175.5
Net Pharmacy Claim Payment Expenses	$657.8	$713.9
Medicare Advantage Premiums	$174.2	$193.4
Administration and Claims-Processing Expenses	$234.1	$237.8
Total	$3,165.5	$3,320.6
Net Operating Income (Loss)	($151.7)	($239.4)

Of the premiums paid in CY 2015, an estimated $2.0 billion is derived from General Fund sources and an estimated $0.1 billion is derived from Highway Fund sources.

Other Information

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, fraud detection, and other authorized actions by the State Treasurer, Executive Administrator, and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Medical claim costs are expected to increase at a rate of 7.0% annually and pharmacy claim costs are expected to increase at a rate of 8.5% annually according to assumptions adopted by the Board of Trustees. The active population is projected to decline by 1% per year and the retired population is projected to increase by 1% per year.

Enrollment as of January 1, 2015

I. No. of Participants	Traditional 70/30	Enhanced 80/20	Consumer Directed	Medicare Advantage	Total	Percent of Total
Actives						
Employees	134,404	168,041	9,279	-	311,724	45.5%
Dependents	78,230	74,173	9,326	-	161,729	23.6%
Sub-total	212,634	242,214	18,605	-	473,453	69.1%
Retired						
Employees	58,623	31,116	847	98,813	189,399	27.6%
Dependents	6,513	4,032	353	7,787	18,685	2.7%
Sub-total	65,136	35,148	1,200	106,600	208,084	30.4%
Other						
Employees	904	1,512	59	-	2,475	0.4%
Dependents	627	582	69	-	1,278	0.2%
Sub-total	1,531	2,094	128	-	3,753	0.5%
Total						
Employees	193,931	200,669	10,185	98,813	503,598	73.5%
Dependents	85,370	78,787	9,748	7,787	181,692	26.5%
Grand Total	**279,301**	**279,456**	**19,933**	**106,600**	**685,290**	**100%**
Percent of Total	**40.8%**	**40.8%**	**2.9%**	**15.6%**	**100.0%**	

II. Enrollment by Contract	Traditional	Enhanced	CDHP	MA	Total
Employee Only	149,351	159,389	5,537	91,026	405,303
Employee Child(ren)	26,212	26,050	2,287	187	54,736
Employee Spouse	6,385	5,616	638	7,600	20,239
Employee Family	10,656	8,812	1,622		
Other (e.g. Split Contract)	1,327	802	101		2,230
Total	**193,931**	**200,669**	**10,185**	**98,813**	**482,508**

Percent Enrollment by Contract	Traditional	Enhanced	CDHP	MA	Total
Employee Only	77.0%	79.4%	54.4%	92.1%	84.0%
Employee Child(ren)	13.5%	13.0%	22.5%	0.2%	11.3%
Employee Spouse	3.3%	2.8%	6.3%	7.7%	4.2%
Employee Family	5.5%	4.4%	15.9%	0.0%	0.0%
Other (e.g. Split Contract)	0.7%	0.4%	1.0%	0.0%	0.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

III. Enrollment by Sex	Traditional	Enhanced	CDHP	MA	Total
Female	164,204	182,573	11,095	70,102	427,974
Male	115,097	96,883	8,838	36,498	257,316
Total	**279,301**	**279,456**	**19,933**	**106,600**	**685,290**

Percent Enrollment by Sex	Traditional	Enhanced	CDHP	MA	Total
Female	58.8%	65.3%	55.7%	65.8%	62.5%
Male	41.2%	34.7%	44.3%	34.2%	37.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Traditional	Enhanced	CDHP	MA	Total
24 & Under	72,665	66,607	7,567	10	146,849
25 to 44	73,396	74,376	5,727	290	153,789
45 to 54	46,998	55,289	3,438	1,128	106,853
55 to 64	47,633	76,519	3,029	1,579	128,760
65 & Over	38,609	6,665	172	103,593	149,039
Total	**279,301**	**279,456**	**19,933**	**106,600**	**685,290**

Percent Enrollment by Age	Traditional	Enhanced	CDHP	MA	Total
24 & Under	26.0%	23.8%	38.0%	0.0%	21.4%
25 to 44	26.3%	26.6%	28.7%	0.3%	22.4%
45 to 54	16.8%	19.8%	17.2%	1.1%	15.6%
55 to 64	17.1%	27.4%	15.2%	1.5%	18.8%
65 & Over	13.8%	2.4%	0.9%	97.2%	21.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	53,743	9,610	63,353
Medicare Eligible in Traditional 70/30	37,538	1,487	39,025
Medicare Eligible in Base Medicare Advantage Plans	60,833	2,831	63,664
Medicare Eligible in Enhanced Medicare Advantage Plans	37,980	4,956	42,936
Total	**190,094**	**18,884**	208,978

Percent Enrollment by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	28.3%	50.9%	30.3%
Medicare Eligible in Traditional 70/30	19.7%	7.9%	18.7%
Medicare Eligible in Base Medicare Advantage Plans	32.0%	15.0%	30.5%
Medicare Eligible in Enhanced Medicare Advantage Plans	20.0%	26.2%	20.5%
Total	**100.0%**	**100.0%**	100.0%

VI. Enrollment By Major Employer Groups	Employees	Dependents	Total
State Agencies	69,629	33,021	102,650
UNC System	51,279	32,033	83,312
Local Public Schools	171,429	86,048	257,477
Charter Schools	3,402	2,044	5,446
Local Community Colleges	15,741	8,517	24,258
Other			
Local Goverments	2,118	980	3,098
COBRA/Reduction in Force/Direct Bill	599	362	961
Nat. Guard, Fire & Rescue	2	2	4
Sub-total	314,199	163,007	477,206
Retirement System	189,399	18,685	208,084
Total	**503,598**	**181,692**	**685,290**

Percent Enrollment by Major Employer Groups	Employees	Dependents	Total
State Agencies	13.8%	18.2%	15.0%
UNC System	10.2%	17.6%	12.2%
Local Public Schools	34.0%	47.4%	37.6%
Charter Schools	0.7%	1.1%	0.8%
Local Community Colleges	3.1%	4.7%	3.5%
Other			
Local Goverments	0.4%	0.5%	0.5%
COBRA/Reduction in Force	0.1%	0.2%	0.1%
Nat. Guard, Fire & Rescue	0.0%	0.0%	0.0%
Sub-total	62.4%	89.7%	69.6%
Retirement System	37.6%	10.3%	30.4%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

The Segal Company; preliminary financial projections updated through Q4 CY2014 under revised benefit proposal; dated February 6, 2015; as presented to the Board of Trustees on February 11, 2015. Filename "CY2014 Preliminary Q4 Update – Revised Proposal.pdf"

-Actuarial Note, Hartman & Associates, "Draft Bill 2015-LL-102 [v.6]: An Act to Authorize Units of Local Government to Enroll Their Employees and Dependents in the State Health Plan", March 20, 2015, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, The Segal Company, "Bill Draft 2015-LL-102 Local Governments in State Health Plan", March 17, 2015, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

-Actuarial Note, Hartman & Associates, "Senate Bill 136: An Act to Authorize Pioneer Springs Community School to Elect to Participate in the State Health Plan for Teachers and State Employees", March 12, 2015, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, The Segal Company, "Senate Bill 136 Charter School in State Health Plan", March 19, 2015, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: David Vanderweide

David Vanderweide

APPROVED BY:

Mark Trogdon, Director
Fiscal Research Division

DATE: June 10, 2015

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 2

HOUSE BILL 154
Committee Substitute Favorable 4/16/15

Short Title: City, Towns, & Authority - State Health Plan. (Public)

Sponsors:

Referred to:

March 5, 2015

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE CITY OF SOUTHPORT, TOWNS OF MARSHVILLE AND WADESBORO, AND THE PIEDMONT TRIAD REGIONAL WATER AUTHORITY TO ENROLL THEIR EMPLOYEES AND DEPENDENTS IN THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-48.47(a) reads as rewritten:

"(a) Eligibility. – The employees and dependents of employees of the following local government units are eligible to participate in the State Health Plan:

(1) Montgomery County.

(2) Towns of ~~Elizabethtown~~ Elizabethtown, Marshville, ~~and Matthews.~~ Matthews, and Wadesboro.

(3) City of Southport.

(4) Piedmont Triad Regional Water Authority.

Employees and dependents participating under this section are not guaranteed participation in the Plan, and participation is contingent on their respective local government units complying with the provisions of this section and this Article, as well as any policies adopted by the Plan."

SECTION 2. This act becomes effective July 1, 2015.

HOUSE BILL 148:
Insurance Required for Mopeds

2015-2016 General Assembly

Committee:	Senate Insurance	**Date:**	June 10, 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.

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.

HOUSE BILL 148:
Insurance Required for Mopeds

2015-2016 General Assembly

Committee:	Senate Insurance	**Date:**	June 10, 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.

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.

Senate Pages Attending

COMMITTEE: Insurance **ROOM:** 1027

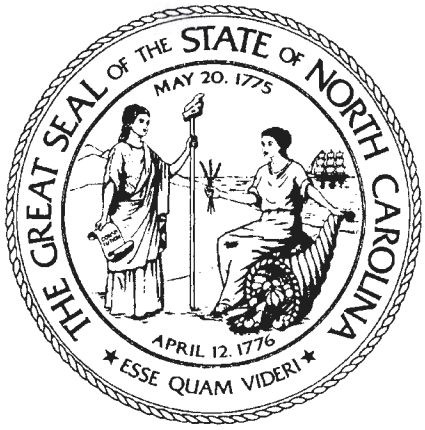
DATE: 6-11 **TIME:** 9:30

PLEASE PRINT LEGIBLY!!!!!!!!!!!!!....*or else!*

	Page Name	Hometown	Sponsoring Senator
1.	Hankins Fickter Feichter	Raleigh	Stein
2.	Clara Booker	Raleigh	Stein
3.	Warren Breden	Wilkesboro	Randleman
4.	Rebecca Lepore	Fuquay - Varina	Brock
5.	Gray Keith	Wilmington	Lee
6.	Larry Lepore	Fuquay-Varina	Brock
7.	Taylor Payne	Burlington	Gunn
8.	Campbell Fowler	Raleigh	Apodaca
9.			
10.			

Do not add names below the grid.

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.



SENATE INSURANCE

COMMITTEE MEETING

JUNE 11, 2015

SENATE SERGEANT-AT-ARMS

LARRY HANCOCK

HAL ROACH

VISITOR REGISTRATION SHEET

SENATE INSURANCE — June 11, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DEBBIE LOWN

NAME	FIRM OR AGENCY AND ADDRESS
John Delfiorino	Brabcliff Assoc.
Debbie Jones	DMV
Kathy Brannon	DMV
Lyonne Hagans	DMV
Brian Mundd	WRA
Courtney [illegible]	[illegible]
Erica McCoy	NCA
[illegible]	LPAs
Preston Jones	NCDOT
Sonny Watts	
Ryan Boyce	NCIC

VISITOR REGISTRATION SHEET

SENATE INSURANCE — June 11, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DEBBIE LOWN

NAME	FIRM OR AGENCY AND ADDRESS
Tim Lucas	NC Rate Bureau
Susan Valaun	Nationwide
Sohari	DST
Friedman	SHP/DST
	NCHA
David Ferrell	VB
	mwc
Michael Fahmen	NCDOT - IT
Robert Sawyer	NCDMV - LGT

VISITOR REGISTRATION SHEET

SENATE INSURANCE — June 11, 2015

Name of Committee — **Date**

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Steve Metcalf	Mission Hosp 14th
Romona Timms	Missin Health
Kelly Thomas	DMV
Hope Mangum	NCDMV
Paul Shen	NCFB
Tonya Horton	TS
Wick Parry-Hill	NCHFA
Natalie Hobson	NCHFA
Jan Andrews	NCDOI
Jackie Obarski	NCDOI
Johanna Reese	NCACC

VISITOR REGISTRATION SHEET

SENATE INSURANCE — June 11, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DEBBIE LOWN

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John Bode	BV~~W~~
Ken Lunch	KC&A
Amanda McQuade	NC Child
J. Grayer Shearill	NCFB
Jake Parker	NC FB
Lori Ann Harris	NHHA
Christopher	Du
Sal Skinner	NCACC

VISITOR REGISTRATION SHEET

SENATE INSURANCE — June 11, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DEBBIE LOWN

NAME	FIRM OR AGENCY AND ADDRESS
Josue Bravo	Intern
Sarah Bales	Brubaker & Assoc.
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Sarah Collins	NCLM
Dana Sipson	SA
Andy Walsh	SA
Isabel Villa-Lara	NCAR
[illegible]	NCCA
[illegible]	SA
Evan Miller	NMHS
[illegible]	NAHRS

VISITOR REGISTRATION SHEET

SENATE INSURANCE — June 11, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DEBBIE LOWN

NAME	FIRM OR AGENCY AND ADDRESS
Walt Gray	MIC

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INDEX OF BILLS
Senate Insurance 2016

HB19
Modify Definition of Firefighter
Representatives C. Graham
June 15, 2016

HB287
Amend Insurance Laws -AB
Representatives Setzer and Bumgardner
June 15, 2016

SB865
State Health Plan/Admin. Changes/Local Govts.
Senator Sanderson
June 23, 2016

SB815
Charter School in State Health Plan
Senator Blue
June 23, 2016

Senate Committee on Insurance
Wednesday, June 15, 2016 at 4:00 PM
Room 1027/1128 of the Legislative Building

MINUTES

The Senate Committee on Insurance met at 4:00 PM on June 15, 2016 in Room 1027/1128 of the Legislative Building. Ten members were present.

Senator Tom Apodaca, Chair, presided.

Kelly Anne Faulk from Sanford, Amy Clemmons from Raleigh, Jordyn Scheitler from Belmont, Reagan Rushing from Wingate and Griffin Sullivan from Raleigh served as pages.

This committee actually convened at 4:30 due to a long Senate Session.

HB 19 Modify Definition of Firefighter. (Representative C. Graham)
Sen. Daniel presented the bill to the members. Sen. Apodaca then asked Wayne Goodwin the Commissioner of Insurance from the North Carolina Department of Insurance to comment on the bill. Sen. Meredith moved for a favorable report and it passed.

HB 287 Amend Insurance Laws.-AB (Representatives Setzer, Bumgardner)
Sen. Meredith presided for this bill. Sen. Apodaca moved to adopt the proposed committee substitute (PCS) to the committee for discussion and it was carried. Sen. Meredith called on the Commissioner of Insurance Wayne Goodwin and the Director of Government Affairs from the North Carolina Department of Insurance M. Benjamin Popkin to explain the bill. Up to that point questions from the members were answered by Mr. Popkin. Sen. Apodaca brought forth Amendment 1 and 2. Both were accepted by the committee. Sen. Lee brought forth Amendment 3 before the committee. Rep. Tine spoke in regards to the 3rd Amendment and answered questions from the members. The 3rd Amendment was then accepted by the committee. Sen. Lee then brought forth Amendment 4 before the committee that offered technical fixes to the 3rd Amendment and it was accepted. Sen. McKissick moved for an unfavorable to the bill – favorable to the PCS as amended (4 times) to be rolled in to a new PCS and it carried. The bill was recommended for a referral to Judiciary II.

The meeting adjourned at 5:20 PM.

Senator Tom Apodaca, Chair
Presiding

Debbie Lown, Committee Clerk

Senate Committee on Insurance
Wednesday, June 15, 2016, 4:00 PM
1027/1128 Legislative Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 19	Modify Definition of Firefighter.	Representative C. Graham
HB 287	Amend Insurance Laws.-AB	Representative Setzer Representative Bumgardner

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Apodaca, Co-Chair
Senator Meredith, Co-Chair

Wednesday, June 15, 2016

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

FAVORABLE

HB **19** **(SCS#1)** Modify Definition of Firefighter.

Draft Number:	None
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Shirley B. Randleman will handle HB 19

HOUSE BILL 19:
Modify Definition of Firefighter.

2016-2017 General Assembly

Committee:	Senate Insurance	**Date:**	June 15, 2016
Introduced by:	Rep. C. Graham	**Prepared by:**	Tim Hovis* Committee Co-Counsel
Analysis of:	PCS to Second Edition H19-CSTG-57		

SUMMARY: ***The Proposed Committee Substitute for House Bill 19 would change the name of the North Carolina State Fireman's Association to the North Carolina State Firefighters' Association, amend the definition of "Firefighter" to include firefighters employed by county fire marshal offices, modify the appointment process for the board of trustees of local Firefighters' Relief funds, provide that that the board of trustees of local Firefighters' Relief funds may disburse funds to cover necessary management and investment costs, and would clarify that fire alarms that are unintentional and result in no damage would not be considered in calculating minimum response requirements for initial rating or classification under G.S. 58-36-10(3). The PCS rewrites the bill.***

BILL ANALYSIS:

Section 1 amends the definition of "Firefighter" in Article 84 to include firefighters employed by county fire marshal offices.

Section 2 changes the words "firemen's relief fund" to "local Firefighters' Relief Fund" to make it consistent with references to this fund used elsewhere in the General Statutes.

Section 3 changes the appointment process for trustees of local Firefighters' Relief Fund. Under current law, each local government that receives benefits under Article 84 must appoint a local board of trustees of the Local Firefighters' Relief Fund. Currently, there are 5 members. Two members are elected by the members of the local fire department each January and have staggered terms of two years. Two members are appointed by the mayor and board of aldermen each January and have staggered terms. The Commissioner of Insurance appoints one representative who serves at the pleasure of the Commissioner.

Section 3 would change the appointment process so that (1) the members of the fire department would elect two representatives to serve at the pleasure of the department and (2) the mayor and other local governing board would appoint two members to serve at the pleasure of the governing body.

Section 4 corrects a misplaced apostrophe in "Firefighters' Relief Fund."

Section 5 provides that the board of trustees of local Firefighters' Relief funds may disburse funds to cover necessary management and investment costs that are reasonable and appropriate.

Section 6 changes the name of the North Carolina State Firemen's Association to the North Carolina State Firefighters' Association. It authorizes the association to amend its corporate documents to correct the association's name by making the appropriate filing with the Secretary of State. It also authorizes the Revisor of Statutes to correct references to the Association's former name in the General Statutes.

Karen Cochrane-Brown
Director

H19-SMRG-26 CSTG-57 -V-1

Legislative Analysis
Division
919-733-2578

Section 7 amends the statute governing standards which apply to rate making in Article 36 of Chapter 58. Currently, for property insurance rates, consideration may be given to the experience of property insurance business during the most recent five year period. For property insurance rates, consideration must be given to the insurance public protection classifications of fire districts established by the Commissioner of Insurance. The Commissioner must establish and modify insurance public protection districts for all rural areas of the State and for cities with populations of 100,000 or fewer. In establishing and modifying these districts, the Commissioner must use standards at least equivalent to those used by the Insurance Services Office, Inc., or any successor organization. Section 7 would provide that fire alarms that are unintentional and result in no damage would not be considered in calculating minimum response requirements for initial rating or classification.

EFFECTIVE DATE: The act becomes effective July 1, 2016.

*This summary was substantially contributed to by Brad Krehely, Legislative Analysts Division.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 3

HOUSE BILL 19
Committee Substitute Favorable 3/10/15
Senate Judiciary I Committee Substitute Adopted 6/9/16

Short Title: Modify Definition of Firefighter. (Public)

Sponsors:

Referred to:

January 29, 2015

A BILL TO BE ENTITLED

AN ACT TO AMEND ARTICLE 84 OF CHAPTER 58 OF THE GENERAL STATUTES TO MAKE A TECHNICAL CORRECTION TO THE DEFINITION OF FIREFIGHTER TO INCLUDE FIREFIGHTERS EMPLOYED BY COUNTY FIRE MARSHAL OFFICES, TO CLARIFY THE AUTHORITY OF LOCAL BOARDS OF TRUSTEES TO PAY EXPENSES OF LOCAL FIREFIGHTERS' RELIEF FUNDS, TO UPDATE THE APPOINTMENT PROCEDURES FOR LOCAL FIREFIGHTERS' RELIEF FUND BOARDS OF TRUSTEES, TO CHANGE THE NAME OF THE NORTH CAROLINA STATE FIREMEN'S ASSOCIATION TO THE NORTH CAROLINA STATE FIREFIGHTERS' ASSOCIATION, AND TO CLARIFY THAT FIRE ALARMS THAT ARE UNINTENTIONAL AND RESULT IN NO DAMAGE ARE NOT CONSIDERED WHEN CALCULATING MINIMUM RESPONSE REQUIREMENTS FOR INITIAL RATING OR CLASSIFICATION UNDER G.S. 58-36-10(3).

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-84-5(3a) reads as rewritten:

"(3a) ~~Firefighter or Fireman.~~Firefighter. – Any person who meets all of the following requirements:

a. Is a volunteer, employee, contractor, or member of a rated and certified fire ~~department.~~department, or employee of a County Fire Marshal's Office whose sole duty is to act as fire marshal, deputy fire marshal, assistant fire marshal, or firefighter of the county.

...."

SECTION 2. G.S. 58-84-25(d) reads as rewritten:

"(d) Administration. – These funds shall be held by the treasurer of a fire district as a separate and distinct fund. The fire district shall immediately pay the funds to the treasurer of the local board of trustees upon the treasurer's election and qualification, for the use of the board of trustees of the ~~firemen's local relief fund~~ local Firefighters' Relief Fund in each fire district to be used by it for the purposes provided in G.S. 58-84-35."

SECTION 3. G.S. 58-84-30 reads as rewritten:

"**§ 58-84-30. Trustees appointed; organization.**

For each county, town or city complying with and deriving benefits from the provisions of this Article, there shall be appointed a local board of trustees, known as the trustees of the local Firefighters' Relief Fund, to be composed of five members, two of whom shall be elected by the members of the local fire department who are qualified as beneficiaries of such fund, two of whom shall be elected by the mayor and board of aldermen or other local governing body, and one of

whom shall be named by the Commissioner of Insurance. Their selection and term of office shall be as follows:

(1) The members of the fire department shall hold an election ~~each January~~ to elect ~~their~~ two representatives to ~~above board. In January 1950, the firefighters shall elect one member to serve for two years and one member to serve for one year, then each year in January thereafter, they shall elect only one member and his term of office shall be for two years.~~ the board to serve at the pleasure of the members of the department. The elected representatives may serve until their resignation or until the department holds an election to replace them. ~~Members~~ Board members elected pursuant to this ~~section~~subdivision shall be either (i) residents of the fire district or (ii) active or retired members of the fire department.

(2) The mayor and board of aldermen or other local governing body shall ~~appoint, in January 1950,~~appoint two representatives to ~~above board, one to hold office for two years and one to hold office for one year, and each year in January thereafter they shall appoint only one representative and his term of office shall be for two years.~~ the board to serve at the pleasure of the governing body. ~~Members~~ Board members appointed pursuant to this ~~section~~ subdivision shall be residents of the fire district.

(3) The Commissioner of Insurance shall appoint one representative to serve as trustee ~~and he~~who shall serve at the pleasure of the Commissioner. The member appointed pursuant to this ~~section~~subdivision shall be either (i) a resident of the fire district or (ii) an active or retired member of the fire department.

All of the above trustees shall hold office for their elected or appointed time, or until their successors are elected or appointed, and shall serve without pay for their services. They shall immediately after election and appointment organize by electing from their members a chairman and a secretary and treasurer, which two last positions may be held by the same person. The treasurer of said board of trustees shall give a good and sufficient surety bond in a sum equal to the amount of moneys in his hand, to be approved by the Commissioner of Insurance. The cost of this bond may be deducted by the Insurance Commissioner from the receipts collected pursuant to G.S. 58-84-10 before distribution is made to local relief funds. If the chief or chiefs of the local fire departments are not named on the board of trustees as above provided, then they shall serve as ex officio members without privilege of voting on matters before the board."

SECTION 4. G.S. 58-84-33(a) reads as rewritten:

"**§ 58-84-33. Maximum fund balances.**

(a) The balance of a local fire department's ~~Firefighter's~~Firefighters' Relief Fund for a given year shall not exceed the product of multiplying the number of members on the department's roster as of January 1 for that year by the sum of two thousand five hundred dollars ($2,500)."

SECTION 5. G.S. 58-84-35(a) reads as rewritten:

"**§ 58-84-35. Disbursement of funds by trustees.**

(a) The board of trustees shall have entire control of the funds derived from the provisions of this Article, and shall disburse the funds only for the following purposes:

...

(8) To cover necessary management and investment costs that are reasonable and appropriate in relation to the assets, purpose, and financial security of the local Firefighters' Relief Fund."

SECTION 6. Chapter 251 of the Private Laws of 1889 is hereby amended by replacing the words "North Carolina State Firemen's Association" with the words "North Carolina State Firefighters' Association."

The entity formerly known as the North Carolina State Firemen's Association, and now known as the North Carolina State Firefighters' Association, is hereby authorized to amend its

corporate documents to conform them to the association's new name by an appropriate filing with the Secretary of State.

The Revisor of Statutes is hereby authorized to replace any occurrences in the General Statutes of the words "North Carolina State Firemen's Association," "North Carolina Firemen's Association," "State Firemen's Association," or any reasonable derivative thereof, with the words "North Carolina State Firefighters' Association," including the following sections of the General Statutes: G.S. 58-2-121, 58-78-1, 58-80-5, 58-80-25, 58-80-60, 58-84-5, 58-84-25, 58-84-33, 58-84-35, 58-84-40, 58-84-41, 58-84-46, 58-84-50, 58-84-52, 58-85-1, 58-85-10, 58-85-20, 58-85-25, 58-85-30, 58-85-35, 58-86-25, 58-87-10, 135-27, 143-136, 143B-1401, 166A-26, and 166A-69.

SECTION 7. G.S. 58-36-10(3) reads as rewritten:

"(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.~~organization, except that fire alarms that are unintentional or the result of malfunction and result in no damage or fire shall not be considered in calculating minimum response requirements for initial rating or classification. 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."

SECTION 8. This act becomes effective July 1, 2016.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 287
Committee Substitute Favorable 4/14/15
Committee Substitute #2 Favorable 7/28/15
PROPOSED SENATE COMMITTEE SUBSTITUTE H287-CSMH-18 [v.22]
06/14/2016 07:03:09 PM

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

Sponsors:

Referred to:

March 19, 2015

A BILL TO BE ENTITLED

AN ACT TO ENHANCE AND IMPROVE CONSUMER PROTECTIONS AND TRANSPARENCY RELATED TO MOTOR VEHICLE MAINTENANCE AND REPAIRS AND LONG-TERM CARE INSURANCE; TO ESTABLISH A PUBLICLY-ACCESSIBLE ONLINE BUILDING CODE; TO STUDY VOLUNTEER FIREFIGHTER RECRUITMENT AND RETENTION EFFORTS; TO INCREASE THE CRIMINAL PENALTY FOR LARGE-SCALE FRAUD COMMITTED BY AN INSURANCE FIDUCIARY AND STRENGTHEN COMMERCIAL AUTO RATE EVASION REFORM; TO MAKE VARIOUS TECHNICAL AND POLICY CHANGES TO NORTH CAROLINA'S CAPTIVE INSURANCE LAW PROVISIONS; TO ENABLE THE ESTABLISHMENT OF A STATE-BASED PRIVATE FLOOD INSURANCE MARKET; TO ENABLE INSURERS TO RECEIVE RESTITUTION FROM CONVICTED DEFENDANTS; TO EXEMPT CERTAIN ACCOUNTABLE CARE ORGRANIZATIONS FROM DEPARTMENT REGULATION; AND TO MAKE OTHER AMENDMENTS TO INSURANCE LAWS, AS RECOMMENDED BY THE DEPARTMENT.

The General Assembly of North Carolina enacts:

PART I. CONSUMER TRANSPARENCY AND ASSISTANCE PROVISIONS

SECTION 1.1. G.S. 58–36–75(a) reads as rewritten:

"(a) The subclassification plan promulgated pursuant to G.S. 58-36-65(b) may provide for separate surcharges for major, intermediate, and minor accidents. A "major accident" is an at-fault accident that results in either (i) bodily injury or death or (ii) only property damage of ~~three thousand eighty five dollars ($3,085)~~four thousand one hundred dollars ($4,100) or more. An "intermediate accident" is an at-fault accident that results in only property damage of more than ~~one thousand eight hundred fifty dollars ($1,850)~~ two thousand five hundred dollars ($2,500) but less than ~~three thousand eighty five dollars ($3,085).~~four thousand one hundred dollars ($4,100). A "minor accident" is an at-fault accident that results in only property damage of ~~one thousand eight hundred fifty dollars ($1,850)~~two thousand five hundred dollars ($2,500) or less. The subclassification plan may also exempt certain minor accidents from the Facility recoupment surcharge. The Bureau shall assign varying Safe Driver Incentive Plan point values and surcharges for bodily injury in at-fault accidents that are commensurate with the severity of the injury, provided that the point value and surcharge assigned for the most severe bodily injury shall not exceed the point value and surcharge assigned to a major accident involving only property damage."

SECTION 1.2. G.S. 58-51-95 is amended by adding a new subsection to read:

"(f1) For long-term care policy forms, the maximum rate increase that may be implemented in any calendar year for any policyholder is an increase of fifteen percent (15%) of the current policy premium rate in effect prior to the increase."

SECTION 1.3.(a) A special fund is created in the Department, for the purpose of handling funds provided for the establishment and operation costs of a publicly-accessible online portal to the current North Carolina Building Code, with content and functions as deemed appropriate by the Commissioner, in consultation with the Building Code Council. The functions shall include at least the following: instant access to a current, updated Building Code, with cross-references to relevant authorities, commentary and other information deemed relevant by the Commissioner, in consultation with the Building Code Council, to the practice of those professions directly and indirectly relying on the Building Code and to the interests of the general public.

There is appropriated from the General Fund to the special fund the sum of four hundred twenty-five thousand dollars ($425,000) for the 2016-17 fiscal year. The Fund shall be placed in an interest-bearing account, and any interest or other income derived from the Fund shall be credited to the Fund. The Fund may only be used for the purpose set forth in this section, and any excess from one year shall be maintained in the Fund for use procuring access to the online Code in future years.

SECTION 1.3.(b) The Commissioner may contract with the International Code Council, the proprietor of the Code, to provide online services to the users of the North Carolina Building Code, as deemed appropriate by the Commissioner and as specified in the contract. The contracts shall not be subject to G.S. 114-2.3, G.S. 147-17, or Articles 3, 3C, and 8 of Chapter 143 of the General Statutes.

SECTION 1.3.(c) The Building Code Council, in consultation with the Department, shall monitor progress in establishing and operating an accurate, comprehensive, online Building Code that meets the needs of builders, inspectors, code officials, and other interested parties, and shall make recommendations to the General Assembly on or before the convening of the 2018 Legislative session. The recommendations shall include at least the following:

(1) Sufficiency of current funding amount and projections of future funding needs.
(2) Propriety of current funding source and recommendations for alternate funding methodologies, including, options of self-purchase by the user and elimination of State funding.
(3) Sufficiency of current capabilities and functions of the online Building Code.
(4) Recommendations for modifications to Code functionality to enhance consumer utilization of the online Code.
(5) Recommendations for legislative action, if any, to address issues and improve function of the online Building Code.

PART II. FIRE AND RESCUE PROVISIONS

SECTION 2.1.(a) G.S. 58-87-1(b) reads as rewritten:

"(b) Eligible Fire Department. – A fire department is eligible for a grant under this section if it meets all of the conditions of this subsection. No fire department may be declared ineligible for a grant solely because it is classified as a municipal fire department.

~~(1) It serves a response area of 12,000 or less in population. In making the population determination, the Department must use the most recent annual population estimates certified by the State Budget Officer.~~
(2) It consists entirely of volunteer members, with the exception that the unit may have paid members to fill the equivalent of six full-time paid positions.
(3) It has been certified by the Department of Insurance."

SECTION 2.1.(b) G.S.58-87-5(a) reads as rewritten:

"(a) There is created in the Department of Insurance the Volunteer Rescue/EMS Fund to provide grants to volunteer rescue units, rescue/EMS units, and EMS units providing rescue or rescue and emergency medical services to purchase equipment and make capital improvements. An eligible unit may apply to the Department of Insurance for a grant under this section. The application form and criteria for grants shall be established by the Department. The North Carolina Association of Rescue and Emergency Medical Services, Inc., shall provide the Department with an advisory priority listing for rescue equipment eligible for funding, and the Department of Health and Human Services shall provide the Department with an advisory priority listing of EMS equipment eligible for funding. The State Treasurer shall invest the Fund's assets according to law, and the earnings shall remain in the Fund. On December 15, or on the first business day after December 15 if December 15 falls on a weekend or a holiday, of each year, the Department shall make grants to eligible units subject to all of the following limitations:

(1) A grant to an applicant who is required to match the grant with non-State funds may not exceed twenty-five thousand dollars ($25,000), and a grant to an applicant who is not required to match the grant with non-State funds may not exceed three thousand dollars ($3,000).

(2) An applicant whose liquid assets, when combined with the liquid assets of any corporate affiliate or subsidiary of the applicant, are more than one thousand dollars ($1,000) shall match the grant on a dollar-for-dollar basis with non-State funds.

(3) The grant may be used only for equipment purchases or capital expenditures.

(4) An applicant may receive no more than one grant per fiscal year.

(5) The grant may be used only for purposes related to services that the unit is authorized to provide.

In awarding grants under this section, the Department shall to the extent possible select applicants from all parts of the State based upon ~~need, subject to the following priority order: (i) rescue units, (ii) rescue/EMS units, (iii) EMS units that are licensed as EMS providers under G.S. 131E-155.1, and, finally, (iv) EMS units that are volunteer fire departments that are a part of a county's EMS system plan.~~need. Up to two percent (2%) of the Fund may be used for additional staff and resources to administer the Fund in each fiscal year. In addition, notwithstanding G.S. 58-78-20, up to four percent (4%) of the Fund may be used for additional staff and resources for the North Carolina Fire and Rescue Commission."

SECTION 2.2. Subsections (e) and (f) of G.S. 58-92-20 read as rewritten:

"(e) For each brand style listed in a certification, a manufacturer shall pay to the Commissioner a fee of two hundred fifty dollars ($250.00). The Commissioner may annually adjust this fee to ensure it defrays the actual costs of the processing, testing, enforcement, fire safety, and oversight activities required by this Article.

(f) There is established in the State treasury a separate, nonreverting fund to be known as the "Fire Safety Standard and Firefighter Protection Act Enforcement Fund." The fund shall consist of all certification fees submitted by manufacturers and shall, in addition to any other monies made available for such purpose, be available to the Commissioner solely to support processing, testing, enforcement, and oversight activities under this Article. For the purposes of this Article, fire safety shall include community education and outreach, and the provision and installation of fire safety devices in high-risk and high-need locations throughout the State."

SECTION 2.3. The Office of State Fire Marshal, Department of Insurance, shall study, in consultation with the North Carolina State Firemen's Association, the North Carolina Association of Fire Chiefs, the North Carolina Association of Rescue and Emergency Medical Services, the North Carolina League of Municipalities, and the North Carolina Association of County Commissioners, and make recommendations regarding the issue of declining recruitment and retention of volunteer firefighters in North Carolina to the General Assembly on or before the

convening of the 2018 Legislative session. The recommendations shall include at least the following:

(a) Assessment of existing programs, initiatives, and efforts to increase the number of volunteer firefighters protecting their communities across the State.

(b) Assessment of other states' programs, initiatives, and efforts to increase the number of volunteer firefighters protecting their communities.

(c) Consideration of financial incentive programs that may be offered to encourage increased volunteer firefighter participation rates, including tax incentives, rebates, or other initiatives.

(d) The impact of current programs and viability of expansion of high school based programs providing firefighter training statewide.

(e) Other issues, initiatives, or matters deemed relevant to consideration of and action on this issue by Office of State Fire Marshall and its collaborators.

(f) Recommendations for legislative action, if any, to address the issue of recruitment and retention of volunteer firefighters statewide.

PART III. ANTI-FRAUD AND CRIMINAL PROVISIONS

SECTION 3.1. 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 F 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 3.2.(a) G.S. 58-2-164 reads as rewritten:

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

(1) "Applicant" means one or more persons applying for the issuance or renewal of an auto insurance ~~policy.~~policy on which the person or persons will be a named insured.

(2) "Auto insurance" means both nonfleet and other than nonfleet private passenger motor vehicle insurance.

(3) "Eligible ~~applicant~~"risk" means a person who is an eligible risk ~~under G.S. 58-37-1(4a).~~as defined in either G.S. 58-37-1(4) or G.S. 58-37-1(4a).

(4) "Insurer" means ~~a member of the North Carolina Rate Bureau~~an insurance company that is licensed to write and is writing auto insurance in this State.

(5) "Nonfleet" means a motor vehicle as defined in G.S. 58-40-10(2).

~~(6)~~(5a) "Principal place of business" means the single physical location from which the majority of the essential operations of the applicant's business are directed and controlled. The location of a consultant, service agent, or attorney of the applicant shall not be sufficient to establish an applicant's principle place of business.

(6) "Private passenger motor vehicle" means a motor vehicle as defined in G.S. 58-40-10(1).

(b) It shall be a Class 3 misdemeanor for any person who, with the intent to deceive an insurer, does any of the following:

(1) ~~Present or cause~~ Presents or causes to be presented a written or oral statement in support of an application for issuance of or amendment to a policy of auto insurance or for vehicle registration pursuant to G.S 20-52(a)(4) and (a)(5), knowing that the application contains false or misleading information that states the applicant is an eligible risk when the applicant is not an eligible risk.

(2) ~~Assist, abet, solicit, or conspire~~ Assists, abets, solicits, or conspires with another person to prepare or make any written or oral statement that is intended to be presented to an insurer in connection with or in support of an application for issuance of or amendment to a policy of auto insurance or for vehicle registration pursuant to G.S. 20-52(a)(4) and (a)(5), if the person knows that the statement contains false or misleading information that states the applicant is an eligible risk when the applicant is not an eligible risk.

In addition to any other penalties authorized by law, a violation of this subsection may be punishable by a fine of not more than one thousand dollars ($1,000) for each violation.

(b1) It shall be a Class H felony for any person who, with the intent to deceive an insurer, knowingly violates G.S. 58-2-164(b) for the purpose of obtaining auto insurance covering one or more vehicles, the operation of which requires a Commercial Driver's License pursuant to G.S. 20-4.01(3c).

In addition to any other penalties authorized by law, a violation of this subsection may be punishable by a fine of not more than ten thousand dollars ($10,000) for each violation.

(c) The insurer and its agent shall also take reasonable steps to verify that the information provided by an applicant regarding the applicant's address and the place the motor vehicle is garaged is correct. The insurer may take its own reasonable steps to verify residency or eligible risk status or may rely upon the agent verification of residency or eligible risk status to meet the insurer's verification obligations under this section. The agent shall retain copies of any items obtained under this section as required under the record retention rules adopted by the Commissioner and in accordance with G.S. 58-2-185. The agent may satisfy the requirements of this section by obtaining from the applicant reliable proof of North Carolina residency ~~from the applicant or the~~ and the applicant's status as an eligible risk. ~~Reliable proof of residency or eligible risk includes but is not limited to:~~

(c1) To the extent relevant to a particular criterion for eligible risk status and for the purpose of obtaining nonfleet private passenger motor vehicle insurance, reliable proof of North Carolina residency or eligible risk status includes one or more of the following:

~~(1) A pay stub with the payee's address.~~

(2) A utility bill in the name of the applicant showing the ~~address of the applicant-payor.~~applicant's current North Carolina address.

~~(3) A lease for an apartment, house, modular unit, or manufactured home with a North Carolina address signed by the applicant.~~

(4) A receipt for personal property taxes ~~paid.~~paid by the applicant within the preceding twelve month period and showing the applicant's current North Carolina address.

(5) A receipt for real property taxes paid by the applicant to a North Carolina ~~locality.~~locality within the preceding twelve month period and showing the applicant's current North Carolina address.

~~(6) A monthly or quarterly financial statement from a North Carolina regulated financial institution.~~

(7) A valid unexpired North Carolina driver's ~~license.~~license issued to the applicant and showing the applicant's current North Carolina address.

(8), (9) Repealed by Session Laws 2015-294, s. 13, effective January 1, 2016, and applicable to insurance policies entered into on or after that date.

(10) A valid North Carolina vehicle ~~registration.~~registration issued to the applicant and showing the applicant's current North Carolina address.

(11) A valid military ID.

(12) A valid student ID of the applicant for a North Carolina school or university.

(13) A Federal Income Tax Return filed by the applicant for the most recent prior filing period showing the applicant's name and current North Carolina address.

(14) A homeowner's or renter's declarations page showing the applicant's current North Carolina address.

(c2) To the extent relevant to a particular criteria for eligible risk status and for the purpose of obtaining other than nonfleet private passenger motor vehicle insurance, reliable proof of North Carolina residency or eligible risk status includes two or more of the following:

(1) A utility bill in the name of the applicant showing a North Carolina address for the principal place of business of the applicant.

(2) A receipt for real property taxes paid by the applicant to a North Carolina locality within the preceding twelve month period and showing the applicant's current North Carolina address.

(3) A valid North Carolina vehicle registration issued to the applicant and showing the applicant's current North Carolina address.

(4) A Federal Income Tax Return filed by the applicant for the most recent prior filing period showing the applicant's name and current North Carolina address.

...

(f) Every insurer shall maintain safeguards within its auto insurance business at the point of sale, renewal, and claim to identify misrepresentations by applicants regarding their ~~addresses~~ addresses, their principal places of business, and the places their motor vehicles are garaged. Identified misrepresentations are subject to the requirements of Article 2 of this Chapter.

(g) If an applicant provides false ~~and~~ or misleading information ~~as~~ material to the applicant's or any named insured's status as an eligible ~~applicant~~ risk and that fraudulent information makes the applicant or any named insured appear to be an eligible ~~applicant~~ risk when that person is in fact not an eligible ~~applicant,~~ risk, the insurer may do any or all of the following:

(1) Refuse to ~~issue~~ issue, amend, or endorse a policy.

(2) Cancel or refuse to renew a policy that has been issued.

(3) Deny coverage for any claim ~~arising out of bodily injury or property damage suffered by the applicant.~~by the applicant for auto liability, comprehensive, or collision coverage. This subdivision does not apply to bodily injury or property damage claims of innocent third ~~parties.~~parties to the extent of any minimum financial responsibility requirement of state or federal law.

(g1) Any motor vehicle liability policy may provide that the insured shall reimburse the insurer for any payment made under a policy of insurance if the issuance of the policy was induced by a knowing and material misrepresentation of facts relating to the insured's status as an eligible risk. For purposes of this subsection, a payment made shall include any sums paid for satisfaction, in whole or in part, of any judgment against the insured or for a reasonable settlement of a claim against the insured for bodily injury or property damage. A payment made shall further include any costs or attorneys' fees incurred by the insurer in the adjustment, investigation, or defense of a claim.

(h) In a civil cause of action for recovery under subsection (g1), a conviction of the defendant for a violation of G.S. 58-2-164(b) or (b1) ~~based upon a claim for which a defendant has been convicted under this section, the conviction~~ may be entered into evidence against the defendant and shall establish the liability of the defendant as a matter of law for ~~such~~ damages, fees, or costs as may be proven. ~~The court may award the prevailing party compensatory damages including but not limited to any costs, losses, expenses, and attorneys' fees incurred in connection with any false statement of eligible risk status made in an application for insurance or incurred in connection with any claim submitted under a policy obtained as a result of a false statement of status as an eligible risk, attorneys' fees, costs, and reasonable investigative costs.~~ If the prevailing party can demonstrate that the defendant has engaged in a pattern of violations of this section, the court may award treble damages.

SECTION 3.2.(b) G.S. 58-37-1 reads as rewritten:

"**§ 58-37-1. Definitions.**

As used in this Article:

...

(4a) "Eligible risk," for the purpose of nonfleet private passenger motor vehicle insurance, means:

a. A resident of this State who owns a motor vehicle registered or principally garaged in this State;

b. A resident of this State and who has a valid driver's license issued by this State;

c. A person who is required to file proof of financial responsibility under Article 9A or 13 of Chapter 20 of the General Statutes in order to register his or her vehicle or to obtain a driver's license in this State;

d. A nonresident of this State who owns a motor vehicle registered and principally garaged in this State;

e. A nonresident of the State who is one of the following:

1. A member of the Armed Forces of the United States stationed in this State, or deployed outside this State from a home base in this State, who intends to return to his or her home state;

2. The spouse of a nonresident member of the Armed Forces of the United States stationed in this State, or deployed outside this State from a home base in this State, who intends to return to his or her home state;

3. An out-of-state student who intends to return to his or her home state upon completion of his or her time as a student enrolled in school in this State; or

f. The State and its agencies and cities, counties, towns, and municipal corporations in this State and their agencies.

However, no person shall be deemed an eligible risk if timely payment or premium is not tendered or if there is a valid unsatisfied judgment of record against the person which the person has not been discharged from paying, for recovery of amounts due ~~for motor~~ for:

1. Motor vehicle insurance ~~premiums~~ premiums; or

2. Payments recoverable under a policy provision authorized by G.S.58-2-164(g1).

Further, no person shall be deemed an eligible risk ~~and the person has not been discharged from paying the judgment or~~ if the person does not furnish the information necessary to effect insurance.

..."

PART IV. CAPTIVE INSURANCE LAW PROVISIONS

SECTION 4.1.(a) G.S. 58-10-340 reads as rewritten:

"**§ 58-10-340. Definitions.**

The following definitions apply in this Part:

(1) ~~Affiliate or affiliated company. – Any person in the same corporate system as a parent, an industrial insured, a member organization, or a participant by virtue of common ownership, control, operation, or management.~~ An "affiliate" of or person "affiliated" with a specific person. – Defined in G.S. 58-19-5.

...

(11) ~~Control, controlling, controlled by, or under common control with.~~ Control – Defined in G.S. 58-19-5.~~The possession, direct or indirect, 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; provided that such power is not the result of an official position or corporate office held by the person. Control shall be presumed to exist if a 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 another person. This presumption may be rebutted by a showing that control does not exist.~~ Notwithstanding this definition, for purposes of this Part, the fact that an SPFC exclusively provides reinsurance to a ceding insurer under an SPFC contract is not by itself sufficient grounds for a finding that the SPFC and ceding insurer are under common control.

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

~~a. The person is not an affiliate.~~

~~b. The person has an existing contractual relationship with an affiliate.~~

~~c. The person's risks are managed by, a captive insurance company, an affiliate of a captive insurance company, a participant, or an affiliate of a participant in accordance with G.S. 58-10-470.~~

...

(20) Industrial insured captive insurance company. - Any company that insures risks of the industrial insureds that comprise the industrial insured group and that may insure the risks of the affiliated companies of the industrial insureds ~~and the risks of the controlled unaffiliated business of an industrial insured or its affiliated companies~~.

...

(28) Parent. - ~~An individual, corporation, limited liability company, partnership, association, or other entity, or individual~~ A person that directly or indirectly controls a captive insurance company.

(29) Participant. - Any person and any affiliate ~~or any controlled unaffiliated business~~ of such person that is insured by a protected cell captive insurance company, where the losses of the participant are limited through a participant contract.

...

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

..."

SECTION 4.1.(b) G.S. 58-10-345 reads as rewritten:

"**§ 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:

(1) No pure captive insurance company shall insure any risks other than those of its parent and affiliated companies ~~or a controlled unaffiliated business or businesses~~.

(2) No association captive insurance company shall insure any risks other than those of its association, those of the member organizations of its association, and those of a member organization's affiliated companies.

(3) No industrial insured captive insurance company shall insure any risks other than those of the industrial insureds that comprise the industrial insured group and those of their affiliated companies~~, and those of the controlled unaffiliated business of an industrial insured or its affiliated companies~~.

...

(b) No captive insurance company shall transact any insurance business in this State unless:

(1) It obtains a license from the Commissioner pursuant to subsection (c) of this section authorizing it to do insurance business in this State.

(2) Its board of directors or committee of managers or, in the case of a reciprocal insurer, its subscribers' advisory committee holds at least one meeting each year in this State. A captive insurance company will be exempt from this board meeting requirement if the captive insurance company utilizes the services of at least two (2) of the following North Carolina-based service providers:

a. Legal
b. Accounting
c. Actuarial
d. Investment advisor
e. Captive manager
f. Other service providers acceptable to the Commissioner

(3) It maintains its principal place of business in this State.

(4) It appoints a registered agent to accept service of process and to otherwise act on its behalf in this State, provided that whenever such registered agent cannot with reasonable diligence be found at the registered office of the captive insurance company, the Commissioner shall be an agent of such captive insurance company upon whom any process, notice, or demand may be served and such service shall be done in accordance with G.S. 58-16-30.

(c) In order to receive a license to issue policies of insurance as a captive insurance company in this State, an applicant business entity shall meet all of the following requirements:

(1) The applicant business entity shall submit its organizational documents to the Commissioner. If the Commissioner approves the organizational documents, then the Commissioner shall issue a certificate to the applicant business entity certifying the Commissioner's approval. The applicant business entity shall submit the organizational documents, along with a copy of the certificate of approval issued by the Commissioner, and the required filing fees for organizational documents prescribed by North Carolina law to the Secretary of State for filing. Upon filing the organizational documents, the Secretary of State shall issue a certificate of filing to the applicant business entity. The applicant business entity shall submit a copy of the certificate of filing relative to the applicant business entity's organizational documents issued by the Secretary of State to the Commissioner.

(2) The applicant business entity shall file a statement under oath of its president and secretary showing its financial condition.

(3) The applicant business entity shall file its plan of operation.

(4) The applicant business entity shall file other documents as required by the Commissioner.

(5) The applicant business entity shall also file with the Commissioner evidence of all of the following:

a. The ~~amount and~~ liquidity of ~~its assets~~ the captive insurance company is sufficient relative to the risks to be ~~assumed~~ insured.
b. The adequacy of the expertise, experience, and character of the person or persons who will manage it.
c. The overall soundness of its plan of operation.
d. The adequacy of the loss prevention programs of its insureds.

e. Such other factors deemed relevant by the Commissioner in ascertaining whether the applicant business entity will be able to meet its policy obligations.

(6) No less than the amount required by G.S. 58-10-370, in a form acceptable to the Commissioner, shall be paid into the applicant business entity.

(7) The applicant business entity shall submit to the Commissioner for approval a description of the coverages, deductibles, coverage limits, and rates, together with such additional information as the Commissioner may require.

...

(g) The Commissioner is authorized to retain legal, financial, and ~~examination~~ audit services from outside the Department, the costs of which shall be reimbursed by the applicant business entity. G.S. 58-2-160 shall apply to ~~examinations,~~ audits, investigations, and processing conducted under the authority of this section.

...

(i) A business entity incorporated, formed, or organized under the laws of another jurisdiction that is licensed as a captive insurance company under the provisions of this Part shall have the privileges and be subject to the provisions of the laws of this State or the laws of such other jurisdiction, as applicable, under which such business entity is incorporated, formed, or organized. In the event of a conflict between the provisions of the laws of this State and the laws of such other jurisdiction under which such business entity is incorporated, formed or organized, the provisions of this Part shall control."

SECTION 4.1.(c) Article 10 of Chapter 58 of the General Statutes is amended by adding a new Section to read:

"**§ 58-10-347. Provisional approval for a license.**

(a) At the Commissioner's discretion, provisional approval for a license may be granted to an applicant business entity for a period not to exceed ninety (90) days.

(b) An applicant business entity may petition the Commissioner to extend the provisional time provided the petition is received in writing not less than ten (10) days before expiration of the provisional time and provides sufficient detail to permit the Commissioner to make an informed decision.

(c) Extensions may be granted by the Commissioner for 30-day periods upon a showing by the applicant business entity of the reasons for requesting an extension and a determination by the Commissioner of good cause for the extension.

(d) As a condition precedent to provisionally approving a license under this section, the applicant business entity shall have filed an application required by this Part and the Commissioner shall have made a preliminary finding that the expertise, experience, and character of the person or persons who will control and manage the applicant business entity are acceptable.

(e) The Commissioner may limit the authority of any provisional licensee in any way deemed necessary.

(f) The Commissioner may rescind the provisional approval at any time if the Commissioner determines that the interests of insureds or the public are at risk.

(g) If the applicant business entity fails to complete the license application process, the provisional approval shall terminate automatically."

SECTION 4.1.(d) G.S. 58-10-350 reads as rewritten:

"**§ 58-10-350. Commissioner use of consultants and other professionals.**

The Commissioner may contract with consultants and other professionals to expedite and complete the application process, ~~examinations~~ audits, and other regulatory activities required pursuant to this Part. Such contracts for financial, legal, ~~examination~~ audit, and other services shall not be subject to any of the following:

(1) G.S. 114-2.3.

(2) G.S. 147-17.

(3) Articles 3, 3C, and 8 of Chapter 143 of the General Statutes, together with rules and procedures adopted under those Articles concerning procurement, contracting, and contract review."

SECTION 4.1.(e) G.S. 58-10-355 reads as rewritten:

"**§ 58-10-355. Organizational ~~examination~~ audit.**

In addition to the processing of the application, an organizational investigation or ~~examination~~ audit may be performed before an applicant business entity is licensed. Such investigation or ~~examination~~ audit shall consist of a general survey of the 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."

SECTION 4.1.(f) G.S. 58-10-370 reads as rewritten:

"**§ 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:

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

(2) In the case of an association captive insurance company, not less than five hundred thousand dollars ($500,000).

(3) In the case of an industrial insured captive insurance company, not less than five hundred thousand dollars ($500,000).

(4) In the case of a risk retention group, not less than one million dollars ($1,000,000).

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

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

(b) The Commissioner may prescribe additional capital and surplus based upon the type, volume, and nature of insurance business to be transacted.

(c) Capital and surplus required by subsections (a) and (b) of this section shall be in the form of cash, securities approved by the Commissioner, a clean irrevocable letter of credit issued by a bank approved by the Commissioner, or other form approved by the Commissioner."

SECTION 4.1.(g) G.S. 58-10-380 reads as rewritten:

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

...

(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 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.

..."

SECTION 4.1.(h) G.S. 58-10-390(a) reads as rewritten:

"**§ 58-10-390. Conflict of interest.**

"(a) Each captive insurance company ~~chartered~~ licensed in this State is required to adopt a conflict of interest statement for officers, directors, and key employees. Such statement shall

disclose that the individual has no outside commitments, personal or otherwise, that would divert him or her from his or her duty to further the interests of the captive insurance company he or she represents, but this shall not preclude such person from being a director or officer in more than one insurance company."

SECTION 4.1.(i) G.S. 58-10-395 reads as rewritten:

"**§ 58-10-395. ~~Change of business.~~Plan of operation change.**

(a) Any material change in a captive insurance company's ~~business~~ plan of operation that was filed with the Commissioner at the time of initial application and any subsequent amendment of the plan requires prior approval from the Commissioner.

..."

SECTION 4.1.(j) G.S. 58-10-400 reads as rewritten:

"**§ 58-10-400. Insurance manager and intermediaries.**

No person shall act in or from this State as a managing general agent, producer, or reinsurance intermediary for captive insurance company business without the authorization of the Commissioner."

SECTION 4.1.(k) G.S. 58-10-405 reads as rewritten:

"**§ 58-10-405. Annual reports.**

(a) No captive insurance ~~companies~~ company shall be required to make any annual report to the Commissioner except as provided in this Part.

(b) Prior to March 15 of each year, each captive insurance company shall submit to the Commissioner a report of its financial 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~~ an 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.

...

(f) Extensions of the due date for filings required by this section may be granted by the Commissioner for 30-day periods upon a showing by the captive insurance company of the reasons for requesting an extension and determination by the Commissioner of good cause for the extension. The request for extension must be received in writing not less than 10 days before the due date and in sufficient detail to permit the Commissioner to make an informed decision with respect to the requested extension."

SECTION 4.1.(l) G.S. 58-10-415 reads as rewritten:

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

...

(c) Captive insurance companies with less than one million two hundred thousand dollars ($1,200,000) in written premium may make a written request for exemption from the annual audit requirement. Such request must be made at least 90 days prior to the captive insurance company's fiscal year-end or as otherwise required by the Commissioner. Requests will be considered on a case-by-case basis and may be subject to the Commissioner receiving an annual audit of the

captive insurance company's parent ~~company~~ in lieu of the annual audit of the captive insurance company.

(c1) Extensions of the due dates for filings required by this section may be granted by the Commissioner for 30-day periods upon a showing by the captive insurance company ~~and its independent certified public accountant~~ of the reasons for requesting an extension and determination by the Commissioner of good cause for the extension. The request for extension must be received in writing not less than 10 days before the due date and in sufficient detail to permit the Commissioner to make an informed decision with respect to the requested extension.

(c2) G.S. 58-10-345(f) shall apply to all information filed pursuant to this section.

(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~~ an other comprehensive basis of accounting, with useful or necessary modifications or adaptations required, 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 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 and will comply with the responsibilities imposed by G.S. 58-10-420(b) and G.S. 58-10-420(c).

(3) Deleted

(4) Deleted

(5) Deleted

..."

SECTION 4.1.(m) G.S. 58-10-420 reads as rewritten:

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

...

(c) A captive insurance company shall require its independent certified public accountant to make available for review by the Commissioner or his or her appointed agent the work papers prepared in the conduct of the audit of the captive insurance company. The captive insurance company shall require that the independent certified public accountant retain the audit work papers for a period of not less than five years after the period reported upon. The aforementioned review by the Commissioner shall be considered an ~~examination~~ audit, and all working papers obtained during the course of such ~~examination~~ audit shall be confidential. The captive insurance company shall require that the independent certified public accountant provide copies, in such form as the

Commissioner deems appropriate, of any of the working papers which the Commissioner considers relevant. Such working papers may be retained by the Commissioner. "Work papers" as referred to in this section include, but are not necessarily limited to, schedules, analyses, reconciliations, abstracts, memoranda, narratives, flow charts, copies of captive insurance company records, or other documents prepared or obtained by the independent certified public accountant and the independent certified public accountant's employees in the conduct of their audit of the captive insurance company.

(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 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; and

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

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

..."

SECTION 4.1.(n) G.S. 58-10-430 reads as rewritten:

"**§ 58-10-430. ~~Examinations.~~ Audits.**

(a) Whenever the Commissioner determines it to be prudent, the Commissioner shall ~~examine~~ audit 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~~ audit shall be paid by the captive insurance company.

(b) G.S. 58-2-160 shall apply to ~~examinations~~ audits conducted under this section.

(c) All ~~examination~~ audit reports, preliminary ~~examination~~ audit reports or results, working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the Commissioner or any other person in the course of an ~~examination~~ audit made under this section are confidential, are not subject to subpoena, and may not be made public by the Commissioner or an employee or agent of the Commissioner. Nothing in this subsection shall prevent the Commissioner from using such information in furtherance of the Commissioner's regulatory authority under this Chapter. The Commissioner shall have the discretion to grant access to such information to public officials having jurisdiction over the regulation of insurance in any other state or country or to law enforcement officers of this State or any other state or agency of the federal government at any time only if the officials receiving the information agree in writing to maintain the confidentiality of the information in a manner consistent with this subsection.

(d) Risk retention groups are not subject to this section and shall instead be ~~examined~~ audited in accordance with the Examination Law, G.S. 58-2-131 through G.S. 58-2-134."

SECTION 4.1.(o) G.S. 58-10-432 reads as rewritten:

"**§ 58-10-435. License suspension or revocation.**

(a) The license of a captive insurance company may be suspended or revoked if the Commissioner finds, upon ~~examination~~ audit, hearing, or other evidence, that a captive insurance company has committed one or more of the violations described in subdivisions (1) through (7) of this subsection, or met any of the criteria in subdivisions (8) through (10) of this subsection, and that the suspension or revocation is in the best interest of the public and the policyholders of such captive insurance company, notwithstanding any other provision of this Chapter:

(1) Insolvency or impairment of capital or surplus.

(2) Failure to meet the requirements of G.S. 58-10-370.

(3) Refusal or failure to submit an annual report, as required by this Part, or any other report or statement required by law or by lawful order of the Commissioner.
(4) Failure to comply with its own charter, bylaws, or other organizational document.
(5) Failure to submit to or pay the cost of an ~~examination~~ audit or any legal obligation relative to an ~~examination~~ audit, as required by this Part.
(6) Use of methods that, although not otherwise specifically prohibited by law, nevertheless render its operation detrimental or its condition unsound with respect to the public or to its policyholders.
(7) Failure otherwise to comply with the laws of this State.
(8) Failure to commence business according to its plan of operation within two years of being licensed.
(9) Failure to carry on insurance business in or from this State.
(10) By request of the captive insurance company.

..."

SECTION 4.1.(p) G.S. 58-10-440(c) reads as rewritten:

§ 58-10-440. Investment requirements.

"(c) No captive insurance company or protected cell shall make a loan to or an investment in ~~its parent company, an affiliated company~~ affiliate, ~~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."

SECTION 4.1.(q) G.S. 58-10-470 is repealed.

SECTION 4.1.(r) Article 10 of Chapter 58 of the General Statutes is amended by adding a new Section to read:

"**§ 58-10-496. Waiver or Modification.**

The Commissioner may waive or modify any provision of this Part if such waiver or modification, in the Commissioner's opinion is justified, based on sound actuarial, or accounting or business principles, and does not diminish the solvency prospects of the captive insurance company. No waiver or modification granted by the Commissioner pursuant to this section shall result in a greater regulatory burden than imposed by this Part prior to the exercise of such waiver or modification."

SECTION 4.1.(s) G.S. 58-10-505 reads as rewritten:

"**§ 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:

(1) Materials demonstrating how the applicant will account for the loss and expense experience of each protected cell at a level of detail found to be sufficient by the Commissioner, and how it will report such experience to the Commissioner.
(2) A statement acknowledging that all records of the applicant, including records pertaining to any protected cells, shall be made available for inspection or ~~examination~~ audit by the Commissioner or the Commissioner's designated agent.
(3) All contracts or sample contracts between the applicant business entity and any participants.
(4) A statement describing how expenses shall be allocated to each protected cell in a fair and equitable manner."

SECTION 4.1.(t) G.S. 58-10-510 reads as rewritten:

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

(a) A protected cell captive insurance company 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:

(1) A protected cell captive insurance company may establish one or more protected cells if the Commissioner has approved in writing a plan of operation or amendments to a plan of operation submitted by the protected cell captive insurance company with respect to each protected cell. A plan of operation shall include, but is not limited to, the specific business objectives and investment guidelines of the protected cell, provided that the Commissioner may require additional information in the plan of operation.

(2) Upon the Commissioner's written approval of the plan of operation, the protected cell captive insurance company may attribute insurance obligations with respect to its insurance business to the protected cell in accordance with the approved plan of operation.

(3) A protected cell shall have its own distinct name or designation that shall include the words "protected cell" or "incorporated cell."

(4) The protected cell captive insurance company shall transfer all assets attributable to a protected cell to one or more separately established and identified protected cell accounts bearing the name or designation of that protected cell. Protected cell assets must be held in the protected cell accounts for the purpose of satisfying the obligations of that protected cell.

(5) Deleted

(6) All attributions of assets and liabilities between a protected cell and the general account shall be in accordance with the plans of operation and participant contracts approved by the Commissioner. Any attribution of assets between the general account and a protected cell shall be in cash or in readily marketable securities with established market values unless otherwise approved by the Commissioner.

...

(l1) In lieu of filing a separate Statement of Actuarial Opinion for a protected cell captive insurance company and each protected cell, a protected cell captive insurance company may file a combined Statement of Actuarial Opinion which shall include a statement of actuarial opinion for each protected cell, and the core, if the core is retaining risk. The combined Statement of Actuarial Opinion shall include a supplemental schedule showing the loss and loss expense reserves for each protected cell and the core, if the core is retaining risk. The loss and loss expense reserve reported in the supplemental schedule must equal the loss and loss expense reserve amount reported in the audited financial statement and the annual report submitted pursuant to this Part.

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

...

(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 insurance company into which the protected cell converts.

..."

SECTION 4.1.(u) G.S. 58-10-515(d) reads as rewritten:

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

"(d) 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."

SECTION 4.1.(v) G.S. 58-10-525 reads as rewritten:

"§ 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 and to each 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, including assets and liabilities attributed to protected cells, pursuant to this Part.

(c) Notwithstanding Article 30 of this Chapter:

(1) No assets of a protected cell shall be used to pay any expenses or claims other than those attributable to such protected cell.

(2) ~~A~~ Subject to G.S. 58-10-512(f), a protected cell captive insurance company's capital and surplus shall at all times be available to pay any expenses of, or claims against, the protected cell captive insurance company."

SECTION 4.1.(w) G.S. 58-10-550 reads as rewritten:

"§ 58-10-550. ~~Examination~~ Audit of a branch captive insurance company.

(a) Any ~~examination~~ audit of a branch captive insurance company pursuant to G.S. 58-10-430 shall be of branch business and branch operations only so long as the branch captive insurance company files annually with the Commissioner a certificate of compliance, or its equivalent, issued by or filed with the licensing authority of the jurisdiction in which the branch captive insurance company is formed, and demonstrates to the Commissioner's satisfaction that it is operating in sound financial condition in accordance with all applicable laws and regulations of such jurisdiction.

(b) As a condition of licensure, an alien captive insurance company shall grant authority to the Commissioner for ~~examination~~ audit of the affairs of the alien captive insurance company in the jurisdiction in which the alien captive insurance company is formed."

SECTION 4.1.(x) G.S. 58-10-565 reads as rewritten:

"§ 58-10-565. Application requirements.

...

(d) In addition to the information required by subsection (c) of this section and by G.S. 58-10-585, when a protected cell is used, an applicant SPFC shall file with the Commissioner:

(1) A business plan demonstrating how the applicant SPFC accounts for the loss and expense experience of each protected cell at a level of detail found to be sufficient by the Commissioner and how the applicant will report the experience to the Commissioner.

(2) A statement acknowledging that all records of the SPFC, including records pertaining to any protected cells, must be made available for inspection or ~~examination~~ audit by the Commissioner.

(3) All contracts or sample contracts between the SPFC and any counterparty related to each protected cell.

(4) A description of the expenses allocated to each protected cell.

...

(h) The Commissioner may retain legal, financial, and ~~examination~~ audit services from outside the Department to ~~examine~~ audit and investigate the application, the cost of which may be charged against the applicant. The Commissioner also may use internal resources to ~~examine~~ audit and investigate the application based upon an hourly rate for the services performed or the usual and customary fee charged by the financial services industry for similar work subject to a minimum fee of twelve thousand dollars ($12,000), six thousand dollars ($6,000) of which is payable upon filing of the application and the remainder upon licensure.

..."

SECTION 4.1.(y) G.S. 58-10-585 reads as rewritten:

"**§ 58-10-585. Establishment of protected cell accounts.**

...

(c) No SPFC contract with or attributable to a protected cell shall take effect without the Commissioner's prior written approval, and the addition of each new protected cell constitutes a change in the business plan requiring the Commissioner's prior written approval. The Commissioner may retain legal, financial, and ~~examination~~ audit services from outside the Department to ~~examine~~ audit and investigate the application for a protected cell, the cost of which may be charged against the applicant, or the Commissioner may use internal resources to ~~examine~~ audit and investigate the application, the cost of which may be charged against the applicant, or both.

..."

SECTION 4.1.(z) G.S. 58-10-625 reads as rewritten:

"**§ 58-10-625. Changes in plan of operation; filing of audit and statement of operation; ~~examinations.~~ audits.**

...

(e) An SPFC shall maintain the SPFC's records in this State unless otherwise approved by the Commissioner and shall make its records available for ~~examination~~ audit by the Commissioner at any time. The SPFC shall keep its books and records in such manner that its financial condition, affairs, and operations can be ascertained and so that the Commissioner may readily verify its financial statements and determine its compliance with this Part.

(f) All original books, records, documents, accounts, and vouchers shall be preserved and kept available in this State for the purpose of ~~examination~~ audit and until authority to destroy or otherwise dispose of the records is secured from the Commissioner. The original records, however, may be kept and maintained outside this State if, according to a plan adopted by the management of the SPFC and approved by the Commissioner, the SPFC maintains suitable copies instead of the originals. The books or records may be photographed, reproduced on film, or stored and reproduced electronically."

PART V. ACOS PARTICIPATING IN MEDICARE PROGRAMS

SECTION 5. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-7. Certain accountable care organizations not subject to this Chapter.**

This Chapter shall not apply to any accountable care organization approved by the Centers for Medicare and Medicaid Services (CMS) to participate in Medicare programs established under 42 U.S.C. § 1315a or 42 U.S.C. § 1395jjj. This exemption is limited to the activities performed by the accountable care organization pursuant to its agreement with CMS for participation in Medicare programs established under 42 U.S.C. § 1315a or 42 U.S.C. § 1395jjj."

PART VI. INSURANCE LAW AMENDMENTS, AS RECOMMENDED BY THE DEPARTMENT

SECTION 6.1. The Department shall be authorized to take appropriate action to plan for and establish a private flood insurance market for North Carolina, in the event that the federal government empowers the States to establish and operate such markets.

SECTION 6.2. G.S. 58-36-87 reads as rewritten:

"**§ 58-36-87. ~~(Expires June 30, 2016)~~ Affiliate transfer of policies.**

Delivery by an insurer of a policy superseding a policy previously issued by the insurer at the end of the previously issued policy period is not a refusal to renew when it is delivered by:

(1) The same insurer; or

(2) An affiliate or subsidiary, as those terms are defined in G.S. 58-19-5, that has a financial strength rating, issued by an industry-recognized independent insurance rating company, which financial strength rating is at least as good as the insurer issuing the superseded policy. The provisions of G.S. 58-36-110 and G.S. 58-36-85 apply to the affiliate or subsidiary as if it were the same insurer issuing the policy."

SECTION 6.3. G.S. 58-56A-10(e) reads as rewritten:

§ 58-56A-10. (Effective July, 1 2016) Civil Penalties for violations; administrative procedure.

"(e) Upon petition of the Commissioner the court may order the pharmacy benefits manager who committed a violation specified in subsection (b) of this section to make restitution to the Department for ~~extraordinary~~ administrative expenses, including expenses under subsection (f) of this section, incurred in the investigation, hearing, and any appeals associated with the violation in such amount that would reimburse the agency for the expenses. The petition may be made at any time and also in any appeal of the Commissioner's order."

SECTION 6.4. G.S. 15A-1340.37(d) is repealed.

SECTION 6.5. G.S. 58-37-1 reads as rewritten:

"**§ 58-70-10. Application to Commissioner for permit renewal.**

Any person, firm, corporation or association desiring to renew a permit issued pursuant to G.S. 58-70-5 shall make application to the Commissioner of Insurance not less than 30 days prior to the expiration date of the then current permit. Such renewal applicant shall be entitled to a renewal permit upon submission to the Commissioner of Insurance of all the information as required by G.S. 58-70-5; provided, however, it shall be sufficient, wherever applicable, to reference the prior year's application if there has been no change as to any of the required information and it shall not be necessary to submit with a renewal application a new director's resolution. In addition, the applicant shall submit to the Commissioner a copy of a "continuation certificate" or paid receipt for renewal premiums for the collection agency bond for the year for which the renewal permit is applied. The application shall include a calculation in accordance with G.S. 58-70-20, and if the bond is increased, an endorsement by the surety. With a renewal application, the applicant shall submit a balance sheet for the last fiscal year ending prior to the application, certified true and correct by a corporate officer, partner, or proprietor, setting forth the current assets, fixed assets, current liabilities and positive net worth of the applicant. In calculating its positive net worth under this section, an applicant is not required to include in its balance sheet liabilities from the purchase of stock by or in connection with the applicant's employee stock ownership plan that is qualified under 26 USC §§ 401(a) and 4975(e)(7) or to include in its balance sheet unallocated or unearned shares held in such a qualified employee stock ownership plan."

PART VII. EFFECTIVE DATE

SECTION 7. Section 1.1 of this act becomes effective on October 1, 2017 and applies to accidents that occur on or after that date. Section 1.2 of this act becomes effective October 1, 2017 and applies to policies issued, renewed, or amended on or after that date. Part III of this act becomes effective December 1, 2016. The remainder of this act is effective when it becomes law.

HOUSE BILL 287:
Amend Ins. Laws- AB.

2016-2017 General Assembly

Committee:	Senate Insurance	**Date:**	June 15, 2016
Introduced by:	Reps. Setzer, Bumgardner	**Prepared by:**	Kristen L. Harris
Analysis of:	PCS to Third Edition H287-CSMH-18		Committee Co-Counsel

SUMMARY: ***The Proposed Committee Substitute for House Bill 287 would increase property damage thresholds under the State's Safe Driver Incentive Plan; place a 15% cap on annual premium increases on long-term care insurance policies; appropriate $425,000 for the operation and establishment of a publicly-accessible on-line Building Code; make various updates to Chapter 58's fire and rescue provisions; provide for a study on the reduction in recruitment and retention of volunteer firefighters in North Carolina; increase penalties in Chapter 58's anti-fraud and criminal provisions; make technical and substantive changes to North Carolina's captive insurance laws; authorize the Department to plan for and establish a private flood insurance market; enable third parties, including insurers, to recover restitution from convicted defendants; exempt accountable care organizations participating in Medicare programs from Department regulation; and make various other changes to insurance laws, as recommended by the Department.***

BILL ANALYSIS:

PART I. CONSUMER TRANSPARENCY AND ASSISTANCE PROVISIONS

Section 1.1. would increase the property damage thresholds for major, intermediate, and minor accidents under the State's Safe Driver Incentive Plan. Major accidents previously defined as involving property damage of $3,085 or more would now require property damage of $4,100 or more. Intermediate accidents would now involve property damage between $2,501 and $4,099. Minor accidents would now have $2,500 or less in property damage rather than $1,850 or less.

Section 1.2. would add a new subsection making fifteen percent (15%) of the current rate the most a long-term care insurance policy premium could be increased in any calendar year.

Section 1.3. would create a special fund of $425,000 for the establishment and operation of a publicly-accessible on-line Building Code by the Commissioner, in consultation with the Building Code Council and would direct both the Council and the Department to make recommendations to the General Assembly on or before the 2018 Legislative session about sufficiency of funding and modifications to the Code.

PART II. FIRE AND RESCUE PROVISIONS

Section 2.1.(a) would remove language that requires a fire department to serve 12,000 or less people to be eligible for a grant from the Volunteer Fire Department Fund.

Section 2.1.(b) would remove previous prioritizing methodology used by the Department to provide grants from the Volunteer Rescue/EMS fund. Grants would now be based on need only.

Section 2.2. would define "fire safety" as including "community education and outreach, and the provision and installation of fire safety devices in high-risk and high-need locations throughout the State" and include fire safety as one of the costs covered by the $250.00 paid by a cigarette manufacturer to the Commissioner for each brand style listed in a certification.

Section 2.3. would direct the Office of State Fire Marshall, Department of Insurance, in consultation with other fire, rescue, and state organizations to study the reduction in recruitment and retention of volunteer firefighters in North Carolina and to make recommendations to the General Assembly before the 2018 Legislative session.

PART III. ANTI-FRAUD AND CRIMINAL PROVISIONS

Section 3.1. would increase the penalty from a Class H felony to a Class F felony if an insurance fiduciary causes the cancellation or nonrenewal, with loss of coverage, of a group health or life insurance policy by willfully failing to pay the premiums or fund the plan or to deliver 45 days' notice of his or her intention to stop payment or funding, when the loss of value is $100,000 or more. For losses of less than $100,000, the penalty would remain a Class H felony.

Section 3.2.(a) would amend G.S. 58-2-164. Rate evasion fraud; prevention programs.

- Would amend the definitions of "applicant," "auto insurance," "eligible risk," and "insurer," and add a definition for "principal place of business".
- Would clarify that the Class 3 misdemeanor penalty for providing or assisting in the provision of false or misleading information on an application for auto insurance applies to both an application for issuance of or an amendment to a policy. G.S. 58-2-164(b)
- Would add a new subsection (G.S. 58-2-164(b1)) creating a Class H felony penalty if someone knowingly violates G.S. 58-2-164(b) to obtain auto insurance to cover a vehicle which requires a commercial driver's license. Would also add a possible fine of up to $10,000 per violation.
- Would amend what documentation can be provided to show proof of North Carolina residency or eligible risk status to obtain nonfleet private passenger motor vehicle insurance.
- Would add a new subsection stating what documentation can be provided to show proof of North Carolina residency or eligible risk status to obtain other than nonfleet private passenger motor vehicle insurance.
- Would require false or misleading information provided by an applicant to be material to status as an eligible applicant before insurer could do any of the following:
    - Refuse to issue, amend, or endorse a policy.
    - Deny the applicant coverage for auto liability, comprehensive, or collision coverage. However, an insurer could not deny bodily injury or property damage claims to innocent third parties to the extent of any minimum financial responsibility requirement of state or federal law.
- Would allow a motor vehicle insurance policy to require an insured to reimburse an insurer for any payment made by the insurer if the issuance of the policy was induced by the insured's knowing and material misrepresentation of facts relating to his or her status as an eligible risk.
- Would allow a conviction of G.S. 58-2-164(b) or (b1) to be entered into evidence against a defendant in a civil cause of action.

Section 3.2.(b) would amend the definition of "eligible risk" by stating that a person who owes a payment for reimbursement under G.S. 58-2-164(g1) is not an eligible risk.

PART IV. CAPTIVE INSURANCE LAW PROVISIONS

Part IV contains various technical and substantive changes to the North Carolina Captive Insurance Act. Substantive changes are outlined below by section.

Section 4.1.(b) would amend G.S. 58-10-345. Licensing; authority; confidentiality.

- Would allow a captive insurance company to be exempt from the annual board meeting requirement if the captive insurance company utilizes the services of at least two North Carolina service providers for either legal, accounting, actuarial, investing, captive management, or other services acceptable to the Commissioner.
- Would add a new subsection to enable companies established in other jurisdictions to be licensed as captive insurance companies in North Carolina.

Section 4.1.(c) would add a new section allowing the Commissioner to grant an applicant business entity a 90-day provisional license after the Commissioner has made a preliminary finding that the expertise, experience, and character of the person or persons who will control or manage the applicant business entity are acceptable. The Commissioner may limit the authority of any provisional licensee in any way deemed necessary and rescind the provisional approval at any time.

Section 4.1.(f) would give the Commissioner discretion when setting the minimum capital and surplus requirements for protected cell captive insurance companies applying for licenses.

Section 4.1.(k) would add a new subsection authorizing the Commissioner to grant 30-day extensions to captive insurance companies to file their annual reports upon a showing and finding of good cause for the extension.

Section 4.1.(l) would remove the requirement that, in addition to the captive insurance company, its independent certified public accountant also has to show good reason when a captive requests an extension to file an annual audit.

Section 4.1.(m) would remove the requirement that the Commissioner consider the number of jurisdictions in which the insurer transacts business when considering whether to allow the lead audit partner to serve in that capacity for more than five years.

Section 4.1.(t) would amend G.S. 58-10-510 Establishment of protected cells.

- Would give the Commissioner the discretion to allow assets other than cash and readily marketable securities with established market values to be attributed to protected cells.
- Would add a new subsection allowing an actuary to file one Statement of Actuarial Opinion for a protected cell captive insurance company if it includes required information on a supplemental schedule of loss and loss expense reserves for each protected cell and the core, if the core is retaining risk.
- Would require a protected cell captive insurance company to give notice to the Commissioner if it becomes unable to meet its claim or expense obligations.

Section 4.1.(v) would clarify that the capital and surplus of a protected cell captive insurance company is not available to pay claims or expenses associated with a contract that an incorporated protected cell entered into in its own name and for its own account and which the protected cell captive insurance company is not a party.

PART V. ACOS PARTICIPATING IN MEDICARE PROGRAMS

Section 5 would add a new section stating that accountable care organizations participating in Medicare programs are not regulated by the Department.

PART VI. INSURANCE LAW AMENDMENTS, AS RECOMMENDED BY THE DEPARTMENT

Section 6.1. would authorize the Department to plan for and establish a private flood insurance market in North Carolina pending federal approval under H.R. 2901, the Flood Insurance Market Parity and Modernization Act.

Section 6.2. would remove the sunset provision from law governing affiliate transfer of policies.

Section 6.3. would delete the word "extraordinary" and allow the court to order a pharmacy benefits manager to make restitution to the Department for administrative expenses, rather than extraordinary administrative expenses, if the pharmacy benefits manager violated a provision of Article 56A, Pharmacy Benefits Management.

Section 6.4. would repeal G.S. 15A-1340.37(d) which would enable courts to order convicted defendants to make restitution to third parties, including insurers.

Section 6.5 would clarify that an applicant renewing a permit for a collection agency business would not be required to disclose information related to his or her employee stock ownership plan.

EFFECTIVE DATE: Section 1.1 of this act becomes effective on October 1, 2017 and applies to accidents that occur on or after that date. Section 1.2 of this act becomes effective October 1, 2017 and applies to policies issued, renewed, or amended on or after that date. Part III of this act becomes effective December 1, 2016. The remainder of this act is effective when it becomes law.

*The Department of Insurance contributed to this summary.

HOUSE BILL 287
Committee Substitute Favorable 4/14/15
Committee Substitute #2 Favorable 7/28/15

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, AND INSURANCE COMPANY NAMES; 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; AND TO ALLOW AN ITEMIZED INDIVIDUAL INCOME TAX DEDUCTION FOR INVESTORS WHO INCUR LOSSES FROM CRIMINALLY FRAUDULENT INVESTMENT ARRANGEMENTS.

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 nonstock 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 F 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. 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."

HEALTH INSURANCE PREMIUM RATE REVIEW MODERNIZATION STUDY

SECTION 7.(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 7.(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 7.(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 7.(d) Consultants. – The Commissioner of Insurance may hire consultants to assist the Department in completing its duties under this section.

SECTION 7.(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.

INDIVIDUAL INCOME TAX ITEMIZED DEDUCTION FOR INVESTORS WHO INCUR LOSSES FROM CRIMINALLY FRAUDULENT INVESTMENT ARRANGEMENTS

SECTION 8. G.S. 105-153.5(a) reads as rewritten:

"(a) Deduction Amount. – In calculating North Carolina taxable income, a taxpayer may deduct from adjusted gross income either the standard deduction amount provided in subdivision (1) of this subsection or the itemized deduction amount provided in subdivision (2) of this subsection that the taxpayer claimed under the Code. The deduction amounts are as follows:

...

(2) Itemized deduction amount. – An amount equal to the sum of the items listed in this subdivision. The amounts allowed under this subdivision are not subject to the overall limitation on itemized deductions under section 68 of the Code:

...

c. The amount allowed as a deduction for losses incurred from criminally fraudulent investment arrangements under section 165(c)(2) of the Code."

EFFECTIVE DATE

SECTION 9. Section 4 of this act becomes effective January 1, 2016. Section 8 of this act becomes effective for taxable years beginning on or after January 1, 2014. The remainder of this act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 287

AMENDMENT NO. 1
(to be filled in by
Principal Clerk)

H287-ATU-48 [v.2]

Amends Title [YES]
Third Edition

Date _____,2016

Senator Apodaca

moves to amend the bill on page 1, lines 4-5 by deleting the phrase "TO ESTABLISH A PUBLICLY-ACCESSIBLE ONLINE BUILDING CODE;";

and on page 2, lines 5-38, by deleting Sections 1.3.(a), 1.3.(b), and 1.3.(c) of the bill.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 287

AMENDMENT NO. 2
(to be filled in by Principal Clerk)

H287-ATU-49 [v.1]

Amends Title [NO]
Third Edition

Date _____,2016

Senator Apodaca

moves to amend the bill on page 1, lines 19-34 by rewriting the lines to read:

"**SECTION 1.1.** G.S. 58–36–75(a) reads as rewritten:

"(a) The subclassification plan promulgated pursuant to G.S. 58-36-65(b) may provide for separate surcharges for major, intermediate, and minor accidents. A "major accident" is an at-fault accident that results in either (i) bodily injury or death or (ii) only property damage of ~~three thousand eighty-five dollars ($3,085)~~ three thousand eight hundred fifty dollars ($3,850) or more. An "intermediate accident" is an at-fault accident that results in only property damage of more than ~~one thousand eight hundred fifty dollars ($1,850)~~ two thousand three hundred dollars ($2,300) but less than ~~three thousand eighty-five dollars ($3,085).~~three thousand eight hundred fifty dollars ($3,850). A "minor accident" is an at-fault accident that results in only property damage of ~~one thousand eight hundred fifty dollars ($1,850)~~ two thousand three hundred dollars ($2,300) or less. The subclassification plan may also exempt certain minor accidents from the Facility recoupment surcharge. The Bureau shall assign varying Safe Driver Incentive Plan point values and surcharges for bodily injury in at-fault accidents that are commensurate with the severity of the injury, provided that the point value and surcharge assigned for the most severe bodily injury shall not exceed the point value and surcharge assigned to a major accident involving only property damage."".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 287

AMENDMENT NO. 3
(to be filled in by Principal Clerk)

H287-ATU-47 [v.2]

Amends Title [YES]
H287-CSMH-18

Date _____,2016

Senator Lee

moves to amend the bill on page 1, lines 3-4 by rewriting the lines to read:
"TRANSPARENCY RELATED TO MOTOR VEHICLE MAINTENANCE AND REPAIRS, LONG-TERM CARE INSURANCE, AND CONSENT TO RATE; TO ESTABLISH A PUBLICLY-ACCESSIBLE";

and on page 2, lines 38-39 by inserting the following between those lines:

"**SECTION 1.4.(a)** G.S. 58-36-30 reads as rewritten:
"**§ 58-36-30. Deviations.**

...

(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 14 point type, bolded and underlined:

"NOTICE: THE PREMIUM USING NORTH CAROLINA RATE BUREAU'S APPROVED 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 _____%."

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 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.

..."

SECTION 1.4.(b) 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 shall consider modeled hurricane losses presented by the Rate Bureau.

...."

SECTION 1.4.(c) 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.

...."

and on page 19, lines 43-46, by rewriting the lines to read:

"**SECTION 7.** Section 1.1 of this act becomes effective on October 1, 2017 and applies to accidents that occur on or after that date. Sections 1.2 and 1.4 of this act become effective October 1, 2017 and apply to policies issued, renewed, or amended on or after that date. Part III of this act becomes effective December 1, 2016. The remainder of this act is effective when it becomes law.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. 287 DATE 6/15/10

S. B. No. _____ Amendment No. 4

(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE X

Rep.)
Sen.) Lee

amendment
1 moves to amend ~~the bill on page~~ 3, line 28

2 ( ) WHICH CHANGES THE TITLE

3 by rewriting the line to read:

4 "of or endorsement to the policy. The insurer shall

5 give at least 30 days' notice to the insured

6 for all written".

7

8

9

10

11

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SIGNED _____

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

Senate Pages Attending

COMMITTEE: Insurance ROOM: 1027

DATE: 15 June TIME: 4pm

PLEASE PRINT LEGIBLY!!!!!!!!!!!!!....*or else!!!!!*

Page Name	Hometown	Sponsoring Senator
1. Kelly anne Faulk	Sanford	Rabin
2. Amy Clemmons	Raleigh	~~Rabin~~ Alexander
3. Jordyn Scheitler	Belmont	Harrington
4. Reagan Rushing	Wingate	Tucker
5. Griffin Sullivan	Raleigh	Alexander
6.		
7.		
8.		

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Senate Committee

On

Insurance

June 15, 2016

Room 1027 / 1128, LB

4:00 PM

Senate Sergeant at Arms:

JIM HAMILTON

SHAM PATEL

Senate Committee On Insurance

June 15, 2016 – Room 1027 / 1128 LB – 4:00 PM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Tonya Horton	TSJ
PATRICK HANNAH	LMI
[illegible]	[illegible]
Sarah Balcs	Brooker ASSO.
[illegible]	NMRS
[illegible]	[illegible]
[illegible]	[illegible]
Dave Horne	SA
Susan Valcarcel	NW
Ann LYON	NAIFGEN
[illegible]	[illegible]
R. LANE BROWN II	NCCIA.
Joanna Biliouris	NC Rate Bureau
Mickey Spivey	Young Moore and Henderson PA
Robert PASCHAL	Young Moore
Michelle Frazier	MFS
[illegible]	MFS
Peter Bolac	NC St. Bar

Senate Committee On Insurance

June 15, 2016 – Room 1027 / 1128 LB – 4:00 PM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
TED HAMBY	NC DOI
Fred Fuller	NCDOT
Matt Bl...	BCBSNC
Ken Melton	K.M.A.
Dana Simpson	SA
Kelly Vogel	KV Strategics
Mary Grabarski	SMYTH HEALTH Plan
RAM K CHITTILLA	Intern to sen. Dorsett Chaudhuri
Chris Houghton	MLRC
Rick McIntyre	OSFM - DOI
Carlyle Weaver	Office of the Governor
Tracy Kimbrell	Parker Poe
Rick Zechini	Williams Mullen
Ryan Blankenship	Cone Health

Senate Committee on Insurance
Thursday, June 23, 2016 at 1:00 PM
Room 1027/1128 of the Legislative Building

MINUTES

The Senate Committee on Insurance met at 1:00 PM on June 23, 2016 in Room 1027/1128 of the Legislative Building. Six members were present.

Senator Tom Apodaca, Chair, presided.

SB 865 State Health Plan/Admin Changes/Local Govts. (Senator Sanderson)
Sen. Lee moved to adopt the proposed committee substitute (PCS) to the committee for discussion and it was carried. Sen. Sanderson was asked to introduce the bill. Kristen Harris and attorney with the Legislative Analysis Department also explained the PCS. Sen. Sanderson brought forth and amendment and it was adopted by the committee. Questions from the members were answered by Sen. Sanderson and Kristen Harris. Tom Friedman the Director of Policy, Planning and Analysis. Sen. Hise moved for an unfavorable to the bill – favorable to the PCS as amended and it carried.

SB 815 Charter School in State Health Plan. (Senator Blue)
Sen. McKissick was asked to speak on the bill. Sen. Hise moved for a favorable report and it carried.

The meeting adjourned at 1:14 PM.

Senator Tom Apodaca, Chair
Presiding

Debbie Lown, Committee Clerk

Senate Committee on Insurance
Thursday, June 23, 2016, 1:00 PM
1027/1128 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
SB 815	Charter School in State Health Plan.	Senator Blue

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

INSURANCE COMMITTEE REPORT
Senator Apodaca, Co-Chair
Senator Meredith, Co-Chair

Thursday, June 23, 2016

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

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

SB **865** State Health Plan/Admin Changes/Local Govts.

Draft Number:	S865-PCS45540-TU-28
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Senator Norman W. Sanderson will handle SB 865

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S D

SENATE BILL 865
PROPOSED COMMITTEE SUBSTITUTE S865-CSTU-28 [v.11]
06/22/2016 06:09:54 PM

Short Title: State Health Plan/Admin Changes/Local Govts. (Public)

Sponsors: Senator Sanderson (Primary Sponsor).

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. 135-48.34 reads as rewritten:

"**§ 135-48.34. ~~Contracts not subject to Article 3 of Chapter 143 of the General Statutes.~~Contract exemptions.**

~~The design, adoption, and implementation of the preferred provider contracts, networks, and optional alternative comprehensive health benefit plans, and programs available under the optional alternative plans, as authorized~~Contracts to provide benefits, contracts with providers or provider networks, and contracts for the design, adoption, and implementation of health benefit plans and programs available under health benefits plans, as authorized under G.S. 135-48.2, are not subject to the requirements of Article 3 of Chapter 143 of the General ~~Statutes,~~Statutes or to the requirements of Parts 3 or 4 of Article 15 of Chapter 143B of the General Statues, but are subject to the requirements of G.S. 135-48.33."

SECTION 5. 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 6.(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 6.(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 7. 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 8. 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 9. 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 10. Section 5 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:	Senate Insurance	**Date:**	June 23, 2016
Introduced by:	Sen. Sanderson	**Prepared by:**	Jason Moran-Bates
Analysis of:	PCS to First Edition S865-CSTU-28		Staff Attorney

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. 135-48.34 to exempt contracts between the Plan and various external parties from Parts 3 and 4 of Article 15 of Chapter 143B, which cover oversight of information technology projects and procurement by the Department of Information Technology.

Section 5: 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.

Karen Cochrane-Brown
Director

Legislative Analysis
Division
919-733-2578

Section 6.(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 6.(b). sets forth a schedule for this increase.

Section 7: 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 8: 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 9: 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 5 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 or renewed on or after that date.

David Vanderweide of the Fiscal Research Division substantially contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

SENATE BILL 865

Short Title:	State Health Plan/Admin Changes/Local Govts.	(Public)
Sponsors:	Senators Sanderson (Primary Sponsor); J. Davis and Rabin.	
Referred to:	Insurance	

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. 135-48.32 reads as rewritten:

"**§ 135-48.32. Contracts to provide benefits.**

The Plan benefits shall be provided under contracts between the Plan and the claims processors selected by the Plan. ~~The 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. Claims processor contractors 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.~~"

SECTION 2. G.S. 135-48.34 reads as rewritten:

"**§ 135-48.34. ~~Contracts not subject to Article 3 of Chapter 143 of the General Statutes.~~Contract exemptions.**

~~The design, adoption, and implementation of the preferred provider contracts, networks, and optional alternative comprehensive health benefit plans, and programs available under the optional alternative plans, as authorized~~Contracts to provide benefits, contracts with providers or provider networks, and contracts for the design, adoption, and implementation of health benefit plans and programs available under health benefits plans, as authorized under G.S. 135-48.2, are not subject to the requirements of Article 3 of Chapter 143 of the General ~~Statutes,~~Statutes or to the

requirements of Parts 3 or 4 of Article 15 of Chapter 143B of the General Statues, but are subject to the requirements of G.S. 135-48.33."

SECTION 3. G.S. 135-47(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,~~20,000 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 4. G.S. 135-48.47(b)(3) reads as rewritten:

"(3) A local government unit shall determine the eligibility of its employees and employees' ~~dependents and what portion of the premiums employees will pay to the local government unit.~~dependents. The portion of the employee and employees' dependents premiums paid to the local government unit may be determined by the local government unit but may not exceed the premiums in the structure set by the Plan."

SECTION 5. 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 October 1, 2016."

SECTION 6. 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 6066 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 7. 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, renewed, or amended on or after that date.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 865

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

S865-ATU-52 [v.4]

Amends Title [NO]
S865-CSTU-28

Date _____,2016

Senator Sanderson

moves to amend the bill on page 1, line 8, through page 3, line 14, by deleting the lines;

and on page 4, lines 47-49 by rewriting the lines to read:

"**SECTION 7.** 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.";

and by renumbering the remaining sections accordingly.

SIGNED Norman Sanderson
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2015

Legislative Actuarial Note
Health Benefits

BILL NUMBER: Senate Bill 865 (First Edition)

SHORT TITLE: State Health Plan/Admin Changes/Local Govts.

SPONSOR(S): Senator Sanderson

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

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

BILL SUMMARY: Senate Bill 865 (First Edition) makes several changes to the statutes governing the State Health Plan. The changes in each section are described below.

Section 1: Amends G.S. 135-48.32 to require claims processing contractors to provide all available claims data elements to the Plan, including the identification of providers and the allowed amounts paid. This information would not be available to anyone other than certain Plan staff unless allowed under the contract.

Section 2: Amends G.S. 135-48.34 to exempt contracts between the Plan and various external parties from Parts 3 and 4 of Article 15 of Chapter 143B, which cover oversight of information technology projects and procurement by the Department of Information Technology.

Section 3: 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 20,000.

Section 4: Amends G.S. 135-48.47(b)(3) to forbid local governments that participate in the Plan from charging employees more for their coverage than in the structure set by the Plan.

Section 5: Provides a window for local governments to withdraw from participating effective January 1, 2017. While the local government is not required to provide a reason, some may wish to withdraw if they do not want to accept the restrictions of Section 3.

Section 6: Specifies 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.

EFFECTIVE DATE: Section 4 becomes effective January 1, 2017. All other sections become effective when they become law and apply to contracts entered into, renewed or amended after that date.

ESTIMATED IMPACT ON STATE:

Section 3: Both The Segal Company, the actuary for the Plan, and Hartman & Associates, the actuary for the General Assembly, state that the impact of this section cannot be determined due to a lack of demographic data and claims experience for the workforce of the local governments that might wish to join. The current cap of 10,000 employees and dependents was just enacted in 2015 and reached in April 2016, so claims data on the current population will not be available for a while.

However, both actuaries note the possibility of a cost due to adverse selection. Adverse selection occurs when local governments and/or employees with higher-than-average claims cost are more likely to join the Plan than those with lower-than-average claims costs and those higher costs cannot be recovered through adjustments to premiums. The following aspects of the bill contribute to the potential for adverse selection:

- Participation is optional for local governments and the Plan cannot deny participation to any local unit. It is possible that local governments with higher-than-average claims costs will be more likely to choose to join.
- Local governments can determine eligibility. Local governments could choose to set eligibility rules that encourage employees with higher-than-average claims costs to enroll.
- Premiums cannot vary with the experienced claims for a particular local government, so the Plan cannot charge a higher premium to a local government whose employees incur higher-than-average claims.

Section 5: Hartman & Associates estimates that Section 5 could have a financial impact on the Plan for the same reason as Section 3 but did not have sufficient data to estimate the magnitude.

Section 6: The Segal Company estimates that Section 6 will reduce costs to the Plan by $2.5 million per year, which is the estimated cost to administer the federal reporting. However, this cost will be shifted to the employing units and thus does not represent a reduction for the State as a whole.

Both The Segal Company and Hartman & Associates estimate that the impacts of all other sections are negligible.

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

Summary Information and Data about the Plan

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

The State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement, with the exception of many Medicare-eligible retirees who are in fully-insured Medicare Advantage plans. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3)

employees and retirees who participate in a plan with a non-zero premium or who elect dependent coverage. Benefit and premium changes are typically effective at January 1. The Plan's PPO benefit design includes three alternative benefit levels listed below:

1) The "Traditional" 70/30 plan that offers higher out-of pocket requirements in return for lower employee and retiree premiums without needing to complete wellness activities,

2) The "Enhanced" 80/20 plan that offers lower out-of-pocket requirements with higher employee and retiree premiums, which can be lowered by completing wellness activities, and

3) The Consumer-Directed Health Plan (CDHP) that applies deductibles and co-insurance to all services and offers lower employee and retiree premiums if one completes wellness activities

Medicare-eligible retirees are offered three alternative plans:

1) The "Traditional" 70/30 plan as coverage secondary to Medicare for medical services plus a pharmacy benefit plan,

2) "Base" Medicare Advantage Prescription Drug Plans (MA-PDPs) from a choice of two carriers, Humana or United Healthcare, that are actuarially equivalent to the "Enhanced" 80/20 Plan and apply in-network out-of-pocket requirements at out-of-network providers

3) "Enhanced" MA-PDPs, identical to the "Base" MA-PDPs, except with lower co-pays and higher retiree premiums

The following tables provide a summary of the most common monthly premium rates for the Plan in 2016:

Active Employees and Non-Medicare Retirees

Wellness Plans

	Employer Share	Employee/Retiree Share	
		Complete All Wellness Activities *	Complete No Wellness Activities
Enhanced 80/20 Plan	$463.68	$14.20	$104.20
Consumer-Directed Health Plan	$463.68	$0.00	$80.00

Alternate Plan

	Employer Share	Employee/Retiree Share
Traditional 70/30 Plan	$463.68	$0.00

* Members receive credits for each activity. We have shown all or none for simplicity.

Medicare Retirees

Medicare Advantage Plans

	Employer Share	Employee/Retiree Share
MA-PDP Base Plan	$360.24	$0.00
MA-PDP Enhanced Plan	$360.24	$66.00

Alternate Plan

	Employer Share	Employee/Retiree Share
Traditional 70/30 Plan	$360.24	$0.00

Dependents (paid by employee/retiree in addition to premiums above)

	All Dependents are Non-Medicare			One or More Medicare Dependents		
	Enhanced 80/20	CDHP	Traditional 70/30	MA-PDP Base	MA-PDP Enhanced	Traditional 70/30
Employee/Retiree + Children	$280.52	$189.82	$210.92	$132.00	$198.00	$150.06
Employee/Retiree + Spouse	$646.32	$489.14	$543.46	$132.00	$198.00	$394.56
Employee/Retiree + Family	$685.22	$520.96	$578.86	$264.00	$396.00	$429.92

The employer share of premiums for retirees is paid from the Retiree Health Benefit Fund. During FY 2015-16, employers contribute 5.60% of active employee payroll into the Fund. Total contributions for the year are projected to be approximately $915 million.

Financial Condition

Projected Results for CY 2016 and CY 2017 – The following summarizes projected financial results for 2016 and 2017, based on financial experience through December, 2015 and enrollments for January, 2016. The projection assumes a 7.0% annual claims growth trend for medical claims, an 8.5% trend for pharmacy claims, benefit provisions and member-paid premiums as currently adopted by the Board, a new pharmacy benefit manager contract approved in March 2016 with an open formulary, and no assumed premium increase in 2017 (corresponds to General Assembly using half of the $71 million Reserve for Future Benefit Needs for premium increases).

	($ millions) Projected CY 2016	Projected CY 2017
Beginning Cash Balance	$1,015.2	$863.2
Receipts:		
Net Premium Collections	$3,118.0	$3,153.0
Medicare Part D / EGWP Subsidies	$18.4	$17.2
Investment Earnings	$3.6	$2.4
Total	$3,139.9	$3,172.6
Disbursements:		
Net Medical Claim Payment Expenses	$2,198.4	$2,309.7
Net Pharmacy Claim Payment Expenses	$748.1	$727.0
Medicare Advantage Premiums	$193.2	$213.0
Administration and Claims-Processing Expenses	$250.4	$249.1
Total	$3,390.1	$3,498.8
Net Operating Income (Loss)	($250.2)	($326.2)

Of the premiums paid in CY 2016, an estimated $2.1 billion is derived from General Fund sources and an estimated $0.1 billion is derived from Highway Fund sources.

Other Information

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, fraud detection, and other authorized actions by the State Treasurer, Executive Administrator, and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Medical claim costs are expected to increase at a rate of 7.0% annually and pharmacy claim costs are expected to increase at a rate of 8.5% annually according to assumptions adopted by the Board of Trustees. The active population is projected to decline by 1% per year and the retired population is projected to increase by 1% per year.

Enrollment as of January 1, 2016

I. No. of Participants	Traditional 70/30	Enhanced 80/20	Consumer Directed	Medicare Advantage	Total	Percent of Total
Actives						
Employees	124,524	172,262	12,987	-	309,773	44.2%
Dependents	74,027	78,800	13,726	-	166,553	23.8%
Sub-total	198,551	251,062	26,713	-	476,326	68.0%
Retired						
Employees	57,363	31,377	1,364	105,878	195,982	28.0%
Dependents	6,221	4,205	507	8,615	19,548	2.8%
Sub-total	63,584	35,582	1,871	114,493	215,530	30.8%
Other						
Employees	1,919	3,686	517	-	6,122	0.9%
Dependents	1,077	1,324	412	-	2,813	0.4%
Sub-total	2,996	5,010	929	-	8,935	1.3%
Total						
Employees	183,806	207,325	14,868	105,878	511,877	73.0%
Dependents	81,325	84,329	14,645	8,615	188,914	27.0%
Grand Total	**265,131**	**291,654**	**29,513**	**114,493**	**700,791**	**100%**
Percent of Total	**37.8%**	**41.6%**	**4.2%**	**16.3%**	**100.0%**	

II. Enrollment by Contract	Traditional	Enhanced	CDHP	MA	Total
Employee Only	141,203	163,058	7,846	97,263	409,370
Employee Child(ren)	24,867	28,046	3,356	191	56,460
Employee Spouse	6,087	5,835	1,023	8,424	21,369
Employee Family	10,327	9,454	2,488		22,269
Other (e.g. Split Contract)	1,322	932	155		2,409
Total	**183,806**	**207,325**	**14,868**	**105,878**	**511,877**

Percent Enrollment by Contract	Traditional	Enhanced	CDHP	MA	Total
Employee Only	76.8%	78.6%	52.8%	91.9%	80.0%
Employee Child(ren)	13.5%	13.5%	22.6%	0.2%	11.0%
Employee Spouse	3.3%	2.8%	6.9%	8.0%	4.2%
Employee Family	5.6%	4.6%	16.7%	0.0%	4.4%
Other (e.g. Split Contract)	0.7%	0.4%	1.0%	0.0%	0.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

III. Enrollment by Sex	Traditional	Enhanced	CDHP	MA	Total
Female	154,763	189,650	16,456	75,648	436,517
Male	110,368	102,004	13,057	38,845	264,274
Total	**265,131**	**291,654**	**29,513**	**114,493**	**700,791**

Percent Enrollment by Sex	Traditional	Enhanced	CDHP	MA	Total
Female	58.4%	65.0%	55.8%	66.1%	62.3%
Male	41.6%	35.0%	44.2%	33.9%	37.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Traditional	Enhanced	CDHP	MA	Total
24 & Under	68,579	71,417	11,272	6	151,274
25 to 44	68,236	77,686	8,265	261	154,448
45 to 54	44,917	57,827	5,192	991	108,927
55 to 64	45,251	77,793	4,524	1,467	129,035
65 & Over	38,148	6,931	260	111,768	157,107
Total	**265,131**	**291,654**	**29,513**	**114,493**	**700,791**

Percent Enrollment by Age	Traditional	Enhanced	CDHP	MA	Total
24 & Under	25.9%	24.5%	38.2%	0.0%	21.6%
25 to 44	25.7%	26.6%	28.0%	0.2%	22.0%
45 to 54	16.9%	19.8%	17.6%	0.9%	15.5%
55 to 64	17.1%	26.7%	15.3%	1.3%	18.4%
65 & Over	14.4%	2.4%	0.9%	97.6%	22.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	53,515	9,734	63,249
Medicare Eligible in Traditional 70/30	36,589	1,199	37,788
Medicare Eligible in Base Medicare Advantage Plans	87,652	6,063	93,715
Medicare Eligible in Enhanced Medicare Advantage Plans	18,226	2,552	20,778
Total	**195,982**	**19,548**	215,530

Percent Enrollment by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	27.3%	49.8%	29.3%
Medicare Eligible in Traditional 70/30	18.7%	6.1%	17.5%
Medicare Eligible in Base Medicare Advantage Plans	44.7%	31.0%	43.5%
Medicare Eligible in Enhanced Medicare Advantage Plans	9.3%	13.1%	9.6%
Total	**100.0%**	**100.0%**	100.0%

VI. Enrollment By Major Employer Groups	Employees	Dependents	Total
State Agencies	68,920	32,894	101,814
UNC System	51,808	33,122	84,930
Local Public Schools	169,576	89,302	258,878
Charter Schools (86 entities)	3,786	2,377	6,163
Local Community Colleges	15,683	8,858	24,541
Other			
Local Goverments (44 entities)	5,354	2,410	7,764
COBRA/Reduction in Force	763	398	1,161
Nat. Guard, Fire & Rescue	5	5	10
Sub-total	315,895	169,366	485,261
Retirement System	195,982	19,548	215,530
Total	**511,877**	**188,914**	**700,791**

Percent Enrollment by Major Employer Groups	Employees	Dependents	Total
State Agencies	13.5%	17.4%	14.5%
UNC System	10.1%	17.5%	12.1%
Local Public Schools	33.1%	47.3%	36.9%
Charter Schools	0.7%	1.3%	0.9%
Local Community Colleges	3.1%	4.7%	3.5%
Other			
Local Goverments	1.0%	1.3%	1.1%
COBRA/Reduction in Force	0.1%	0.2%	0.2%
Nat. Guard, Fire & Rescue	0.0%	0.0%	0.0%
Sub-total	61.7%	89.7%	69.2%
Retirement System	38.3%	10.3%	30.8%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

The Segal Company; baseline financial projections updated through Q2 FY2016 with 0% employer and employee premium increase in 2017 and new PBM contract with open formulary; dated March 11, 2016. Filename "FY16 Q2- Baseline - 0% for ER and EE with PBM BAFO (Open).pdf"

-Actuarial Note, Hartman & Associates, Senate Bill 865, "Senate Bill 865: An Act to Make Administrative Changes to the State Health Plan, 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 Governments", May 23, 2016, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, The Segal Company, Senate Bill 865, "State Health Plan/Admin Changes/Local Gov", May 26, 2016, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: David Vanderweide

APPROVED BY:

Mark Trogdon, Director
Fiscal Research Division

DATE: June 7, 2016

Signed Copy Located in the NCGA Principal Clerk's Offices

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S 1

SENATE BILL 815

Short Title:	Charter School in State Health Plan.	(Public)
Sponsors:	Senator Blue (Primary Sponsor).	
Referred to:	Insurance	

May 5, 2016

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE LONGLEAF SCHOOL OF THE ARTS TO ELECT TO PARTICIPATE IN THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. Notwithstanding the time limitation contained in G.S. 135-48.54, the Board of Directors of Longleaf School of the Arts, a charter school located in Raleigh, may elect to become a participating employing unit in the State Health Plan for Teachers and State Employees in accordance with Article 3B of Chapter 135 of the General Statutes. The election authorized by this act shall be made no later than 30 days after the effective date of this act and shall be made in accordance with all other requirements of G.S. 135-48.54.

SECTION 2. This act is effective when it becomes law.

SENATE BILL 815:
Charter School in State Health Plan.

2016-2017 General Assembly

Committee:	Senate Insurance	**Date:**	June 23, 2016
Introduced by:	Sen. Blue	**Prepared by:**	Jason Moran-Bates
Analysis of:	First Edition		Staff Attorney

SUMMARY: Senate Bill 815 authorizes another opportunity for the Board of Directors of Longleaf School of the Arts to elect to participate in the State Health Plan for Teachers and State Employees. (Longleaf School of the Arts is a charter school located in Raleigh.)

CURRENT LAW: G.S. 135-48.54 outlines provisions for charter schools operated by private nonprofit corporations to participate in the State Health Plan for Teachers and State Employees (Plan). G.S. 135-48.54(b) provides that no later than 30 days after both parties have signed the written charter, the board of directors of a charter school operated by a private nonprofit corporation shall elect whether to become a participating employer in the Plan. The election shall be in writing and filed with the Plan and the State Board of Education and is effective for each charter school employee as of the date of that employee's entry into eligible service.

BILL ANALYSIS: Senate Bill 815 authorizes another opportunity for the Board of Directors of Longleaf School of the Arts, located in Raleigh, to elect to participate in the State Health Plan for Teachers and State Employees. The bill requires that these elections be made no later than 30 days after the effective date of the act and in accordance with all other requirements of G.S. 135-48.54.

EFFECTIVE DATE: Senate Bill 815 would become effective when it becomes law.

Karen Cochrane-Brown
Director

S815-SMBC-10 E1 -V-3

Legislative Analysis
Division
919-733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2015

Legislative Actuarial Note
Health Benefits

BILL NUMBER: Senate Bill 815 (First Edition)

SHORT TITLE: Charter School in State Health Plan.

SPONSOR(S): Senator Blue

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

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

BILL SUMMARY: Senate Bill 815 (First Edition) permits the Board of Directors of Longleaf School of the Arts, a public charter school, to become a participating employer under the Plan within 30 days after the act becomes law. Under G.S. 135-48.54, an election to join the Plan by the board of a charter school is irrevocable and shall require all eligible employees of the charter school to participate.

EFFECTIVE DATE: When it becomes law.

ESTIMATED IMPACT ON STATE:

The consulting actuary for the Plan, The Segal Company, estimates a financial loss to the Plan of $34,000 for FY 2016-2017 if Longleaf School of the Arts elects to participate in the Plan. Segal estimates claims would increase by 0.02% after joining the Plan, relative to claims under the School's current medical benefits plan. In addition, for the purposes of estimating the potential cost impact to the Plan, Segal assumes potential claims for the School would be 150% greater on average due to expected adverse selection of costlier plan members entering the Plan. Even with this assumption, and given the small size of the School, Segal estimates the projected costs would have a negligible impact on the Plan.

Hartman & Associates, consulting actuary for the General Assembly, estimates that the financial impact on the Plan would not be material upon Longleaf School of the Arts electing to participate in the Plan. Hartman & Associates noted that the employee demographics of the School's group would be expected to produce 20% lower average claim costs than the Plan's membership, and that given the minimal number of prospective employees and dependents to be enrolled, there is not expected to be a significant financial impact as a percent of total claims. Hartman & Associates, however, also noted the lack of available historical claims experience from the School to assess potential adverse selection against the Plan.

The additional cost impact of the bill, projected by either consulting actuary, would be expected to impact total claims growth by approximately two thousandths of one percent (0.002%) for the 2016-2017 fiscal year based on the highest estimate of additional cost (i.e., $34,000).

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

Authorized Charter Schools: As of January, 2016, there were 86 charter schools with 6,163 enrolled active employees and dependents participating in the Plan.

Data submitted by the School: The Segal Company and Hartman & Associates based their respective analyses in part on a Distribution of Participants schedule submitted by the School. The schedule below reflects the age and sex demographic data for employees and dependents of the School. Complete claims experience data is usually unavailable on a group this size. However, the School did note that it currently pays total medical premiums of $13,119 per month and provided details on the benefits in its current program, which include:

- In-network office visit and therapy co-pay: $20 Primary Care; $40 Specialist
- Preventive care: $0
- Deductible: $1,500 (individual, in-network)
- Out-of-pocket maximum: $4,500 (individual, in-network)
- Inpatient and outpatient hospital: 20% coinsurance after deductible (in-network)
- Prescription drug co-pays: $4 generic; $35 preferred brand

Distribution of Participants - Longleaf School of the Arts

	Active Employees			Dependents of Active Employees		
Ages	Male	Female	Total	Male	Female	Total
0-4			0	1	1	2
5-9			0			0
10-14			0			0
15-19			0			0
20-24	2	1	3			0
25-29	1	6	7			0
30-34		3	3		1	1
35-39	2	2	4			0
40-44	1	1	2	1		1
45-49		2	2			0
50-54	1	1	2			0
55-59		1	1			0
60-64		1	1			0
65-69			0			0
70-74			0			0
75-79			0			0
>79			0			0
Unknown			0			0
TOTAL	7	18	25	2	2	4

Summary Information and Data about the Plan

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

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Joe McClees	McClees Consulting
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Paul Sherman	NCFB
[illegible]	ND
Susan Valenti	National

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