GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

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SENATE BILL 534

Short Title:	High Risk Insurance Pool.	(Public)
Sponsors:	Senators Berger of Rockingham; Allran, Bingham, Brown, Garwood, Goodall, Hartsell, Jacumin, Stevens, and Tillman.	
Referred to:	Commerce.	

March 15, 2005

A BILL TO BE ENTITLED

AN ACT TO CREATE THE NORTH CAROLINA HEALTH INSURANCE PLAN, BASED ON THE HEALTH PLAN FOR UNINSURABLE INDIVIDUALS MODEL ACT OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, TO MEET THE NEEDS OF INDIVIDUALS WHO HAVE DIFFICULTY OBTAINING HEALTH INSURANCE.

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 Plan.

"**§ 58-50-160. Definitions.**

For the purposes of this Part:

(1) "Board" means the Board of Directors of the Plan.

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

(3) "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.

(4) "Dependent" means a resident spouse or resident unmarried child under the age of 19 years, a child who is a student under the age of 23 years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent.

(5) "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.

(6) "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.

(7) "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.

(8) "Health insurance coverage" means any hospital and medical expense incurred policy, nonprofit health care service plan 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.

(8a) "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.

(8b) "Health insurance coverage" does not include any of the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the coverage:

a. Limited-scope dental or vision benefits.

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

c. Other similar, limited benefits specified in federal regulations issued under P.L. 104-191.

(8c) "Health insurance coverage" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

a. Coverage only for a specified disease or illness.

b. Hospital indemnity or other fixed indemnity insurance.

(8d) "Health insurance coverage" does not include any of the following if offered as a separate policy, certificate, or contract of insurance:

a. Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act.

b. 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).
c. Similar supplemental coverage provided to coverage under a group health plan.

(9) "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 plan of health insurance coverage or health benefits subject to State insurance regulation.

(10) "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.

(11) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. § 1395, et seq., as amended.

(12) "Participating insurer" means any insurer providing health insurance coverage to residents of this State.

(13) "Plan" means the North Carolina Health Insurance Plan as created in this Part.

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

(15) "Resident" means an individual who 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.

(16) "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. Operation of the Plan.**

(a) There is hereby created a nonprofit entity to be known as the North Carolina Health Insurance Plan.

(b) The Plan shall operate subject to the supervision and control of the Board. The Board shall consist of the Commissioner of Insurance, who shall serve as an ex officio member of the Board, and 10 members appointed by the Commissioner. At least two Board members shall represent health insurance consumers, at least one Board member shall represent businesses other than the insurance industry, and at least two Board members shall be representatives of insurers, including the domestic company

selling the largest amount of health insurance in this State. A majority of the Board shall be composed of individuals who are not representatives of insurers.

(c) The initial Board members shall be appointed as follows: four of the members to serve a term of three years; three of the members to serve a term of one year; and three 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 his or her 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.

(d) Vacancies on the Board shall be filled by the Commissioner. Board members may be removed by the Commissioner for cause.

(e) 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.

(f) The Board shall submit to the Commissioner a plan of operation for the Plan and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Plan. 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.

(g) The plan of operation shall:

(1) Establish procedures for operation of the Plan.

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

(3) Establish procedures to create a fund, under the management of the Board, for administrative expenses.

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

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

(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 Plan 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 Plan shall have the general powers and authority granted under the laws of this State to health insurers and, in addition thereto, 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 Plan.

(3) Take such legal action as necessary to:

a. Avoid the payment of improper claims against the Plan 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 Plan as a result of mistake of fact or law.

d. Recover other amounts due the Plan.

(4) Establish, and modify from time to time 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 Plan. 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.

(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 Plan, policy, and other contract design, and any other function within the Plan's authority.

(7) Borrow money to effect the purposes of the Plan. Any notes or other evidence of indebtedness of the Plan 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 Plan coverages in their own name. Provision of reinsurance shall not subject the Plan 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 Plan.
(12) Issue additional types of health insurance policies to provide optional coverages, 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 Plan 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 Plan.

(i) The Board shall operate the Plan in a manner so that the estimated cost of providing health insurance coverage during any fiscal year will not exceed the total income the Plan expects to receive from policy premiums and funds collected through the funding mechanisms approved by the General Assembly and from other sources of revenue available to the Plan. 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 Plan 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 Plan in the preceding calendar year, including the net written and earned premiums, 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 Plan. 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. Adoption of rules.**

The Commissioner may adopt temporary rules to implement this Part.

"**§ 58-50-175. Eligibility for Plan coverage.**

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

(1) A notice of rejection or refusal to issue substantially similar insurance for health reasons by one insurer; or

(2) A refusal by an insurer to issue insurance except at a rate exceeding the Plan rate.

(b) Any federally defined eligible individual who has not experienced a significant break in coverage and who is and continues to be a resident shall be eligible for Plan coverage.

(c) A rejection or refusal by an insurer offering only stop loss, excess of loss, or reinsurance coverage with respect to an applicant under subsection (a) of this section shall not be sufficient evidence under this subsection.

(d) The Board shall adopt a list of medical or health conditions for which a person shall be eligible for Plan 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 list may be amended from time to time by the Board as the Board considers appropriate.

(e) Each resident dependent of a person who is eligible for Plan coverage shall also be eligible for Plan coverage.

(f) A person is not eligible for coverage under the Plan if:

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

a. A person may maintain other coverage for the period of time the person is satisfying any preexisting condition waiting period under a Plan policy; and

b. A person may maintain Plan coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the Plan policy.

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

(3) The person has previously terminated Plan 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 Plan has paid out the lifetime maximum benefits, which is one million dollars ($1,000,000) on behalf of the person.

(5) The person 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 person'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.

(g) Coverage under the Plan shall cease:

(1) On the date a person is no longer a resident of this State.
(2) On the date a person requests coverage to end.
(3) Upon the death of the covered person.
(4) On the date State law requires cancellation of the Plan policy.
(5) At the option of the Plan, 30 days after the Plan makes any inquiry concerning the person's eligibility or residence to which the person does not reply.

(h) Except as provided in subsection (g) of this section, a person who ceases to meet the eligibility requirements of this section may be terminated at the end of the Plan period for which the necessary premiums have been paid.

"**§ 58-50-180. Unfair referral to Plan.**

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 Plan or arrange for an individual employee to apply to the Plan for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

"**§ 58-50-185. Plan administrator.**

(a) The Board shall select a Plan administrator through a competitive bidding process to administer the Plan. 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 Plan administrator based on at least the following, as demonstrated in the bids submitted:
(1) Proven ability to handle health insurance coverage to individuals.
(2) Efficiency and timeliness of the Plan administrator's claim processing procedures.
(3) Estimated total charges for administering the Plan.
(4) Ability to apply effective cost containment programs and procedures and to administer the Plan in a cost-efficient manner.
(5) Financial condition and stability.

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

(c) The Plan administrator shall perform such functions relating to the Plan 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 persons covered under the Plan.

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

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

(e) Following the close of each calendar year, the Plan 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 Department on a form prescribed by the Commissioner.

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

"**§ 58-50-190. Premiums.**

(a) The Board shall establish premium rates for Plan coverage in accordance with this section. Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks. Premium rates and schedules shall not be applicable until approved by the Commissioner.

(b) The Board, with the assistance of the Commissioner, shall determine a 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 such coverage. Initial rates for Plan coverage shall not be less than one hundred twenty-five percent (125%) and not more than one hundred fifty percent (150%) of rates established as applicable for individual standard risks. Subject to the limits provided in this section, 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 Plan rates exceed one hundred fifty percent (150%) of rates applicable to individual standard risks.

"**§ 58-50-195. Plan benefits.**

(a) The Plan shall offer at least two types of health insurance coverage for persons 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 Plan 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 Plan, including the coverage's schedule of benefits, exclusions, and other limitation of the coverage.

"**§ 58-50-200. Preexisting conditions.**

(a) Plan 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 Plan coverage is made not later than 63 days following the involuntary termination, and in such case coverage in the Plan 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 Plan coverage.

"**§ 58-50-205. Nonduplication of benefits.**

(a) The Plan shall be payor of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under Plan 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 Plan 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 Plan may be reduced or refused as a setoff against any amount recoverable under this subsection.

"**§ 58-50-210. Collective action.**

The participation in the Plan 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 Plan or any participating insurer.

"**§ 58-50-215. Taxation.**

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

SECTION 2. The Board of Directors of the North Carolina Health Insurance Plan, as appointed under Section 1 of this act, shall recommend a method or methods for financing the Plan 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 Plan 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 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 Plan 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. Service charges 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 Plan 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 Plan 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 Plan 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 Plan."

SECTION 5. The North Carolina Health Insurance Plan 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 Plan as specified in Section 2 of this act.

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