GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H **D**

HOUSE DRH10654-LN-88 (2/19)

Short Title:	Cover NC Health Care Access Program.	(Public)
Sponsors:	Representative Neumann.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH "COVER NC," A HEALTH CARE ACCESS PROGRAM FOR UNINSURED INDIVIDUALS AND THEIR DEPENDENTS; AND TO ESTABLISH THE NC HEALTH INSURANCE MARKET CHOICES PROGRAM.

The General Assembly of North Carolina enacts:

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

"Part 7. Cover NC Health Care Access Program.

"**§ 58-50-270. Definitions.**

As used in this Part, unless the context clearly requires otherwise, the following definitions apply:

(1) "Approved entity." – A health care insurer, a health maintenance organization, a preferred provider organization, a hospital, medical, and dental service corporation, or a local health department that develops and implements an approved Cover NC plan and is responsible for administering the Plan and paying all claims for Cover NC plan coverage by enrollees.

(2) "Board." or "Board of Directors." – The Board of Directors of the North Carolina Health Insurance Risk Pool.

(3) "Cover NC." – the Cover NC Health Care Access Program established under this Part.

(4) "Cover NC Plus." – a supplemental insurance product, such as for additional catastrophic coverage or dental, vision, or cancer coverage, approved under this Part and offered to all enrollees.

(5) "Department." – The North Carolina Department of Insurance.

(6) "Health benefit plan." and "Insurer." – the definitions applicable under G.S. 58-3-167.

(7) "Plan." or "Plans." – Approved Cover NC health care plans offered by approved entities.

(8) "Program." – The Cover NC Health Care Access Program.

"**§ 58-50-271. Findings.**

(a) The General Assembly finds that a significant number of State residents are unable to obtain affordable health insurance coverage. One approach to providing health care access to uninsured individuals and their families is the development of a health care product that:

(1) Emphasizes coverage for basic and preventive health care services;

(2) Provides inpatient hospital, urgent, and emergency care services; and

(3) Is offered statewide by approved health insurers, health maintenance organizations, preferred provider organizations, hospital, medical, and dental service corporations, and local health departments.

"**§ 58-50-272. Program established.**

(a) There is established the Cover NC Health Care Access Program. The Program shall be administered by the Board of Directors of the North Carolina Health Insurance Risk Pool and shall contain the following components:

(1) Plans offered under the Program shall be offered on a guaranteed-issue basis to enrollees, subject to exclusions for preexisting conditions approved by the Board.

(2) Plans are portable such that the enrollee remains covered regardless of employment status or the cost-sharing of premiums.

(3) Plans provide for cost containment through limits on the number of services, caps on benefit payments, and copayments for services.

(4) An approved entity makes all benefit plan marketing materials available in English and Spanish.

(5) Approved entities shall develop and offer two alternative benefit option plans having different cost and benefit levels, including at least one plan that provides catastrophic coverage.

(6) Plans that do not offer catastrophic coverage must provide coverage options for services including:

a. Preventive health services, including immunizations, annual health assessments, well-woman and well-care services, and preventive screenings such as mammograms, cervical cancer screenings, and noninvasive colorectal or prostate screenings.

b. Incentives for routine preventive care.

c. Office visits for the diagnosis and treatment of illness or injury.

d. Office or outpatient surgery, including anesthesia.

e. Behavioral health services.

f. Durable medical equipment and prosthetics.

g. Diabetic supplies.

(7) Plans that provide catastrophic coverage shall provide coverage options for all of the services listed under subdivision (6) of this subsection and may also include coverage for:

a. Inpatient hospital stays.

b. Hospital emergency care services.

c. Urgent care services.

d. Outpatient facility services, outpatient surgery, and outpatient diagnostic services.

(8) Plans shall offer prescription drug benefit coverage and shall use a prescription drug manager or offer a discount drug card for covering drug benefits.

(9) Plan enrollment materials providing information in plain language on policy benefit coverage, benefit limits, cost-sharing requirements, and exclusions and a clear representation of what is not covered in the plan. The enrollment materials shall include a standard disclosure form adopted approved by the Commissioner of Insurance, which must be reviewed and signed by all consumers purchasing Cover NC plans.

(10) Plans offered through a qualified employer must meet the requirements of section 125 of the Internal Revenue Code.

(b) The Department shall develop guidelines to ensure that Cover NC plans meet minimum standards for quality of care and access to care and the plans follow standardized grievance procedures.

(c) Changes to plan benefits, premiums, and policy forms are subject to regulatory oversight by the Department in accordance with rules adopted by the Department for this purpose.

(d) The Department shall develop a public awareness program that shall be implemented throughout the State for the promotion of the Program.

"**§ 58-50-273. Plan proposals.**

(a) The Department shall announce an invitation to negotiate for Cover NC plan entities to design a Cover NC plan proposal in which benefits and premiums are specified. The invitation to negotiate shall include guidelines for the review of Cover NC plan applications, policy forms, and all associated forms, and shall provide regulatory oversight of plan advertisement and marketing procedures. The guidelines shall state that a plan shall be disapproved or withdrawn if any of the following apply to the plan:

(1) Contains ambiguous, inconsistent, or misleading provisions or exceptions or conditions that deceptively affect or limit the benefits proposed to be assumed in the general coverage provided under the plan.

(2) Provides benefits that are unreasonable in relation to the premium charged or contains provisions that are unfair or inequitable, that are contrary to the public policy of this State, that encourage misrepresentation, or that result in unfair discrimination in sales practices.

(3) Cannot demonstrate that the plan is financially sound and that the applicant is able to underwrite or finance the health care coverage provided.

(4) Cannot demonstrate that the applicant for plan approval and its management are in compliance with the standards established by the Commissioner in accordance with this Article.

(5) Does not guarantee that enrollees may participate in the approved entity's comprehensive network of providers as determined by the Department.

(b) The Department may announce an invitation to negotiate for the design of Cover NC Plus products to companies that are authorized under this Chapter to offer supplemental insurance or other similar products.

(c) The Board, in consultation with the Department, shall approve the plan or plans of at least one approved entity having an existing statewide network of providers.

"**§ 58-50-274. License not required; exemption from mandated benefits.**

(a) Unless otherwise made applicable under this Part, the licensure requirements of this Chapter do not apply to a Cover NC plan approved under this Part. Article 63 of this Chapter applies to Cover NC plans approved under this Part.

(b) Sections of this Chapter mandating benefits under health insurance plans authorized under this Chapter do not apply to Cover NC plans approved under this Part.

(c) Cover NC plans are not covered under Article 62 of this Chapter.

"**§ 58-50-275. Eligibility to enroll in Cover NC plans.**

(a) Enrollment in a Cover NC approved plan is limited to residents of North Carolina who:

(1) Are between 19 and 64 years of age, inclusive;

(2) Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program such as Medicare, Medicaid, NC Health Choice, or NC Kids' Care unless eligibility for the public health insurance program lapses due to no longer meeting income or categorical requirements of the public health insurance program;

(3) Have not been covered by any health insurance program at any time during the six months previous to application for enrollment in Cover NC, unless coverage under a health insurance program was terminated within the previous six months due to:

a. Loss of a job that provided an employer-sponsored health benefit plan;

b. Exhaustion of coverage that was continued under COBRA or other continuation-of-coverage requirements of this Chapter;

c. Reaching the age limit under the policy;

d. Death of or divorce from a spouse who was provided an employer-sponsored health benefit plan; and

(4) Have applied for health care coverage through a Cover NC plan and have agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided.

"**§ 58-50-276. Maintenance of records; no entitlement; program evaluation; reporting; rules.**

(a) Each approved plan under Cover NC shall maintain enrollment data and provide network data and reasonable records to enable the Department and the Board to monitor approved plans and to determine the financial viability of the Cover NC approved plan, as necessary.

(b) Coverage under the Program or an approved plan is not an entitlement, and a cause of action does not arise against the State, a local government entity, the Department, the Board, or any other entity for failure to make coverage available to eligible persons under this Part.

(c) The Department and the Board shall:

(1) Evaluate the Cover NC Health Care Access Program and its effect on the entities that seek approval as Cover NC plans, on the number of enrollees, and on the scope of the health care coverage offered under the plan.

(2) Provide an assessment of the Cover NC plans and their potential applicability in other settings.

(3) Use Cover NC plans to gather more information to evaluate low-income, consumer-driven benefit packages.

(d) The Department and the Board shall report annually to the Governor and the General Assembly on the implementation and administration of the Program.

(e) The Department may adopt rules to implement this Part.

§§ 58-50-246 through 58-50-249: Reserved for future codification purposes.

SECTION 2. Article 50 of Chapter 58 of the General Statutes is amended by adding the following new Part to read:

"Part 8. NC Health Insurance Competitive Market Program.

"**§ 58-50-280. Definitions.**

As used in this Part, the following terms have the meanings applied:

(1) "Corporation." – the NC Health Insurance Market Corporation.

(2) "Department." – the North Carolina Department of Insurance.

(3) "Insurer." – has the meaning applied under G.S. 58-3-167.

(4) "Program." – the NC Health Insurance Competitive Market Program.

"**§ 58-50-281. Findings, program established.**

(a) The General Assembly finds that increasing access to affordable, quality health care can be best accomplished by establishing a competitive market for purchasing health insurance and health services.

(b) There is established the NC Health Insurance Competitive Market Program. The purposes of the Program are to:

(1) Expand opportunities for North Carolinians to purchase affordable health insurance and health services.
(2) Preserve the benefits of employment-sponsored insurance while easing the administrative burden for employers who offer these benefits.
(3) Enable individual choice in both the manner and amount of health care purchased.
(4) Provide for the purchase of individual, portable health care coverage.
(5) Disseminate information to consumers on the price and quality of health services.
(6) Sponsor a competitive market that stimulates product innovation, quality improvement, and efficiency in the production and delivery of health services.

"**§ 58-50-282. Program components.**

(a) The NC Health Insurance Competitive Market Program is established as a single, centralized market for the sale and purchase of various products that enable individuals to pay for health care. These products include health insurance plans, health maintenance organization plans, prepaid services, service contracts, and flexible spending accounts.

(b) Program components include:
(1) Enrollment of employers.
(2) Administrative services for participating employers, including:
a. Assistance in seeking federal approval of cafeteria plans.
b. Collection of premiums and other payments.
c. Management of individual benefit accounts.
d. Distribution of premiums to insurers and payments to other eligible vendors.
e. Assistance for participants in complying with reporting requirements.
(3) Services to individual participants, including:
a. Information about available products and participating vendors.
b. Assistance with assessing the benefits and limits of each product, including information necessary to distinguish between policies offering creditable coverage and other products available through the Program.
c. Account information to assist individual participants with managing available resources.
d. Services that promote healthy behaviors.
(4) Recruitment of vendors, including insurers, health maintenance organizations, prepaid clinic service providers, provider service networks, and other providers.
(5) Certification of vendors to ensure capability, reliability, and validity of offerings.
(6) Collection of data, monitoring assessment, and reporting of vendor performance.
(7) Information services for individuals and employers.
(8) Program evaluation.

(c) Eligibility and Participation. – Participation in the Program is voluntary and shall be available to employers, individuals, vendors, and health insurance agents as provided in this Part.
(1) Employers eligible to enroll in the program include:
a. Employers that have one to 50 employees, inclusive.
b. Tier 1 and 2 counties as defined in G.S. 143B-437.08(a).
c. Municipalities having populations of fewer than 50,000 residents.

d. School districts in Tier 1 and Tier 2 counties.

(2) Individuals eligible to participate in the Program include:

a. Individual employees of enrolled employers.

b. Individuals not covered by insurance and not eligible for government provided health insurance.

(3) Employers that choose to participate in the Program may enroll by complying with the procedures established by the NC Health Insurance Market Corporation. The procedures shall include:

a. Submission of required information.

b. Compliance with federal tax requirements for the establishment of a cafeteria plan, including designation of the employer's plan as a premium payment plan, a salary reduction plan that has flexible spending arrangements, or a salary reduction plan that has a premium payment and flexible spending arrangements.

c. Determination of the employer's contribution, if any, per employee. If an employer makes a contribution for coverage, the contribution must be equal for each eligible employee.

d. Establishment of payroll deduction procedures, subject to the agreement of each individual employee who voluntarily participates in the Program.

e. Designation of the Corporation as the third-party administrator for the employer's health benefit plan.

f. Identification of eligible employees.

g. Arrangement for periodic payments.

h. Employer notification to employees of the intent to transfer from an existing employee health plan to the Program at least 90 days before the transition becomes effective.

(4) Eligible vendors and the products and services that the vendors are permitted to sell are as follows:

a. Insurers licensed under this Chapter may sell health insurance policies, limited benefit policies, other risk-bearing coverage, and other products or services.

b. Health maintenance organizations licensed under Article 67 of this Chapter may sell health insurance policies, limited benefit policies, other risk-bearing products, and other products or services.

c. Prepaid health clinic service providers licensed under this Chapter may sell prepaid service contracts and other arrangements for a specified amount and type of health services or treatments.

d. Health care providers, including hospitals and other licensed health facilities, health care clinics, licensed health professionals, pharmacies, and other licensed health care providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

e. Provider organizations, including service networks, group practices, professional associations, and other incorporated organizations of providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

f. Corporate entities providing specific health services in accordance with applicable State law may sell service contracts and arrangements for a specified amount and type of health services or treatments.

(5) A vendor described in sub-subdivision c. through f. of subdivision (4) of this subsection may not sell products that provide risk-bearing coverage unless that vendor is authorized under a certificate of authority issued by the Department. Otherwise eligible vendors may be excluded from participating in the program for deceptive or predatory practices, financial insolvency, or failure to comply with the terms of the participation agreement or other standards set by the Corporation.

(6) Health care providers, including hospitals and other licensed health facilities, health care clinics, licensed health professionals, pharmacies, and other licensed health care providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

(7) Provider organizations, including service networks, group practices, professional associations, and other incorporated organizations of providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

(8) Corporate entities providing specific health services in accordance with applicable State law may sell service contracts and arrangements for a specified amount and type of health services or treatments.

(9) Eligible individuals may voluntarily continue participation in the program regardless of subsequent changes in job status or Medicaid eligibility. Individuals who join the program may participate by complying with the procedures established by the Corporation. These procedures must include, but are not limited to:

a. Submission of required information.
b. Authorization for payroll deduction.
c. Compliance with federal tax requirements.
d. Arrangements for payment in the event of job changes.
e. Selection of products and services.

(10) Vendors who choose to participate in the program may enroll by complying with the procedures established by the corporation. These procedures must include, but are not limited to:

a. Submission of required information, including a complete description of the coverage, services, provider network, payment restrictions, and other requirements of each product offered through the program.
b. Execution of an agreement to make all risk-bearing products offered through the program guaranteed-issue policies, subject to preexisting-condition exclusions established by the corporation.
c. Execution of an agreement that prohibits refusal to sell any offered non-risk-bearing product to a participant who elects to buy it.
d. Establishment of product prices based on age, gender, and location of the individual participant.
e. Arrangements for receiving payment for enrolled participants.
f. Participation in ongoing reporting processes established by the corporation.
g. Compliance with grievance procedures established by the Corporation.

(11) Health insurance agents licensed under this Chapter are eligible to voluntarily participate as buyers' representatives. A buyer's representative acts on behalf of an individual purchasing health insurance and health services through the program by providing information about products and services available through the program and assisting the individual with the

decision and the procedure of selecting specific products. Serving as a buyer's representative does not constitute a conflict of interest with continuing responsibilities as a health insurance agent if the relationship between each agent and any participating vendor is disclosed before advising an individual participant about the products and services available through the program. In order to participate, a health insurance agent shall comply with the procedures established by the Corporation, including:

a. Completion of training requirements.

b. Execution of a participation agreement specifying the terms and conditions of participation.

c. Disclosure of any appointments to solicit insurance or procure applications for vendors participating in the program.

d. Arrangements to receive payment from the corporation for services as a buyer's representative.

(d) Products. – The products that may be made available for purchase through the program include, but are not limited to:

(1) Health insurance policies.

(2) Limited benefit plans.

(3) Prepaid clinic services.

(4) Service contracts.

(5) Arrangements for purchase of specific amounts and types of health services and treatments.

(6) Flexible spending accounts.

(7) Health insurance policies, limited benefit plans, prepaid service contracts, and other contracts for services must ensure the availability of covered services and benefits to participating individuals for at least one full enrollment year.

(8) Products may be offered for multiyear periods provided the price of the product is specified for the entire period or for each separately priced segment of the policy or contract.

(9) The corporation shall provide a disclosure form for consumers to acknowledge their understanding of the nature of, and any limitations to, the benefits provided by the products and services being purchased by the consumer.

(e) Pricing. – Prices for the products sold through the program must be transparent to participants and established by the vendors based on age, gender, and location of participants. The Corporation shall develop a methodology for evaluating the actuarial soundness of products offered through the program. The methodology shall be reviewed by the Department prior to use by the Corporation. Before making the product available to individual participants, the Corporation shall use the methodology to compare the expected health care costs for the covered services and benefits to the vendor's price for that coverage. The results shall be reported to individuals participating in the program. Once established, the price set by the vendor must remain in force for at least one year and may only be redetermined by the vendor at the next annual enrollment period. The Corporation shall annually assess a surcharge for each premium or price set by a participating vendor. The surcharge may not be more than 2.5 percent of the price and shall be used to generate funding for administrative services provided by the Corporation and payments to buyers' representatives.

(f) Exchange Process. – The program shall provide a single, centralized market for purchase of health insurance and health services. Purchases may be made by participating individuals over the Internet or through the services of a participating health insurance agent. Information about each product and service available through the program shall be made

available through printed material and an interactive Internet Web site. A participant needing personal assistance to select products and services shall be referred to a participating agent in the agent's area.

(1) Participation in the program may begin at any time during a year after the employer completes enrollment and meets the requirements specified by the Corporation.

(2) Initial selection of products and services must be made by an individual participant within 60 days after the date the individual's employer qualified for participation. An individual who fails to enroll in products and services by the end of this period is limited to participation in flexible spending account services until the next annual enrollment period.

(3) Initial enrollment periods for each product selected by an individual participant must last at least 12 months, unless the individual participant specifically agrees to a different enrollment period.

(4) If an individual has selected one or more products and enrolled in those products for at least 12 months or any other period specifically agreed to by the individual participant, changes in selected products and services may only be made during the annual enrollment period established by the corporation.

(5) The limits established in subsections (b)-(d) apply to any risk-bearing product that promises future payment or coverage for a variable amount of benefits or services. The limits do not apply to initiation of flexible spending plans if those plans are not associated with specific high-deductible insurance policies or the use of spending accounts for any products offering individual participants specific amounts and types of health services and treatments at a contracted price.

(g) Consumer Information. – The corporation shall establish a secure Web site to facilitate the purchase of products and services by participating individuals. The Web site must provide information about each product or service available through the program.

(1) Prior to making a risk-bearing product available through the program, the Corporation shall provide information regarding the product to the Department. The Department shall review the product information and provide consumer information and a recommendation on the risk-bearing product to the Corporation within 30 days after receiving the product information.

(2) Upon receiving a recommendation that a risk-bearing product should be made available in the marketplace, the corporation may include the product on its Web site. If the consumer information and recommendation is not received within 30 days, the Corporation may make the risk-bearing product available on the Web site without consumer information from the office.

(3) Upon receiving a recommendation that a risk-bearing product should not be made available in the marketplace, the risk-bearing product may be included as an eligible product in the marketplace and on its Web site only if a majority of the board of directors votes to include the product.

(4) If a risk-bearing product is made available on the Web site, the Corporation shall make the consumer information and office recommendation available on the Web site and in print format. The Corporation shall make late-submitted and ongoing updates to consumer information available on the Web site and in print format.

(h) Risk Pooling. – The program shall utilize methods for pooling the risk of individual participants and preventing selection bias. These methods shall include, but are not limited to, a

post-enrollment risk adjustment of the premium payments to the vendors. The corporation shall establish a methodology for assessing the risk of enrolled individual participants based on data reported by the vendors about their enrollees. Monthly distributions of payments to the vendors shall be adjusted based on the assessed relative risk profile of the enrollees in each risk-bearing product for the most recent period for which data are available.

(i) Exemptions. –

(1) Policies sold as part of the program are not subject to the licensing requirements of this Chapter.

(2) The Corporation may act as an administrator but is not required to be certified pursuant to this Chapter. However, a third party administrator used by the Corporation must be certified under this Chapter.

"**§ 58-50-283. NC Health Insurance Market Corporation established.**

(a) There is created the NC Health Insurance Market Corporation, Inc., a nonprofit organization. The purpose of the Corporation is to administer the program created in this section and to conduct such other business as may further the administration of the program.

(b) The Corporation shall be governed by a 15-member Board of Directors ("Board") consisting of:

(1) Three ex officio, nonvoting members to include:

a. The Commissioner of Insurance.

b. The Secretary of the Department of Health and Human Services.

c. The Secretary of the Department of Administration.

(2) Four members appointed by the Governor.

(3) Four members appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate.

(4) Four members appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives.

(c) Board members may not include insurers, health insurance agents or brokers, health care providers, health maintenance organizations, prepaid service providers, or any other entity, affiliate or subsidiary of eligible vendors.

(d) Members shall be appointed for terms of up to three years. Any member is eligible for reappointment. A vacancy on the Board shall be filled for the unexpired portion of the term in the same manner as the original appointment.

(e) The board shall select a chief executive officer for the Corporation who shall be responsible for the selection of such other staff as may be authorized by the Corporation's operating budget as adopted by the board.

(d) Board members shall receive no compensation but shall receive travel and per diem expenses in accordance with Chapter 138 of the General Statutes.

(e) There is no liability on the part of, and no cause of action shall arise against, any member of the Board or its employees or agents for any action taken by them in the performance of their powers and duties under this section.

(f) The Board shall develop and adopt bylaws and other corporate procedures as necessary for the operation of the Corporation and carrying out the purposes of this section. The bylaws shall:

(1) Specify procedures for selection of officers and qualifications for reappointment, provided that no board member shall serve more than nine consecutive years.

(2) Require an annual membership meeting that provides an opportunity for input and interaction with individual participants in the program.

(3) Specify policies and procedures regarding conflicts of interest, which prohibit a member from participating in any decision that would inure to the benefit of the member or the organization that employs the member. The

policies and procedures shall also require public disclosure of the interest that prevents the member from participating in a decision on a particular matter.

(g) The Corporation may exercise all powers granted to it and necessary to carry out the purposes of this section, including, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value to be held, used, and applied for the purposes of this section.

(h) The Corporation may establish technical advisory panels consisting of interested parties, including consumers, health care providers, individuals with expertise in insurance regulation, and insurers.

(i) The Corporation shall:

(1) Determine eligibility of employers, vendors, individuals, and agents.

(2) Establish procedures necessary for the operation of the program, including, but not limited to, procedures for application, enrollment, risk assessment, risk adjustment, plan administration, performance monitoring, and consumer education.

(3) Arrange for collection of contributions from participating employers and individuals.

(4) Arrange for payment of premiums and other appropriate disbursements based on the selections of products and services by the individual participants.

(5) Establish criteria for disenrollment of participating individuals based on failure to pay the individual's share of any contribution required to maintain enrollment in selected products.

(6) Establish criteria for exclusion of vendors in accordance with this Part.

(7) Develop and implement a plan for promoting public awareness of and participation in the program.

(8) Secure staff and consultant services necessary to the operation of the program.

(9) Establish policies and procedures regarding participation in the program for individuals, vendors, health insurance agents, and employers.

(10) Develop a plan, in coordination with the Department of Revenue, to establish tax credits or refunds for employers that participate in the program. The Corporation shall submit the plan to the Governor, the General Assembly, and the Commissioner of Insurance, by January 1, 2011.

(j) Report. – Beginning in the 2009-2010 fiscal year, the Corporation shall submit by February 1 an annual report to the Governor, the General Assembly, and the Commissioner of Insurance documenting the Corporation's activities in compliance with its duties set forth in this Part.

(k) Program Integrity. – To ensure program integrity and to safeguard the financial transactions made under the auspices of the program, the Corporation is authorized to establish qualifying criteria and certification procedures for vendors, require performance bonds or other guarantees of ability to complete contractual obligations, monitor the performance of vendors, and enforce the agreements of the program through financial penalty or disqualification from the program."

SECTION 3. There is appropriated from the General Fund to the Department of Insurance the sum of one million dollars ($1,000,000) for the 2009-2010 fiscal year. These funds shall be allocated by the Commissioner of Insurance only for activities necessary to implement Parts 7 and 8 of Article 50 of Chapter 58 of the General Statutes, as enacted by this act, on January 1, 2011.

SECTION 4. This act becomes effective January 1, 2011.