GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H **D**

HOUSE DRH80301-LN-103A (3/1)

Short Title:	Establish NC Health Insurance Risk Pool.	(Public)
Sponsors:	Representatives Insko and Holliman (Primary Sponsors).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO CREATE THE NORTH CAROLINA HEALTH INSURANCE RISK POOL TO MEET THE NEEDS OF INDIVIDUALS WHO CANNOT OBTAIN HEALTH INSURANCE BECAUSE OF HIGH-RISK HEALTH CONDITIONS AND UNAFFORDABLE PREMIUMS; AND TO PROVIDE A TAX CREDIT AGAINST THE GROSS PREMIUMS TAX FOR ASSESSMENTS PAID BY INSURERS TO THE NORTH CAROLINA HEALTH INSURANCE RISK POOL.

The General Assembly of North Carolina enacts:

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

"Part 6. North Carolina Health Insurance Risk Pool.

"**§ 58-50-160. Definitions.**

For the purposes of this Part:

(1) "Administrator" means the Pool Administrator selected by the Board in accordance with this Part.

(2) "Benefit plan" means coverage offered by the Pool to eligible individuals.

(3) "Board" means the Board of Directors of the Pool.

(4) "Covered person" means any individual resident of this State, excluding dependents, who is eligible to receive health benefits from any insurer.

(5) "Church plan" has the meaning given that term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(6) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

a. A group health plan.

b. Health insurance coverage.

c. Part A or Part B of Title XVIII of the Social Security Act.
d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.
e. Chapter 55 of Title 10, United States Code.
f. A medical care program of the Indian Health Service or of a tribal organization.
g. A state health benefits risk pool.
h. A health plan offered under Chapter 89 of Title 5, United States Code.
i. A public health plan as defined in federal regulations.
j. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. § 2504(e)).

A period of creditable coverage shall not be counted, with respect to the enrollment of an individual who seeks coverage under this Part, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

(7) "Dependent" means a resident spouse or unmarried child under the age of 19 years, a child who is a full-time student under the age of 23 years and who is financially dependent upon the parent, a child who is over 18 years of age and for whom a person may be obligated to pay child support, or a child of any age who is disabled and dependent upon the parent.

(8) "Family member" means a parent, grandparent, brother, sister, or child of a dependent residing with the insured.

(9) "Federally defined eligible individual" means an individual:

a. For whom, as of the date on which the individual seeks coverage under this Part, the aggregate of the periods of creditable coverage is 18 or more months;
b. Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with such a plan;
c. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (Medicare), or a State plan under Title XIX of the Act (Medicaid), or any successor program, and who does not have other health insurance coverage;
d. With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e. Who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected this coverage; and

f. Who has exhausted continuation coverage under this provision or program, if the individual elected the continuation coverage described in sub-subdivision e. of this subdivision.

(10) "Governmental plan" has the meaning given under section 3(32) of the Employee Retirement Income Security Act of 1974 and any governmental plan established or maintained for its employees by the government of the United States or by an agency or instrumentality of the government of the United States.

(11) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, including items and services paid for as medical care to employees or their dependents, as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(12) "Health insurance coverage" means any hospital and medical expense incurred policy, nonprofit health care services contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise.

"Health insurance coverage" does not include one or more, or any combination of, the following:

a. Coverage only for accident or disability income insurance, or any combination thereof.
b. Coverage issued as a supplement to liability insurance.
c. Liability insurance, including general liability insurance and automobile liability insurance.
d. Workers' compensation or similar insurance.
e. Automobile medical payment insurance.
f. Credit-only insurance.
g. Coverage for on-site medical clinics.
h. Other similar insurance coverage, specified in federal regulations issued pursuant to P.L. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
i. Limited-scope dental or vision benefits.
j. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.
k. Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act.
l. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services – CHAMPUS).
m. Similar supplemental coverage provided to coverage under a group health plan.

(13) "Insurance arrangement" means a plan, program, contract, or other arrangement through which health care services are provided by an employer to its officers or employees, but does not include health care services covered through an insurer.

(14) "Insured" means an individual who is a resident of this State and a citizen of the United States, and who is eligible to receive benefits from the Pool. The term "insured" includes dependents and family members, as applicable.

(15) "Insurer" means any entity that provides health insurance coverage in this State. For the purposes of this Part, insurer includes an insurance company, a hospital or medical service corporation, a health maintenance organization, a multiple employer welfare arrangement, or any other nongovernmental entity providing a health benefit plan subject to State insurance regulation.

(16) "Medical care" means amounts paid for:

a. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

b. Transportation primarily for and essential to medical care referred to in sub-subdivision a. of this subdivision; and

c. Insurance covering medical care referred to in sub-subdivisions a. and b. of this subdivision.

(17) "Plan of operation" means the articles, bylaws, and operating rules and procedures adopted by the Board in accordance with this Part.

(18) "Pool" means the North Carolina Health Insurance Risk Pool.

(19) "Resident" means an individual who:

a. Has been legally domiciled in this State for a period of at least 30 days, except that for a federally defined eligible individual, there shall not be a 30-day requirement;

b. Is legally domiciled in this State on the date of application to the Pool and who is eligible for enrollment in the Pool as a result of the Health Insurance Portability and Accountability Act of 1996; or

c. Is legally domiciled in this State on the date of application to the Pool and is eligible for the credit for health insurance costs under section 35 of the Internal Revenue Code of 1986.

(20) "Significant break in coverage" means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

"**§ 58-50-165 Risk Pool established; board of directors; plan of operation.**

(a) High-Risk Pool Established. – There is hereby created a nonprofit entity to be known as the North Carolina Health Insurance Risk Pool. The Pool shall operate under the supervision and control of the Board of Directors of the Pool.

(b) Board of Directors Appointment; Membership. – The Board of Directors of the North Carolina Health Insurance Risk Pool shall consist of the Commissioner of Insurance, who shall serve as an ex officio nonvoting member of the Board, and seven members appointed as follows:

(1) One member of the general public appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives. The appointee shall be an individual who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider. An individual whose only affiliation with health insurance or health care coverage is as a covered member may be appointed as a member of the general public.

(2) One member of the general public appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate. The appointee shall be an individual who can reasonably be expected to qualify for coverage in the Pool.

(3) Five members appointed by the Commissioner of Insurance, as follows:

a. Two who are insurers, at least one of whom covers the largest number of persons in the State.

b. One who is licensed to sell health insurance in this State.

c. One who represents the medical provider community, as recommended by the North Carolina Medical Society.

d. One who represents small business, as recommended by the North Carolina Citizens for Business and Industry.

Two representatives of the general public who are not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, and can reasonably be expected to qualify for coverage in the Pool. Representatives of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member.

(c) Board of Directors; Terms of Appointment; Vacancies; Compensation. – The initial Board members shall be appointed as follows: two of the members to serve a term of three years; three of the members to serve a term of one year; and two of the members to serve a term of two years. Subsequent Board members shall serve for terms of three years. A Board member's term shall continue until the member's successor is appointed. The Commissioner shall appoint a chair to serve for the initial two years of the Plan's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms. The Commission shall fill vacancies in membership and may remove members from the Board for cause. Board members shall not be compensated in their capacity as Board members but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties.

(d) Plan of Operation. – The Board shall submit to the Commissioner a Plan of Operation for the Pool and any amendments necessary or suitable to assure the fair,

reasonable, and equitable administration of the Plan of Operation. The Plan of Operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this Part must be made available. If the Board fails to submit a suitable Plan of Operation within 180 days after the appointment of the Board of Directors, or at any time thereafter fails to submit suitable amendments to the Plan of Operation, the Commissioner shall adopt temporary rules necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the Commissioner or superseded by a Plan of Operation submitted by the Board and approved by the Commissioner. The Plan of Operation shall:

(1) Establish procedures for operation of the Pool.

(2) Establish procedures for selecting a Pool administrator in accordance with G.S. 58-50-185.

(3) Establish procedures to create a fund for administrative expenses, which shall be managed by the Board.

(4) Establish procedures for the collection, handling, accounting, and auditing of assets, monies, and claims of the Pool and the Pool administrator.

(5) Develop and implement a program to publicize the existence of the Pool, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the Pool.

(6) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the Board. The grievances shall be reported to the Board after completion of the review. The Board shall retain all written complaints regarding the Pool for at least three years.

(7) Provide for other matters as may be necessary and proper for the execution of the Board's powers, duties, and obligations under this Part.

(h) The Pool shall have the general powers and authority granted under the laws of this State to health insurers and the specific authority to do all of the following:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Part, including the authority, with the approval of the Commissioner, to enter into contracts with similar plans of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions.

(2) Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the Pool.

(3) Take legal action as necessary to:

a. Avoid the payment of improper claims against the Pool or the coverage provided by or through the Plan.

b. Recover any amounts erroneously or improperly paid by the Plan.

c. Recover any amounts paid by the Pool as a result of mistake of fact or law.

d. Recover other amounts due the Pool.

(4) Establish rates and rate schedules in accordance with this Part.

(5) Issue policies of insurance in accordance with the requirements of this Part.

(6) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the Pool, policy, and other contract design, and any other function within the Pool's authority.

(7) Borrow money to effect the purposes of the Pool. Any notes or other evidence of indebtedness of the Pool not in default are legal investments for insurers and may be carried as admitted assets.

(8) Establish rules, conditions, and procedures for reinsuring risks of participating insurers desiring to issue Pool coverage in their own name. Provision of reinsurance shall not subject the Pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

(9) Employ and fix the compensation of employees.

(10) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public.

(11) Provide for reinsurance of risks incurred by the Pool.

(12) Issue additional types of health insurance policies to provide optional coverage, including Medicare supplemental insurance coverage.

(13) Provide for and employ cost containment measures and requirements including preadmission screening, second surgical opinion, concurrent utilization review, disease management, individual case management, and other commonly used benefit plan design features for the purpose of making health insurance coverage offered by the Pool more cost-effective.

(14) Design, utilize, contract, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

(15) Adopt bylaws, policies, and procedures as may be necessary or convenient for the implementation of this Part and the operation of the Pool.

(i) The Board shall operate the Pool in a manner so that the estimated cost of providing health insurance coverage during any fiscal year will not exceed the total income the Pool expects to receive from policy premiums and other revenue available to the Pool. The financing mechanisms recommended to and approved by the General Assembly shall provide for a means to adjust those mechanisms annually, or more frequently if necessary, in order to assure that the Pool has the financial capacity to insure the projected number of enrollees.

(j) The Board shall make an annual report to the Commissioner, to the Speaker of the House of Representatives, and to the President Pro Tempore of the Senate. The report shall summarize the activities of the Pool in the preceding calendar year, including the net written and earned premiums, benefit plan enrollment, the expense of administration, and the paid and incurred losses.

(k) Neither the Board nor its employees are liable for any obligations of the Pool. No current or former member or employee of the Board is liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this Part, unless such act or omission constitutes willful or wanton misconduct. The Board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

"**§ 58-50-170. Administrator.**

(a) The Board shall select through a competitive bidding process one or more insurers or a third-party administrator to administer the Pool. The Board shall evaluate bids submitted based on criteria established by the Board. The criteria shall allow for the comparison of information about each bidding administrator and selection of a Pool Administrator based on at least the following:

(1) Proven ability to handle health insurance coverage to individuals.

(2) Efficiency and timeliness of the claim processing procedures.

(3) Estimated total charges for administering the Pool.

(4) Ability to apply effective cost containment programs and procedures and to administer the Pool in a cost-efficient manner.

(5) Financial condition and stability.

(b) The Administrator shall serve for a period specified in the contract between the Pool and the Administrator subject to removal for cause and subject to any terms, conditions, and limitations of the contract between the Pool and the Administrator. At least one year before the expiration of each period of service by an Administrator, the Board shall invite eligible entities, including the current Administrator, to submit bids to serve as the Administrator. Selection of the Administrator for the succeeding period shall be made at least six months before the end of the current period.

(c) The Administrator shall perform such functions relating to the Pool as may be assigned to it, including:

(1) Determination of eligibility.

(2) Payment of claims.

(3) Establishment of a premium billing procedure for collection of premiums from individuals covered under the Pool.

(4) Other necessary functions to assure timely payment of benefits to covered persons under the Pool.

(d) The Administrator shall submit regular reports to the Board regarding the operation of the Pool. The contract between the Board and the Administrator shall specify the frequency, content, and form of the report.

(e) Following the close of each calendar year, the Administrator shall determine net written and earned premiums, the expense of administration, and the paid and

incurred losses for the year and report this information to the Board and the Commissioner on a form prescribed by the Commissioner.

(f) The Administrator shall be paid as provided in the contract between the Board and the Administrator.

"**§ 58-50-175. Risk Pool rates.**

(a) The Pool shall adopt and modify, as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of the Pool. Rates and rate schedules may be adjusted for appropriate factors such as age, sex, and geographic variation in claim cost and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices.

(b) The Pool shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques, and shall reflect anticipated experience and expenses for the coverage. Initial Pool rates may not be less than one hundred twenty-five percent (125%) and may not exceed one hundred fifty percent (150%) of rates established as applicable for individual standard rates. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in this subsection. In no event shall Pool rates exceed one hundred fifty percent (150%) of rates applicable to individual standard risks.

(c) The Pool shall submit all rates and rate schedules to the Commissioner for approval, and the Commissioner must approve the rates and rate schedules before the Pool may use them. The Commissioner, in evaluating the rates and rate schedules, shall consider the factors provided in this section.

"**§ 58-50-180. Eligibility for Pool coverage.**

(a) Any individual who is and continues to be a resident of this State is eligible for Pool coverage if evidence is provided of:

(1) A notice of rejection or refusal to issue substantially similar insurance for health reasons by two insurers. A rejection or refusal by an insurer offering only stop-loss, excess loss, or reinsurance coverage with respect to the applicant is not sufficient evidence of eligibility;

(2) Two offers to issue insurance only with conditional riders;

(3) A refusal by an insurer to issue insurance except at a rate exceeding the Pool rate;

(4) Diagnosis of the individual with one of the medical or health conditions listed by the Board in accordance with this section. An individual diagnosed with one or more of these conditions is eligible for Pool coverage without applying for other health insurance coverage;

(5) In the case of an individual who is eligible for coverage under the Health Insurance Portability and Accountability Act of 1996, the individual's maintenance of health insurance coverage, of which the

most recent coverage was through an employer-sponsored plan, for the previous 18 months with no gap in coverage greater than 63 days and exhaustion of any available COBRA or State continuation benefits; or

(6) An individual who is legally domiciled in this State and is eligible for the credit for health insurance costs under the Trade Adjustment Assistance Reform Act of 2002, section 35 of the Internal Revenue Code of 1986.

(b) The Board shall adopt a list of medical or health conditions for which a person shall be eligible for Pool coverage without applying for health insurance pursuant to subsection (a) of this section. Persons who can demonstrate the existence or history of any medical or health conditions on the list adopted by the Board shall not be required to provide the evidence specified in subsection (a) of this section. The Board may amend the list as the Board considers appropriate.

(c) Each dependent of an individual who is eligible for Pool coverage shall also be eligible for Pool coverage.

(d) An individual is not eligible for coverage under the Pool if:

(1) The individual has or obtains health insurance coverage substantially similar to or more comprehensive than a Pool policy, or would be eligible to have coverage if the person elected to obtain it; except that:

a. An individual may maintain other coverage for the period of time the individual is satisfying any preexisting condition waiting period under a Pool policy; and

b. An individual may maintain Pool coverage for the period of time the individual is satisfying a preexisting conditions waiting period under another health insurance policy intended to replace the Pool policy.

(2) The individual is determined to be eligible for enrollment in the State Medical Assistance Plan.

(3) The individual has previously terminated Pool coverage unless 12 months have lapsed since the termination, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual.

(4) The Pool has paid out the lifetime maximum benefits, which is one million dollars ($1,000,000) on behalf of the individual.

(5) The individual is an inmate or resident of a public institution, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual.

(6) The individual's premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider.

(7) The individual has in effect on the date Pool coverage takes effect health insurance coverage from an insurer or insurance arrangement.

(e) Coverage under the Pool shall cease:

(1) On the date an individual is no longer a resident of this State.

(2) On the date an individual requests coverage to end.

(3) Upon the death of the covered individual.

(4) On the date State law requires cancellation of the Pool policy.

(5) At the option of the Pool, 30 days after the Pool makes any inquiry concerning the individual's eligibility or residence to which the individual does not reply.

(f) Except as provided in subsection (e) of this section, an individual who ceases to meet the eligibility requirements of this section may be terminated at the end of the Pool period for which the necessary premiums have been paid.

"**§ 58-50-185. Unfair referral to Pool.**

It is an unfair trade practice under Article 63 of this Chapter for an insurer, insurance producer, as defined in G.S. 58-33-10(7), or third-party administrator to refer an individual employee to the Pool or arrange for an individual employee to apply to the Pool for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

"**§ 58-50-190. Minimum Pool benefits.**

(a) The Pool shall offer at least two types of health insurance coverage for individuals eligible under G.S. 58-50-175. The covered services and benefit levels may vary between the types of coverage, but at least two types of coverage must, at a minimum, cover the benefits and services outlined in the National Association of Insurance Commissioners' Model Health Pool for Uninsurable Individuals Act and consistent with comprehensive coverage generally available to persons who are eligible for health insurance other than Medicare.

(b) Subject to approval by the Commissioner, the Board shall establish the health insurance coverage issued by the Pool, including the coverage's schedule of benefits, exclusions, and other limitation of the coverage.

"**§ 58-50-195. Preexisting conditions.**

(a) Pool coverage shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage as to any condition for which medical advice, care, or treatment was recommended or received as to such conditions during the 12-month period immediately preceding the effective date of coverage, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual.

(b) Subject to subsection (a) of this section, the preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage that was involuntarily terminated; provided, that:

(1) Application for Pool coverage is made not later than 63 days following the involuntary termination, and in such case coverage in the Pool shall be effective from the date on which the prior coverage was terminated; and

(2) The applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to Pool coverage.

"**§ 58-50-200. Nonduplication of benefits.**

(a) The Pool shall be payor of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under coverage shall be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or no-fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any State or federal law or program.

(b) The Pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the Pool may be reduced or refused as a setoff against any amount recoverable under this subsection.

"**§ 58-50-205. Assessments.**

(a) For the purposes of providing the funds necessary to carry out the powers and duties of the Pool, the Board shall assess member insurers at such time and for such amounts as the Board finds necessary. Assessments shall be due in not less than 30 days after prior written notice to the member insurers and shall accrue interest at twelve percent (12%) per annum on and after the due date.

(b) Each insurer shall be assessed in an amount not to exceed two dollars ($2.00) per covered individual insured or reinsured by each insurer per month. The assessment will be based on actual and expected losses, actuarially appropriate reserves, and administrative expenses in excess of expected and collected premiums and federal loss reimbursements, if any, received by the Pool. There shall be no assessment on any insurer or policies or contracts insuring federal or State employees.

(c) The Board shall make reasonable efforts designed to ensure that each covered individual is counted only once with respect to any assessment. For that purpose, the Board shall require each insurer that obtains excess or stop-loss insurance to include in its count of covered individual all individuals whose coverage is insured (including by way of excess or stop-loss coverage) in whole or in part. The Board shall allow a reinsurer to exclude from its number of covered individuals those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop-loss insurer for the purposes of determining its assessment under this section.

(d) The Board may verify each insurer's assessment based on annual statements and other reports deemed to be necessary by the Board. The Board may use any reasonable method of estimating the number of covered individuals of an insurer if the specific number is unknown.

(e) If assessments and other receipts by the Pool, Board, or administering insurer exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the Board to offset future losses or to reduce plan premiums. Future losses include reserves for claims incurred but not reported.

(f) The Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any member insurer that fails to pay an assessment. As an alternative, the Commissioner may levy a forfeiture on any

member insurer that fails to pay an assessment when due. The forfeiture may not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100.00) per month.

"**§ 58-50-210. Complaint procedures.**

An applicant or participant in coverage from the Pool is entitled to have complaints against the Pool reviewed by a grievance committee appointed by the Board. The grievance committee shall report to the Board after completion of the review of each complaint. The Board shall retain all written complaints regarding the Pool at least until the third anniversary of the date the Pool received the complaint. An applicant or participant may file for external review of the applicant's grievance after having exhausted the Pool's internal grievance procedure. External review shall be conducted in accordance with Part 4 of this Article.

"**§ 58-50-215. Audit.**

The State Auditor shall conduct annually a special audit of the Pool. The State Auditor's report shall include a financial audit and an economic and efficiency audit. The State Auditor shall report the cost of each audit conducted under this Part to the Board and the Comptroller, and the Board shall remit that amount to the Comptroller for deposit to the General Fund.

"**§ 58-50-220. Taxation.**

The Pool established under this Part is exempt from any and all taxes.

"**§ 58-50-225. Rules.**

The Commissioner may adopt rules, including temporary rules, to implement this Part.

"**§ 58-50-230. Collective action.**

The participation in the Pool as participating insurers, the establishment of rates, forms, or procedures, and any other joint or collective action required by this Part may not be the basis of any legal action or criminal or civil liability or penalty against the Pool or any participating insurer."

SECTION 2. The Board of Directors of the North Carolina Health Insurance Risk Pool, as appointed under Section 1 of this act, shall recommend a method or methods for financing the Pool that will provide a stable funding source and allow for its continued operation. In developing its recommendation for financing, the Board shall review coverage available under health insurance high-risk pools enacted in other states, the National Association of Insurance Commissioners' Model Health Pool for Uninsurable Individuals Act, including proposed amendments to that model act, and actuarial and other information necessary for the development and financing of a fair, reasonable, and equitable comprehensive health insurance benefit plan. No later than April 1, 2006, the Board shall submit a report of its findings and recommendations, including proposed legislative changes, to the Commissioner of Insurance and the General Assembly. The report shall include the following:

(1) The Board's recommended method or methods for financing the Pool and the rationale for the recommendation. In developing a recommendation for financing, the Board shall consider and choose one or more of the following:

a. Premium rates, coinsurance, deductibles, lifetime coverage, and other limitations that provide for a reasonable and affordable benefit plan.
b. Assessments of insurers and reinsurers in this State in a manner that fairly and reasonably spreads the cost of covering high-risk individuals.
c. Assessments on admissions to hospitals and other health care facilities in a manner that fairly and reasonably spreads the cost of covering high-risk individuals.
d. Methods of financing used in other states for high-risk pool coverage and the adequacy of those methods.

(2) Recommendations of supplementary sources of funding, such as funds obtained from public and private not-for-profit foundations, or other appropriate and available State or non-State funds.

(3) Information on all of the following:
a. The estimated number of individuals in this State who are uninsured as of a date certain because of high-risk conditions.
b. The estimated number of those individuals who would qualify for coverage under the Pool based on G.S. 58-50-175 and its Plan of Operation.
c. The cost of coverage under each of the health insurance plans developed by the Board, including administrative costs.
d. The effective date upon which Pool coverage can be offered based upon the recommended financing for the Plan.

SECTION 3. There is appropriated from the General Fund to the Department of Insurance the sum of two hundred thousand dollars ($200,000) for the 2005-2006 fiscal year. These funds shall be placed in a Special Reserve for the North Carolina Health Insurance Risk Pool in the Department of Insurance and shall be allocated for the reasonable expenses of the Board in conducting its duties under Section 2 of this act.

SECTION 4. G.S. 58-6-25(d) reads as rewritten:

"(d) Use of Proceeds. – The Insurance Regulatory Fund is created in the State treasury, under the control of the Office of State Budget and Management. The proceeds of the charge levied in this section and all fees collected under Articles 69 through 71 of this Chapter and under Articles 9 and 9C of Chapter 143 of the General Statutes shall be credited to the Fund. 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. Moneys in the Fund may be spent only pursuant to appropriation by the General Assembly and in accordance with the line item budget enacted by the General Assembly. The Fund is subject to the provisions of the Executive Budget Act, except that no unexpended surplus of the Fund shall revert to the General Fund. All money credited to the Fund shall be used to reimburse the General Fund for the following:

(1) Money appropriated to the Department of Insurance to pay its expenses incurred in regulating the insurance industry and other industries in this State.
(2) Money appropriated to State agencies to pay the expenses incurred in regulating the insurance industry, in certifying statewide data processors under Article 11A of Chapter 131E of the General Statutes, and in purchasing reports of patient data from statewide data processors certified under that Article.
(3) Money appropriated to the Department of Revenue to pay the expenses incurred in collecting and administering the taxes on insurance companies levied in Article 8B of Chapter 105 of the General Statutes.
(4) Money appropriated for the office of Managed Care Patient Assistance Program established under G.S. 143-730 to pay the actual costs of administering the program.
(5) Money appropriated to the Department of Insurance for the implementation and administration of independent external review procedures required by Part 4 of Article 50 of this Chapter.
(6) Money appropriated to the Department of Insurance for the Special Reserve for the North Carolina Health Insurance Risk Pool."

SECTION 5.(a) Article 8B of Chapter 105 of the General Statutes is amended by adding a new section to read:

"**§ 105-228.5B. Credit against gross premium tax for assessments paid to the North Carolina Health Insurance Risk Pool.**

(a) The following definitions apply in this section:
(1) Assessment. – An assessment as described in G.S. 58-50-205.
(2) Member insurer. – An insurer as defined in G.S. 58-50-160.
(3) Pool. – The North Carolina Health Insurance Risk Pool as established under Part 6 of Article 50 of Chapter 58 of the General Statutes.

(b) Credit. – A member insurer who pays an assessment is allowed as a credit against the tax imposed under G.S. 105-228.5 an amount equal to twenty percent (20%) of the amount of the assessment in each of the five taxable years following the year in which the assessment was paid. In the event a member insurer ceases doing business, all assessments for which it has not taken a credit under this section may be credited against its premium tax liability for the year in which it ceases doing business. The amount of the credit allowed by this section may not exceed the member insurer's premium tax liability for the taxable year."

SECTION 5.(b) This section is effective for taxable years beginning on or after January 1, 2005.

SECTION 6. The North Carolina Health Insurance Risk Pool shall not offer or provide coverage under Section 1 of this act until the effective date of an act of the General Assembly that establishes a method or methods for financing the Pool as specified in Section 2 of this act.

SECTION 7. This act is effective when it becomes law.